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S3 LEITLINIE

Borderline-Persönlichkeitsstörung

Leitlinienreport | Fassung vom 14.11.2022

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S3-Leitlinie
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Federführende/Herausgebende Fachgesellschaft:

Deutsche Gesellschaft für Psychiatrie und Psychotherapie, Psychosomatik und Nervenheilkunde e. V. (DGPPN)

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Borderline-Persönlichkeitsstörung, emotional-instabile Persönlichkeitsstörung, Persönlichkeitsstörungen

Keywords:

borderline personality disorder, emotionally unstable personality disorder, personality disorders

Inhalt

1. Geltungsbereich und Zweck

1.1 Begründung für die Auswahl des Leitlinienthemas

Die Borderline-Persönlichkeitsstörung (BPS) tritt in etwa bei 1.5% der Allgemeinbevölkerung auf[1,2]. Sie wird häufiger bei Frauen diagnostiziert (in etwa drei Viertel aller Diagnosen betreffen Frauen[3]), wobei einige Studien darauf hinweisen, dass sie bei Männern tatsächlich in etwa gleich häufig ist[4]. In der klinischen Versorgung werden Menschen mit BPS häufig erstmals in krisenhaften Situationen vorstellig [5]. Suizidales Verhalten ist häufig und tritt ungefähr bei 70% aller Betroffenen im Laufe Ihrer Erkrankung auf [6].
Die Entwicklung und Erforschung möglicher Ansätze zur Behandlung der Borderline-Persönlichkeitsstörung (BPS) hat in den letzten Jahren große Fortschritte gemacht, nachdem sie lange Zeit als therapeutisch kaum zugänglich galt. Sowohl auf psychotherapeutischer als auch medikamentöser Ebene werden vielerlei verschiedene Ansätze vorgeschlagen. Dennoch bestehen in der Praxis erhebliche Optimierungspotenziale bezüglich Diagnostik, Indikationsstellung und Therapie der BPS, insbesondere auch beim Vorliegen komorbider Erkrankungen. Dies betrifft ebenso Hilfsmöglichkeiten für Angehörige, welche häufig ebenfalls eine hohe Belastung aufweisen [7].

1.2 Zielorientierung der Leitlinie

Die Klassifikationssysteme DSM-5[8] und ICD-10[9]sprechen von einer Persönlichkeitsstörung, wenn bei einer Person bestimmte Verhaltens-, Gefühlsund Denkmuster vorhanden sind, die merklich von den Erwartungen der soziokulturellen Umgebung abweichen und sich in einem breiten Spektrum sozialer und persönlicher Situationen bemerkbar machen. Dabei sind die Persönlichkeitszüge überdauernd vorhanden, unflexibel und wenig angepasst und führen in klinisch bedeutsamer Weise zu Leiden oder Beeinträchtigung in sozialen, beruflichen oder anderen wichtigen Funktionsbereichen. Dies kann sich in mangelnder Beziehungsfähigkeit und Isolation oder in konflikthaft und instabil verlaufenden Beziehungen ausdrücken, oder aber die Balance zwischen Nähe und Autonomie stören. Dabei kann die Person selbst dieses Muster problematisch und veränderungswürdig erleben oder nicht.

Die Emotional instabile (ICD-10) bzw. Borderline-Persönlichkeitsstörung (BPS; DSM-5) manifestiert sich als eine schwerwiegende Störung der Affektregulation, begleitet von tiefgreifenden Störungen des Selbstbildes und des zwischenmenschlichen Verhaltens[10]. Meist manifestiert sich die Problematik bereits in der frühen Adoleszenz[11]. Ausgeprägte Stimmungsschwankungen und schwere Selbstzweifel sind begleitet von dysfunktionalen Mustern auf der Verhaltensebene, wie beispielsweise Selbstverletzungen, Suizidversuchen, Drogenproblemen und Essstörungen. Die meisten klinischen Auffälligkeiten lassen sich entweder als Folge einer gestörten Affektregulation verstehen oder als (dysfunktionaler) Versuch, diese zu bewältigen [12]. So werden etwa Selbstverletzungen oder auch Essanfälle oder Alkoholabusus häufig zur Milderung von intensiven Erregungszuständen eingesetzt. Langfristig können sich diese dysfunktionalen Kompensationsmechanismen als komorbide Störungen manifestieren, welche die Entwicklung der Symptomatik negativ beeinflussen und die Therapie häufig erschweren.

Die Leitlinie verfolgt folgende Gesamtziele:

- Verbesserung der Erkennung ***und differenziellen*** Diagnostik von BPS
- Verbesserung der Versorgung von Menschen mit BPS, Linderung ihrer Belastung und ihres Leids

- Zusammenfassung der aktuellen Evidenz zur absoluten und relativen Wirksamkeit und Effizienz vorhandener Behandlungsmöglichkeiten
- Orientierungshilfen für Akteure des Gesundheitswesens innerhalb des deutschen Gesundheitssystems, basierend auf evidenz- bzw. (im Falle unzureichender Evidenz) konsensbasierter Empfehlungen
- Verbesserung der Unterstützung von Familien und Angehörigen von Menschen mit BPS
- Hilfestellungen zur Organisation und Abstimmung verschiedener Versorgungsbereiche und Hilfsmöglichkeiten
- ***Vermeidung nicht hilfreicher oder schädlicher Interventionen***

Erwartete Effekte:

- Rechtzeitige und präzise Indikationsstellung
- Verbesserung der Versorgung durch Empfehlung adäquater Therapiemöglichkeiten und Hilfen für Betroffene und Angehörige sowie Nicht-Empfehlung nicht hilfreicher oder schädlicher Interventionen und Angebote
- Optimierung von Schnittstellen innerhalb des Gesundheitssystems
- Effektive Verbreitung und Umsetzung der Empfehlungen durch Einbeziehung und Konsensbildung verschiedener Professionen, Organisationen und von Betroffenen in die Leitlinienerstellung

1.3 Zielpopulation

Der Geltungsbereich dieser Leitlinie umfasst Menschen mit Voll- oder Teilbild einer Borderline-Persönlichkeitsstörung, ab einem Behandlungsalter von 12 Jahren. Eingeschlossen werden ebenfalls alle Arten psychiatrischer und nichtpsychiatrischer Komorbiditäten. Die gängigere Bezeichnung **„Borderline-Persönlichkeitsstörung**“ entstammt dem Diagnostischen und Statistischen Manual Psychischer Störungen (**DSM 301.83**[8,13], während die im deutschen Sprachraum übliche ICD-10 Klassifikation[9] jedoch von der **„Emotional-instabilen Persönlichkeitsstörung“** (F60.3) spricht. Die Emotional-instabile Persönlichkeitsstörung umfasst wiederum die Subtypen **„impulsiver Typ“ (F60.30)** und **„Borderline-Typ“ (F60.31)**, wobei letztere den DSM-Kriterien mehr ähnelt. Ebenso sind Personen, die mit der Einführung des ICD-11 diagnostiziert werden, in die Zielpopulation dieser Leitlinie eingeschlossen. Die dort vergebene Diagnose lautet **„Persönlichkeitsstörung, Borderline-Muster“ (6D11.5)**[14] und entspricht der DSM-5-Diagnose DSM 301.83. Der Versorgungsrealität entsprechend werden ausdrücklich Patientinnen und Patienten mit jeglicher Art psychischer und somatischer Komorbidität eingeschlossen. Die häufigsten Komorbiditäten umfassen affektive Störungen, insbesondere depressive und Angsterkrankungen, substanzbezogene Störungen, Essstörungen, Posttraumatische Belastungsstörungen, Aufmerksamkeitsdefizit und Hyperaktivitätsstörung (ADHS) sowie anderweitige Persönlichkeitsstörungen[4,15–17].

Die Leitlinie befasst sich ebenso mit Versorgung und Hilfsangeboten für **Angehörige** von Menschen mit Voll- oder Teilbild einer BPS, da diese häufig ebenfalls sehr belastet sind[7,18–20].

1.4 Versorgungsbereich

Die Leitlinie richtet sich an alle ambulanten, teilstationären und stationären Versorgungsbereiche des deutschen Gesundheits- und Sozialwesens. Grundsätzlich sind sowohl der

Jugendlichen- wie auch der Erwachsenenbereich eingeschlossen, insbesondere auch Einrichtungen der Jugendhilfe.

1.5 Adressierte und potenziell Anwendende der Leitlinien

Die Leitlinie richtet sich an alle Agierenden, die an der Versorgung von Menschen mit einer BPS beteiligt sind:

- Fachärztinnen und -ärzte für Psychiatrie und Psychotherapie
- Fachärztinnen und -ärzte für Psychosomatische Medizin und Psychotherapie
- Fachärztinnen und -ärzte für Kinder- und Jugendpsychiatrie und -psychotherapie
- Psychologische und Ärztliche Psychotherapeutinnen und Psychotherapeuten Kinder- und Jugendlichenpsychotherapeutinnen und -psychotherapeuten
- Klinisch tätige Psychologinnen und Psychologen
- Fachpflegepersonal

Zudem richtet sich die Leitlinie an

- alle Menschen mit Diagnose, Verdacht auf oder mit Teilbild einer BPS und an
- deren Angehörige bzw. Bezugs-, Vertrauens- oder Betreuungspersonen.
- alle weiteren Personen, die mit Menschen mit einer BPS in Kontakt stehen.

Sie dient zur Information für

- weitere haus- und fachärztlich Tätigen, die in die Versorgung von betroffenen Personen einbezogen sind (u.a. Fachärztinnen und Fachärzte für Nervenheilkunde, Fachärztinnen und Fachärzte für Allgemeinmedizin und andere hausärztlich tätige Ärztinnen und Ärzte, Fachärztinnen und Fachärzte für Neurologie)
- Sozialarbeiterinnen und Sozialarbeiter
- Fachtherapeutinnen und -therapeuten
- Krankenpflegepersonal
- Entscheidungs- und Kostenträger im Gesundheitswesen.

2. Zusammensetzung der Leitliniengruppe: Beteiligung von Interessengruppen

Die Konsensgruppe bestand aus allen Stimmberechtigten. Alle beteiligten Organisationen, Verbände und Fachgesellschaften besaßen jeweils eine Stimme. Die Konsensgruppe sprach sich im Rahmen der konstituierenden Sitzung am 09.10.2017 in Berlin dafür aus, dass bei den Sitzungen jeweils nur der oder die benannte Mandatstragende oder deren stellvertretend Mandatstragenden anwesend sein sollten. Eine Ausnahme bildeten die Betroffenen- und Angehörigenvertreter, die sowohl mit Hauptmandatsträgerin und Stellvertreterin anwesend sein konnten, jedoch ebenfalls nur über eine Stimme verfügten (Beschlussfassung Konsensgruppe vom 05.03.2018).

2.1 Repräsentativität der Leitliniengruppe: Beteiligte Berufsgruppen

Die für den Anwenderkreis der Leitlinie repräsentativ zusammengestellte Konsensusgruppe umfasste die an der therapeutischen Versorgung von Menschen mit BPS maßgeblich beteiligten Fachgesellschaften und Berufsverbände.

In der Konsensgruppe waren folgende Fachrichtungen vertreten: Mediziner, Psychologen, Sozialpädagogen, Sozialarbeiter, Pflegewissenschaftler, Pädagogen, Pflegefachpersonen, Gesundheitswissenschaftler, Gesundheitsökonomen. Die beteiligten Fachgesellschaften, Organisationen und Berufsverbände wurden erstmals durch den Leitlinienkoordinator Prof. Lieb angesprochen und zur Mitarbeit eingeladen. Kriterien hierfür waren: Mitgliedschaft in der AWMF, thematische Relevanz und (nach Möglichkeit) Vorerfahrung in der Erstellung thematisch ähnlicher Leitlinien.

2.2 Repräsentativität der Leitliniengruppe: Berücksichtigung der Ansichten und Präferenzen der Zielpopulationen

Der Konsensgruppe selbst oblag es, ihre Vollständigkeit zu überprüfen und festzustellen. Im Rahmen der konstituierenden Auftaktsitzung am 09.10.2017 in Berlin wurden insbesondere mit dem Anliegen, eine ausgeglichene Repräsentierung der großen Therapieschulen sowie der wesentlichen BPS-spezifischen Therapieansätze zu erreichen, verschiedene Fachgesellschaften nachnominiert: Deutsche Fachgesellschaft Psychiatrische Pflege e. V. (DFPP), Deutsche Gesellschaft für Systemische Therapie, Beratung und Familientherapie (DGSF), Deutsche Psychoanalytische Vereinigung (DPV) sowie als Vertreterin der Mentalisierungsbasierten Therapie im deutschsprachigen Bereich Frau Prof. Taubner. Zusätzlich wurde die Deutsche Gesellschaft für Gesundheitsökonomie e. V. (DGGÖ) um Ihre Teilnahme gebeten.

Im Zuge der Konkretisierung der zu bearbeitenden Fragestellungen entschloss sich die Konsensgruppe bei ihrer zweiten Sitzung am 05.03.2018 in Berlin, weitere Verbände aus dem Kinder- und Jugendbereich nachzubenennen, die Vereinigung Analytischer Kinder- und Jugendlichenpsychotherapeuten in Deutschland (VAKJP) sowie den Berufsverband der Kinder- und Jugendlichenpsychotherapeutinnen und Kinder- und Jugendlichenpsychotherapien (bkj). Alle eingeladenen Fachgesellschaften und Verbände waren bereit, an der Leitlinienerstellung mitzuarbeiten.

Die Betroffenen- und Angehörigenperspektive wurde von Beginn an in allen Konsensrunden durch die stimmberechtigte Vertreterin des Borderline Trialog e. V. abgebildet.

2.3 Konsensrunde

Folgende Fachgesellschaften und Organisationen waren durch die untentstehenden Mandatstragenden und Stellvertretend Mandatstragenden an den Konsensrunden und der Leitlinienerstellung beteiligt (Tabelle 1):

	Fachgesellschaft/Organisation	Mandatstragende
BDP	Berufsverband deutscher Psychologinnen und Psychologen e. V.	Dipl.-Psych. Ralph Schliewenz Dipl.-Psych. Inge Neiser (Stv.)

BKJ	Berufsverband für Kinder- und Jugendlichenpsychotherapie e. V.	Dipl.-Soz.päd. Beate Leinberger, M.A. Dipl.-Soz.päd. Kerstin Kubesch (Stv.)
	Borderline-Trialog	Dipl.-Soz.päd. Anja Link Katrin Zeddies, B.Sc. (Stv.)
BPtK	Bundespsychotherapeutenkammer	Dr. Andrea Benecke Dr. Alessa Jansen (Stv.)
bvvp	Bundesverband der Vertragspsychotherapeuten	Dipl.-Psych. Rainer Cebulla Dipl.-Päd. Ariadne Sartorius (Stv.)
DÄVT	Deutsche Ärztliche Gesellschaft für Verhaltenstherapie e. V.	Dr. Michael Armbrust Dr. Markus Reicherzer (Stv.)
DDBT	Dachverband Dialektisch Behaviorale Therapie e. V.	Prof. Dr. Martin Bohus Prof. Dr. Christian Schmahl (Stv.)
DeGPT	Deutschsprachige Gesellschaft für Psychotraumatologie	Prof. Dr. Ingo Schäfer Prof. Dr. Astrid Lampe (Stv.)
DFPP	Deutsche Fachgesellschaft Psychiatrische Pflege e. V.	Dr. Susanne Schoppmann Dorothea Sauter (Stv.)
DGGÖ	Deutsche Gesellschaft für Gesundheitsökonomie e. V.	Prof. Dr. Hans-Helmut König Dr. Christian Brettschneider (Stv.)
DGKJP	Deutsche Gesellschaft für Kinder- und Jugenpsychiatrie, Psychosomatik und Psychotherapie	Prof. Dr. Michael Kaess Prof. Dr. Paul Plener (Stv.)
DGPM	Deutsche Gesellschaft für Psychosomatische Medizin und ärztliche Psychotherapie e. V.	Prof. Dr. Stephan Doering Prof. Dr. Anna Buchheim (Stv.)
DGPs	Deutsche Gesellschaft für Psychologie	Prof. Dr. Babette Renneberg Prof. Dr. Christop Kröger (Stv.)
DGPPN	Deutsche Gesellschaft für Psychiatrie, Psychotherapie und Nervenheilkunde	Prof. Dr. Sabine Herpertz Prof. Dr. Martin Driessen (Stv.) Prof. Dr. Christian Schmahl (Stv.)
DGPT	Deutsche Gesellschaft für Psychoanalyse, Psychotherapie, Psychosomatik und Tiefenpsychologie e. V.	Prof. Dr. Silke Wiegand-Grefe PD Dr. Claudia Subic-Wrana (Stv.)
DGSF	Deutsche Gesellschaft für Systemische Therapie, Beratung und Familientherapie e. V.	Dipl.-Soz.Arb. Martina Lochmann
DGVT	Deutsche Gesellschaft für Verhaltenstherapie e. V.	Dr. Rudi Merod Dr. Prisca Weiser (Stv.) Prof. Dr. Matthias Witthöft (Stv.)
DKPM	Deutsches Kollegium für Psychosomatische Medizin	Prof. Dr. Anna Buchheim Prof. Dr. Stephan Doering (Stv.)
DPV	Deutsche Pychoanalytische Vereinigung	Prof. Dr. Joachim Küchenhoff Dipl.-Psych. Christa Leiendecker (Stv.)
DVT	Deutscher Fachverband für Verhaltenstherapie	Prof. Dr. Ulrich Schweiger Dr. Claudia Stromberg (Stv.)
GePs	Gesellschaft zur Erforschung und Therapie von Persönlichkeitsstörungen e. V.	Dr. Birger Dulz Prof. Dr. Carsten Spitzer (Stv.)
MBT-D-A-CH	Berufsverband Mentalisierungs-basierte Therapie für die deutschsprachigen Länder e. V.	Prof. Dr. Svenja Taubner Prof. Jana Volkert (Stv.)

VAKJP	Vereinigung Analytischer Kinder- und Jugendlichen-Psychotherapeuten in Deutschland e. V.	Prof. Dr. Annette Streeck-Fischer Prof. Dr. Simone Salzer (Stv.)
	Fachgesellschaft/Organisation	**Weitere Teilnehmende**
DGPPN	Deutsche Gesellschaft für Psychiatrie und Psychotherapie, Psychosomatik und Nervenheilkunde e. V.	Prof. Dr. Klaus Lieb (Koordinator der Leitlinie)
AWMF	Arbeitsgemeinschaft der Wissenschaftlich Medizinischen Fachgesellschaften	Dr. Monika Nothacker Dr. Susanne Blödt

Tabelle 1: Zusammensetzung der Konsensrunde

2.4 Steuergruppe

Die Steuergruppe rekrutierte sich aus der Konsensgruppe. Ihre Mitglieder wurden bei der konstituierenden Sitzung am 09.10.2017 von der gesamten Konsensgruppe im Hinblick auf ihre individuelle Expertise nominiert und per Beschlussfassung bestätigt. Aufgaben der Steuergruppe waren insbesondere die Bewertung der Evidenz, das Abstimmen und Aussprechen von Empfehlungsvorschlägen für die Konsensgruppe sowie das Verfassen der Hintergrundtexte der Leitlinie. Die Mitglieder der Steuergruppe verfügten über keine besonderen Stimmrechte.

- Prof. Dr. Martin Bohus, Institut für Psychiatrische und Psychosomatische Psychotherapie, Zentralinstitut für Seelische Gesundheit, Mannheim
- Prof. Dr. Stephan Doering, Universitätsklinik für Psychoanalyse und Psychotherapie, Medizinische Universität Wien
- Prof. Dr. Michael Kaess, Universitätsklinik für Kinder- und Jugendpsychiatrie und Psychotherapie, Universität Bern
- Prof. Dr. Sabine C. Herpertz, Klinik für Allgemeine Psychiatrie, Universitätsklinikum Heidelberg
- Prof. Dr. Babette Renneberg, Arbeitsbereich Klinische Psychologie und Psychotherapie, Freie Universität Berlin
- Prof. Dr. Svenja Taubner, Institut für Psychosoziale Prävention, Universitätsklinikum Heidelberg

Als weiteres Mitglied der erweiterten Steuergruppe wurde hinzugezogen und mit der Verfassung des Hintergrundtexts zu Kapitel 4.4 (Medikation) betraut

- Prof. Dr. Christian Schmahl, Zentralinstitut für Seelische Gesundheit, Mannheim

2.5 Leitlinienkoordination und methodische Begleitung

Das Koordinationsteam bestand aus Prof. Dr. Klaus Lieb und Dipl.-Psych. Jutta Stoffers-Winterling von der Universitätsmedizin Mainz sowie Frau Dr. Monika Nothacker und Frau Dr. Susanne Blödt von der AWMF. Die Leitung der Koordination und die Verantwortlichkeit des Erstellungsprozesses oblag Prof. Dr. Klaus Lieb als Repräsentant der federführenden Fachgesellschaft DGPPN. Frau Dr. Nothacker und Frau Dr. Blödt übernahmen die Beratung und Moderation des formalisierten Konsensverfahrens.

Die Aufgaben des Koordinationsteams bestanden in

- der Einladung der Fachgesellschaften, Berufsverbände und Organisation zur konstituierenden Sitzung der Leitliniengruppe
- Einforderung der Interessenkonflikterklärungen der Konsensgruppenmitglieder
- Auswertung der deklarierten Interessenkonflikte
- Vorbereitung der Sitzungen der Konsensgruppe
- Aufbereitung der Evidenz
- Erstellung der Hintergrundtexte
- Vorbereitung von Empfehlungsvorschlägen
- Redaktion

Die Mitglieder des Koordinationsteams (Tabelle 2) besaßen im Konsensverfahren kein Stimmrecht.

	Fachgesellschaft/Organisation	Mitglieder	Aufgaben
DGPPN	Deutsche Gesellschaft für Psychiatrie und Psychotherapie und Nervenheilkunde e. V.	Prof. Dr. Klaus Lieb	Leitlinienkoordinator und Verantwortlicher für den Erstellungsprozess
	wissenschaftliche Mitarbeiterin der Universitätsmedizin Mainz	Dipl.-Psych. Jutta Stoffers-Winterling	Wissenschaftliche Koordination, Redaktion
AWMF	Arbeitsgemeinschaft der Wissenschaftlichen Medizinischen Fachgesellschaften e. V.	Dr. Monika Nothacker Dr. Susanne Blödt	methodische Beratung der Leitlinienestellung und Moderation der Konsensrunden

Tabelle 2: Koordinatinsteam

3. Methodologische Exaktheit

3.1 Recherche, Auswahl und Bewertung wissenschaftlicher Belege (Evidenzbasierung)

3.1.1 Verwendung existierender Leitlinien zum Thema

Bei der vorliegenden Leitlinie handelt es sich um die erste S3-Leitlinie zu dieser Thematik. Insofern wurde zunächst entsprechend der Empfehlungen zur systematischen Literaturrecherche für die Erstellung von Leitlinien[21] national und international nach thematisch relevanten, methodisch hochwertigen Leitlinien recherchiert. Dabei wurden vor Beginn der Leitlinienerstellung die folgenden Leitliniendatenbanken durchsucht:

Nationale Leitlinien-Datenbanken:

- AWMF http://www.awmf.org/leitlinien/leitlinien-suche.html
- Portal des ÄZQ: Leitlinien.de http://www.leitlinien.de/leitlinien-finden/leitlinien-finden
- Arzneimittelkommission der deutschen Ärzteschaft (AkdÄ) https://www.akdae.de

Internationale Leitlinien-Datenbanken

- G-I-N http://www.g-i-n.net/
- National Guideline Clearinghouse (NGC) der US-amerikanischen Agency for Healthcare Research and Quality (AHRQ; https://www.ahrq.gov/gam/updates/index.html)
- Guidelines Central ® (American Medical Association)
- SIGN Scottish Intercollegiate Guidelines Network http://www.sign.ac.uk/
- National Institute for Health and Care Excellence (NICE) http://guidance.nice.org.uk/CG/Published
- KCE Belgian Health Care Knowsledge Center https://kce.fgov.be
- Nederlands huisartsen genootschap https://guidelines.nhg.org/
- MAGICapp

Auswahlkriterien für mögliche Quellleitlinien waren Evidenzbasierung[22] (Empfehlungen beruhen auf systematischer Literaturrecherche und -auswahl, Evidenz- und/oder Empfehlungsgraduierung, Verknüpfung der Empfehlungen mit zugrundeliegender Evidenz), methodologische Exaktheit und Transparenz gemäß DELBI-Kriterien[23] sowie thematische Relevanz und Verfügbarkeit auf Deutsch oder Englisch.

Neben der Schweizer BPS-Leitlinie[24], die vorwiegend im Expertenkonsens erarbeitet wurde und insofern nicht den Auswahlkriterien entsprach, ergab die Suche zwei potenzielle, evidenzbasierte Quellleitlinien, die britischen NICE-Leitlinien[25] sowie die australischen NHMRC-Leitlinien[26]. Da letztere ihrerseits bereits die NICE-Leitlinien als Quellleitlinien adaptiert und aktualisiert hatte, entschied sich die Leitliniengruppe in der Konsensrunde vom 05.03.2018 zur Verwendung der NHMRC-Leitlinien als primäre Quellleitlinie. Ergänzend wurden einige Fragestellungen, die die NHMRC-Leitlinie nicht bearbeitet hatten, jedoch in der ursprünglichen Fassung der NICE-Leitlinie enthalten waren, zur Übernahme in die vorliegende Leitlinie diskutiert.

3.1.2 Formulierung von klinisch relevanten Fragestellungen, Priorisierung von Endpunkten

Nach Übersetzung der Fragestellungen der NHMRC-Quellleitlinie durch Prof. Kaess wurden diese durch die Leitliniengruppe diskutiert und in der Konsensrunde vom 05.03.2018 adaptiert bzw. ergänzt (vgl. Anhang 1: Übersicht der Fragestellungen und Empfehlungen). In dieser Sitzung wurde auch beschlossen, die Fragestellungen zum Themenbereich „Organisation of Healthcare“ (deutsch: „Versorgung“, vgl. Kapitel 5 der Leitlinie) in einem späteren Leitlinientreffen zu betrachten und zu diskutieren, da hier weitreichendere Adaptionen notwendig schienen. Diese wurden in der Konsensrunde vom 21.10.2019 beschlossen.

Die Konsensrunde verständigte sich in ihrer Sitzung vom 05.03.2018 für interventionelle Fragestellungen auf folgende, jeweils untereinander gleichwertige primäre (in der Versorgungspraxis kritische) und sekundäre (wichtige) Endpunkte:

Primäre Endpunkte (untereinander gleichwertig)
- Selbst- und fremdgefährdendes Verhalten
- Psychopathologie, einschließlich selbstverletzendem Verhalten
- Psychosoziales Funktionsniveau
- Lebensqualität

Sekundäre Endpunkte (untereinander gleichwertig)
- Kosten
- Unerwünschte Wirkungen

3.1.3 Systematische Literaturrecherche

Es wurde beschlossen, die in der NHMRC-Leitlinie dargelegten Suchstrategien für die Aktualisierungsrecherchen so weit als möglich beizubehalten, sofern dies nach Adaption der jeweiligen Fragestellungen angemessen schien. Die vollständigen Suchstrategien sind Anhang 2 zu entnehmen. Letztmalig wurde die Literatursuche am 06. September 2021 aktualisiert. Dabei wurde der Suchzeitraum ab Januar 2011 (NHMRC-Leitlinien bis April 2011) bis August 2022 abgedeckt und die Datenbanken MEDLINE (Ovid), PsycINFO (Ovid) und EMBASE (Ovid) durchsucht. Die Literaturrecherche zu Fragestellung 2, deren Gegenstand diagnostische Verfahren zur Erkennung bzw. Diagnosesicherung der BPS sind, wurde durch eine zusätzliche Recherche in der deutschsprachigen Datenbank „Psyndex“ ergänzt.

3.1.4 Auswahl der Evidenz

Eingeschlossen wurden Studien, deren Gegenstand die Diagnostik, Behandlung oder Versorgung von Menschen mit Diagnose oder Teilbild einer BPS war, oder Hilfsangebote für deren Angehörige. Die Studien mussten im Zeitraum seit 2011 publiziert (adaptierte Fragestellungen; neue Fragestellungen: keine Einschränkung des Suchzeitraums) und auf Englisch oder in Deutsch verfügbar sein. Um eingeschlossen zu werden, mussten Interventionsstudien bei von BPS Betroffenen mindestens einen der unter 3.1.2 genannten Endpunkte berichten. Die Studien konnten in jeglichen Settings durchgeführt worden sein, hier gab es keinerlei Ausschlusskriterien. Ausgeschlossen waren dagegen Analogstudien am Tiermodell.

Die Kriterien zur Evidenzgraduierung der NHMRC-Leitlinien wurden beibehalten. Tabelle 3 gibt einen Überblick der Evidenzgrade für Fragestellungen zur Wirksamkeit von Interventionen. Evidenzlevel für anderweitige Fragestellungen sind Anhang 3 zu entnehmen.

Level	Fragestellung zu Interventionen
I	Systematisches Review auf Basis (mehrerer Level-II-Studien)
II	Randomisiert-kontrollierte Studie
III-1	Quasi-randomisierte Studie
III-2	Vergleichsstudie mit gleichzeitigen Kontrollen: > Nicht-randomisierte, experimentelle Studie > Kohortenstudie > Fall-Kontroll-Studie > Unterbrochene Zeitreihe mit Kontrollgruppe
III-3	Vergleichsstudie ohne gleichzeitige Kontrollen > Studie mit historischen Kontrollen > Zwei oder mehrere einarmige Studien > Unterbrochene Zeitreihe ohne parallele Kontrollgruppe
IV	Fallserie mit Zwischengruppen- oder „within-subject“-Vergleich

Tabelle 3: Evidenzlevel

Zur Beantwortung der Fragestellungen wurden zunächst Studien der Evidenzlevel I und II herangezogen. Sofern die Evidenzsuche nicht erfolgreich war oder nur wenig belastbare Evidenz

erbrachte, und dies inhaltlich angemessen und ausreichend erfolgversprechend erschien, wurde die Suche nach Rücksprache mit dem jeweils verantwortlichen Mitglied der Steuergruppe auch auf die Level III-1 und/oder III-2 ausgeweitet.

3.1.5 Kritische Bewertung der Evidenz und Erstellung von Evidenzzusammenfassungen

Auf Basis der Ergebnisse dieser Aktualisierungsrecherchen und kritischer Bewertung der Qualität der identifizierten Evidenz wurden seitens der Steuergruppe Empfehlungen zur Beibehaltung oder Modifikation der entsprechenden Empfehlungen der Quellleitlinie vorbereitet, die dann mit den übrigen Mandatstragenden in den Leitlinientreffen diskutiert wurden. Modifikationen, Erweiterungen oder Streichungen von Empfehlungen der Quellleitlinie wurden dabei eindeutig benannt und begründet.

Für jede klinische Fragestellung, die in einer Empfehlung mündete, wurden Evidenztabellen angefertigt (vgl. Anhang 4).

3.1.6 Verknüpfung von Evidenz und Empfehlung

Anhand der Evidenztabellen nahmen jeweils mindestens zwei Mitglieder der Leitliniengruppe eine Qualitätsbeurteilung der identifizierten Evidenz vor (vgl. Anhang 5), die maßgeblich in die Graduierung der Empfehlungen einfloss. Die Qualitätsbeurteilung erfolgte anhand der Kriterien

- Methodische Qualität des Designs der eingeschlossenen Studien/Evidenzgrad
- Konsistenz der Studienresultate (*consistency)*
- Validität der Studien/Rückführbarkeit der beobachteten Effekte auf die getesteten Interventionen (c*linical impact*)
- Direktheit der Evidenz/Generalisierbarkeit der Befunde (*generalisability*)
- Anwendbarkeit im klinischen Kontext/Übertragbarkeit auf das deutsche Versorgungssystem (*applicability*)
- Methodische Schwächen (Stichprobe, Verblindung, verdeckte Zuteilung, Angemessenheit der statistischen Methoden; *other factors*)

Weiterhin floss in die Gradierung der Empfehlung die Relation von Nutzen und Schaden/unerwünschten Wirkungen ein. Zusammenfassend wird die Qualität der für eine bestimmte Fragestellung identifizierten Evidenz in den jeweiligen Hintergrundtexten der Leitlinie dargestellt und anhand der o.g. Kriterien kritisch gewürdigt. Auf die entsprechenden Evidenztabellen wird jeweils im Leitlinientext verwiesen. Wo die Evidenz ausreichend war, um Empfehlungen unmittelbar abzuleiten und hinreichend zu begründen, wird diese unmittelbar im Zusammenhang mit dem jeweiligen Evidenzgrad (A, B, O; vgl. Kapitel 3.2.3) dargestellt, vgl. bspw. Empfehlung 10 (Tabelle 4: Verknüpfung von Evidenz und Empfehlung (Beispielhafte Darstellung).

Empfehlung 10	**Wenn der primäre Fokus in der Reduktion schwerwiegenden selbstverletzenden Verhaltens (inklusive suizidalem Verhalten) besteht, soll DBT oder MBT angeboten werden.**
Empfehlungsgrad A[27–32]	91% Konsens

Tabelle 4: Verknüpfung von Evidenz und Empfehlung (Beispielhafte Darstellung)

3.2 Formulierung und Graduierung von Empfehlungen und strukturierte Konsensfindung

3.2.1 Strukturierte Konsensfindung: Verfahren und Durchführung

Auf Basis der Ergebnisse dieser Aktualisierungsrecherchen und kritischer Bewertung der Qualität der identifizierten Evidenz wurden seitens der Steuergruppe Empfehlungen zur Beibehaltung oder Modifikation der entsprechenden Empfehlungen der Quellleitlinie vorbereitet, die dann mit den übrigen Mandatstragenden in den Leitlinientreffen diskutiert wurden. Modifikationen, Erweiterungen oder Streichungen von Empfehlungen der Quellleitlinie wurden dabei eindeutig benannt und begründet.

Die strukturierte Konsensfindung innerhalb der gesamten Leitliniengruppe erfolgte in Anlehnung an den Nominalen Gruppenprozesses unter unabhängiger Moderation durch jeweils eine Vertreterin der AWMF (Dr. Nothacker oder Dr. Blödt) in den folgenden Schritten:

- Präsentation der zu konsentierenden Aussagen/Empfehlungen
- Präsentation der seitens der Steuergruppe im Vorfeld der Sitzung erarbeiteten Beschlussempfehlung mit ausführlicher Begründung
- Überprüfung: Wird der Empfehlung/dem Empfehlungsgrad zugestimmt?
- Klärung inhaltlicher Nachfragen
- Einholen von Änderungsvorschlägen mit Begründung
- Ggf. Priorisieren von Änderungsvorschlägen nach Diskussion
- Endgültige Abstimmung über jede Empfehlung und ggf. Alternativen

Entsprechend der AWMF-üblichen Konsensregel erforderte die Annahme einer Empfehlung die Zustimmung von mindestens 75% der Teilnehmenden. Die Konsensstärke wurde gemäß Tabelle 5 klassifiziert.

Klassifikation der Konsensusstärke	
Starker Konsens	> 95 % der Stimmberechtigten
Konsens	>75–95 % der Stimmberechtigten
Mehrheitliche Zustimmung	>50–75 % der Stimmberechtigten
Dissens	>50 % der Stimmberechtigten

Tabelle 5: Klassifikation der Konsensusstärke

Die Leitliniengruppe verständigte sich darauf, im Leitlinientext bei jeder Empfehlung den Prozentsatz der Zustimmung darzustellen, ohne die Stimmen einzelnen Fachgesellschaften namentlich zuzuordnen.

3.2.2 Berücksichtigung von Nutzen, Nebenwirkungen und Risiken

In die Graduierung der Empfehlungen floss neben der Qualität der Evidenz und dem berichteten Nutzen einer Intervention auch Evidenz zu unerwarteten Effekten und Risiken ein. Unerwartete Effekte wurden als ein sekundärer Endpunkte der Leitlinie definiert und entsprechend in den Evidenztabellen erfasst. Bei der Formulierung der Empfehlungen wurden insbesondere folgende Fragestellungen erwogen:

- Wie substanziell sind der erwartete Nutzen und der erwartete Schaden der Intervention?
- Wie sehr spricht die Abwägung von Nutzen und Schaden für die Intervention?
- Zu welchen potenziell erwartbaren unerwünschten Effekten fehlt Evidenz?
- Spricht die Kosten-Nutzen-Abwägung für die Intervention?
- Gibt es relevante soziale, ethische, und/oder rechtliche Erwägungen, insbesondere in Bezug auf Fragestellungen, welche die Eltern-Kind-Konstellation betreffen?

3.2.3 Formulierung der Empfehlungen und Vergabe von Evidenz- und/oder Empfehlungsgraden

Bei der Graduierung der Empfehlung wurde zunächst die methodisch aufbereitete und nach den Kriterien Anwendbarkeit und Übertragbarkeit bewertete Evidenz berücksichtigt (vgl. Abschnitt 3.1.6), ebenso jedoch auch die klinische Expertise und Betroffenenpräferenzen.

Die Empfehlungsstärken wurden durch die Leitliniengruppe im Rahmen eines formalen Konsensverfahrens bestimmt, je nach dem Grad der Überzeugung, dass der größte Teil der beschriebenen Betroffenengruppe von einem bestimmten Vorgehen oder einer bestimmten Intervention profitiert. Folgende Faktoren wurden bei diesen Erwägungen berücksichtigt:

- die Qualität bzw. Aussagekraft der Evidenz, beurteilt anhand von: Konsistenz, Validität, Relevanz, Übertragbarkeit/Anwendbarkeit
- das Nutzen-Schaden-Verhältnis
- alternative Handlungsoptionen
- Behandlungsziele und Betroffenenpräferenzen
- die Umsetzbarkeit im klinischen Alltag, in verschiedenen Versorgungssettings/Sektoren
- ethische und sonstige Erwägungen.

Entsprechend dem AWMF-Regelwerk[33] wurden bei evidenzbasierten Empfehlungen folgende Empfehlungsgraduierungen vorgenommen (vgl. Tabelle 6):

Empfehlungsgrad	Beschreibung	Formulierung	Symbol
A	Starke Empfehlung	soll (nicht)	●●●
B	Empfehlung	sollte (nicht)	●●
0	Offen	kann	●

Tabelle 6: Empfehlungsgraduierung: Schema zur Einstufung der Empfehlungen

Die zugrundeliegende Evidenz ist in den Evidenztabellen im Anhang der Leitlinie ausführlich beschrieben, und wird im Hintergrundtext der jeweiligen Empfehlungen nochmals zusammengefasst und hinsichtlich ihrer Qualität kritisch gewürdigt. Wo bei evidenzbasierten Empfehlungen Evidenzgrade angegeben werden, sind diese unmittelbar mit der begründenden Evidenz verknüpft (vgl. Tabelle 4). Sofern Evidenz und Empfehlungen erheblich voneinander abweichen, wird dies im Hintergrundtext begründet.

3.2.4 Empfehlungsarten

Zu allen Fragestellungen erfolgten aktualisierte Literatursuchen entsprechend der in der australischen Quellleitlinie dokumentierten Suchstrategien[26]. Entscheidungen, für die keine hinreichende Evidenz aus Level-I- oder Level-II-Studien vorliegt, und die trotz erfolgter Evidenzsuche daher wesentlich auf der klinischen Expertise der an der Leitlinienerstellung beteiligten Experten beruhen, sind im Text als „klinischer Konsenspunkt“ (KKP) gekennzeichnet.

4. Externe Begutachtung und Verabschiedung

4.1 Externe Begutachtung

Die Leitlinie wurde vom 22.03.2022 bis 05.05.2022 zur externen Konsultation bzw. Kommentierung durch die (Fach-)Öffentlichkeit und Betroffene im Leitlinienregister der AWMF bereitgestellt. Die beteiligten Fachgesellschaften und Organisationen wurden darüber informiert und um Verbreitung unter ihren Mitgliedern und weiteren interessierten Kreisen gebeten. Externe Kommentare, d.h. von nicht an der Leitlinienerstellung beteiligten Personen und Organisationen, wurden mittels eines standardisierten Kommentierungsbogens erfasst (vgl. Anhang 6) und der Umgang damit dokumentiert (vgl. Anhang 7).

4.2 Verabschiedung durch die Vorstände der herausgebenden Fachgesellschaften und Organisationen

Die an der Leitlinienaktualisierung beteiligten Organisationen und Fachgesellschaften erteilten ihre Freigabe wie folgt (Tabelle 7):

Tabelle 7: Freigabe der Leitlinie durch die beteiligten Fachgesellschaften und Organisationen

	Fachgesellschaft/Organisation	Freigabe erteilt am
BDP	Berufsverband deutscher Psychologinnen und Psychologen e. V.	01.04.2022
BJK	Berufsverband der Kinder- und Jugendlichentherapeutinnen und Kinder- und Jugendlichenpsychotherapeuten e. V.	29.04.2022
	Borderline Trialog e. V.	18.04.2022
BPtK	Bundespsychotherapeutenkammer	07.04.2022
BVVP	Bundesverband der Vertragspsychotherapeuten	17.04.2022
DÄVT	Deutsche Ärztliche Gesellschaft für Verhaltenstherapie e. V.	22.03.2022
DDBT	Dachverband Dialektisch-Behaviorale Therapie e. V.	07.04.2022
DeGPT	Deutschsprachige Gesellschaft für Psychotraumatologie	10.04.2022
DFPP	Deutsche Fachgesellschaft Psychiatrische Pflege e. V.	10.03.2022
DGGÖ	Deutsche Gesellschaft für Gesundheitsökonomie e. V.	27.04.2022
DGPs	Deutsche Gesellschaft für Psychologie	02.05.2022
DGPM	Deutsche Gesellschaft für Psychosomatische Medizin und ärztliche Psychotherapie e. V.	24.05.2022
DGKJP	Deutsche Gesellschaft für Kinder- und Jugendpsychiatrie, Psychosomatik und Psychotherapie	29.04.2022
DGPPN	Deutsche Gesellschaft für Psychiatrie und Psychotherapie, Psychosomatik und Nervenheilkunde	04.05.2022

DGPT	Deutsche Gesellschaft für Psychoanalyse, Psychotherapie, Psychosomatik und Tiefenpsychologie e. V.	14.04.2022
DGSF	Deutsche Gesellschaft für Systemische Therapie, Beratung und Familientherapie e. V.	20.04.2022
DGVT	Deutsche Gesellschaft für Verhaltenstherapie e. V.	25.03.2022
DKPM	Deutsches Kollegium für Psychosomatische Medizin	24.05.2022
DPV	Deutsche Psychoanalytische Vereinigung	04.04.2022
DVT	Deutscher Fachverband für Verhaltenstherapie	11.04.2022
GePs	Gesellschaft zur Erforschung und Therapie von Persönlichkeitsstörungen e. V.	15.07.2022
MBT	Mentalisierungsbasierte Therapie	10.04.2022
VAKJP	Vereinigung Analytischer Kinder- und Jugendlichenpsychotherapeuten in Deutschland e. V.	06.04.2022

5. Redaktionelle Unabhängigkeit

5.1 Finanzierung der Leitlinie

Die Leitlinienerstellung wurde ausschließlich von der DGPPN, der federführenden Fachgesellschaft, mit einem Gesamtbetrag von 49.700 € finanziell unterstützt. Diese Mittel wurden zur Finanzierung der Personalkosten zur wissenschaftlichen Koordination und Redaktion der Leitlinie, zur Finanzierung der unabhängigen Moderation der Leitlinientreffen durch die Moderatorinnen der AWMF, von Reisekosten der Moderatorinnen der AWMF und der Betroffenenvertreterinnen (Borderline-Trialog) sowie für die Veranstaltungskosten während der Präsenztreffen verwendet. Die Räumlichkeiten wurden von der Klinik für Psychiatrie und Psychotherapie der Universitätsmedizin Mainz unentgeltlich zur Verfügung gestellt, einmalig wurde für ein Treffen in den Räumen der Humboldt-Universität Berlin eine Raummiete bezahlt. Weiterhin wurde aus den Mitteln der DGPPN die Miete des elektronischen Abstimmungssystems finanziert, welches von der Deutschen Krebsgesellschaft ausgeliehen wurde. Die DGPPN hat keinen Einfluss auf Inhalte der Leitlinie genommen.

5.2 Darlegung von Interessen und Umgang mit Interessenkonflikten

Bei der Leitlinienerstellung wurde besonderer Wert auf die Transparenz von Interessen und einen adäquaten Umgang mit Interessenkonflikten (IK) der Leitlinienautorinnen und -autoren gelegt, um unangemessene Einflüsse durch das Vorliegen von IK auf die Inhalte der Leitlinie möglichst weitgehend zu vermeiden. Bei der Leitlinienerstellung für ein Krankheitsbild, dessen primäre Therapie nicht in der Pharmakotherapie, sondern in der Psychotherapie besteht, stellt der Umgang mit IK eine besondere Herausforderung dar. Dies liegt darin begründet, dass nichtfinanzielle IK wie z.B. die Zugehörigkeit zu einer bestimmten Therapieschule (z.B. Verhaltenstherapie oder Psychoanalyse) in möglicherweise noch größerem Ausmaß zu verzerrten Bewertungen von wissenschaftlichen Befunden führen kann als finanzielle Verbindungen zu pharmazeutischen Unternehmen[34].

Es wurde daher bereits bei der Auswahl der Mandatstragenden darauf geachtet, Personen mit finanziellen IK zu pharmazeutischen Unternehmen möglichst vollständig auszuschließen und

bei der Auswahl verschiedener Verbände bzw. Organisationen mit der Nähe zu bestimmten Therapie-Schulen für ein ausgewogenes Verhältnis zu sorgen.

Um eine möglichst vollständige Transparenz über finanzielle und nicht-finanzielle IK herzustellen, legten vor Beginn der Leitlinienarbeit alle Mandatstragenden obligat mittels eines Formulars zur Erklärung von IK ihre Interessen bzw. IK offen. Das Formular und die pro Mandatstragenden offengelegten Interessen und IK sowie eine Übersicht, welche Mandatstragenden welche Psychotherapieverfahren oder – schulen vertreten, finden sich in Anhang 9). Im Wesentlichen umfasste die Abfrage finanzielle Vorteile durch pharmazeutische Unternehmen durch Eigentümerinteressen und Aktien, Beraterverträge oder Honorare für Vorträge oder andere Aufträge von Herstellern sowie private Beziehungen zu pharmazeutischen Unternehmen. Darüber hinaus wurden Forschungsaktivitäten erfasst, die ebenfalls Interessenkonflikte bedingen können. Als Besonderheit wurde darüber hinaus erhoben, ob die Mandatstragenden ein bestimmtes psychotherapeutisches Verfahren oder einen Therapieansatz entweder selbst erlernt haben, selber ausüben oder in leitender Position (z.B. in einer Klinik) verantworten. Mehrfachnennungen waren möglich.

Die transparente Erfassung der Interessen und IK ergab folgendes Gesamtbild: Innerhalb der Steuergruppe lagen keine finanziellen IK bzw. Verbindungen zu pharmazeutischen Unternehmen vor. Ein Mandatstragender aus der erweiterten Steuergruppe gab an, beratend für ein pharmazeutisches Unternehmen tätig zu sein. Ansonsten legten drei weitere der 47 Mandatstragenden eine Zusammenarbeit mit pharmazeutischen Unternehmen offen (vgl. Anhang 9).

Weiterhin gaben 21 der 47 Mandatstragenden eine Affiliation zur Verhaltenstherapie an, 16 zu teifenpsychologisch fundierter Psychotherapie und 15 zu Psychoanalyse (Mehrfachnennungen möglich). Hinsichtlich BPS-spezifischer Methoden gaben 18 der Mandatstragenden eine Affiliation zur DBT zu haben (d.h., diese Methode erlernt zu haben, selbst anzuwenden, und/oder in einer Leitungsposition zu verantworten). Acht Mandatstragende nannten eine Affiliation zu MBT sowie weitere acht zur TFP, fünf zur ST und zwei zur PiM (vgl. Anhang 9). Auch hinsichtlich der Methoden waren Mehrfachnennungen möglich.

Auf Verbandsebene zeigt sich laut Selbstbeschreibung der jeweiligen Fachgesellschaften bzw. Verbände für vier Verbände (inklusive der Mandatstragenden für die MBT) eine psychodynamische, für drei eine verhaltenstherapeutische Ausrichtung. Ein Verband vertrat die Systemische Therapie, 15 Fachgesellschaften bzw. Organisationen sind keiner spezifischen Therapieschule zuzuordnen, darunter jedoch zwei Verbände mit psychosomatischer Ausrichtung. Unter den BPS-spezifischen Ansätzen wurden zwei explizit (DBT, MBT) durch Verbände bzw. Mandatstragende repräsentiert, während die restlichen Verbände keiner spezifischen Methode zuzuordnen waren. Auf Ebene der Fachgesellschaften wurden Professionen Medizin und Psychologie durch jeweils vier Verbände repräsentiert, die restlichen waren interdisziplinär ausgerichtet. Der Kinder-Jugend-Bereich wurde durch drei Verbände vertreten, während die übrigen weder explizit auf den Kinder-/Jugendbereich noch auf Erwachsene ausgerichtet waren.

Die erklärten IK wurden durch eine externe IK-Management-Gruppe (bestehend aus Dr. Nothacker, Prof. Dr. David Klemperer in Zusammenarbeit mit Prof. Dr. Lieb und Fr. Stoffers-Winterling) aus- und vor Beginn der inhaltlichen Leitlinienarbeit zusammenfassend wie folgt bewertet: Die Ausgeglichenheit der Leitliniengruppe war sowohl auf Ebene der Mandatstragenden als auch der Verbände gegeben. Bei keinem einzigen Faktor (Therapieschulen- oder Methodenaffiliation) bestand eine absolute Mehrheit, so dass rein interessengeleitete Entscheidungen (oder Blockaden von Entscheidungen) auszuschließen waren.

Die einzelnen Interessenerklärungen wurden entsprechend des AWMF -Regelwerks im Hinblick auf geringe/moderate und hohe Interessenkonflikte geprüft. Als gering wurden einzelne Vorträge finanziert von der Industrie oder Ausbildungsinstituten gewertet. Als moderat wurden Berater- bzw. Advisorboardtätigkeiten oder Autorenschaften (bspw. bei zu evaluierenden diagnostischen Messinstrumenten oder psychotherapeutischen Interventionen) bewertet. Als hoch wurde relevanter Aktienbesitz oder Eigentümerinteresse gewertet. Hohe Interessenkonflikte wurden nicht festgestellt. Für IK-relevante Empfehlungen (moderate IK) wurde eine Doppelabstimmung unter Verwendung eines elektronischen Abstimmungssystems durch die IK-Management-Gruppe angeregt und dann auch durchgeführt, welches eine anonyme Abstimmung ermöglicht, sowie eine Darstellung beider Abstimmungsergebnisse in der Leitlinie, d.h. mit und ohne Wertung der Mandatstragenden mit IK. Die Leitliniengruppe beschloss auf der Basis dieser Empfehlungen, für jeden Themenkomplex spezifisch zu prüfen, ob bei den anwesenden Mandatstragenden IK vorliegen und dann das doppelte Abstimmungsverfahren durchzuführen und die Enthaltungen der Mandatstragenden mit IK bei den jeweiligen Leitlinienempfehlungen transparent zu dokumentieren.

Als protektive Faktoren, die einer Verzerrung durch IK entgegenwirken, wurde seitens der IK-Management-Gruppe genannt:

- Die grundsätzliche Evidenzbasierung der Leitlinienerstellung und die unabhängige Aufarbeitung der Studienevidenz durch eine methodisch erfahrene Wissenschaftlerin (J. Stoffers-Winterling), die nicht Teil der Leitliniengruppe war,
- die bezüglich der Therapieschulen plural zusammengesetzte Leitliniengruppe mit zusätzlicher Beteiligung von Methodikern und Personen, die die Betroffenenperspektive vertraten,
- die ebenfalls bezüglich der Therapieschulen plural zusammengesetzte Steuergruppe
- die Unabhängigkeit des Leitlinien-Koordinators Prof. Dr. Lieb und der gesamten Steuergruppe/den federführenden Autorinnen und Autoren bezüglich finanzieller IK
- die strukturierte Konsensfindung unter neutraler Moderation,
- die Diskussion zu nicht-finanziellen Interessen innerhalb der Leitliniengruppe sowie die externe Bewertung der Interessenkonflikte
- die vollständig dokumentierten Enthaltungen bei Mandatstragenden, die bzgl. bestimmter Entscheidungen Interessenkonflikte durch die Zugehörigkeit zu bestimmten Therapieschulen aufwiesen
- der in der überwiegenden Mehrheit der Fälle starke Konsens bei den Empfehlungen
- die externe Begutachtung des Leitlinientexts im Rahmen der öffentlichen Konsultation durch die Fachöffentlichkeit und Betroffene mit einer entsprechenden Dokumentation, wie mit den eingegangenen Änderungsvorschlägen umgegangen wurde (vgl. Kapitel 4.1 sowie Anhang 7)

Im Falle von Fragestellungen bzw. Empfehlungen, für welche Interessenkonflikte (IK) bei den abstimmenden Mandatstragenden nicht ausgeschlossen werden konnten, wurden Doppelabstimmungen durchgeführt, und die Abstimmungsergebnisse unter Ausschluss und Einbezug der von IK Betroffenen vollumfänglich berichtet. Beide Abstimmungsergebnisse (d.h. mit und ohne Wertung der Stimmen der affiliierten Mandatstragenden als Enthaltungen) werden in der Leitlinie berichtet. Die Abstimmung erfolgte mittels eines elektronischen Abstimmungssystems, welches die Stimmabgabe anonym erfasste und protokollierte. Grundsätzlich war es auch möglich, Minderheitsvoten z.B. eines einzelnen Verbandes oder einer Organisation abzugeben. Davon wurde aber während des gesamten Konsensusprozesses nicht Gebrauch gemacht.

6. Verbreitung und Implementierung

6.1 Konzept zur Verbreitung und Implementierung

Die Langversion der Leitlinie wird kostenlos über die Homepage der DGPPN und das Leitlinienregister der AWMF im Internet zugänglich gemacht. Der Leitlinienreport mit Anhängen ist ebenfalls über diese beiden Internetquellen erhältlich. Zur weiteren Verbreitung der Leitlinie sind Beiträge in nationalen und internationalen Fachzeitschriften, Publikationsorganen der einzelnen Fachgesellschaften sowie die Vorstellung der Leitlinie im Rahmen von Fachkongressen vorgesehen.

6.2 Unterstützende Materialien für die Anwendung der Leitlinie

Die Aufnahme der Leitlinie in die DGPPN-APP ist in Planung. Weiterhin wird die Leitlinie über das „Amboss Leitlinien Telegramm“ (https://www.amboss.com/de/leitlinien-telegramm), welches v.a. von in Ausbildung befindlichen Kollegen aller Fachrichtungen genutzt wird, einem breiten, fächerübergreifenden Publikum bekannt gemacht.

6.3 Diskussion möglicher förderlicher und hinderlicher Faktoren für die Anwendung der Leitlinie.

Mögliche Barrieren bei der Implementierung der Leitlinie können auf Seiten der Betroffenen, der Angehörigen, der Behandler oder aufgrund der Rahmenbedingungen des Gesundheitssystems vorhanden sein. Bei den Betroffenen und den Angehörigen spielen insbesondere deren Präferenzen für bestimmte Versorgungsformen oder therapeutische Verfahren eine Rolle. Bei den Behandelnden kommen ebenfalls deren Präferenzen, insbesondere jeoch auch deren eigene Therapieausbildung und Informiertheit über die Leitlinienempfehlungen sowie zeitlichen Ressourcen zum Tragen. Organisatorische Einflüsse, die die Implementierung der Leitlinienempfehlungen hindern könnten, sind mangelnde Ressourcen im Gesundheitswesen, mangelnde Kooperation zwischen verschiedenen Behandlern, mangelnde Kontinuität der Versorgung durch Abteilungs- und Sektorengrenzen oder fehlende Übertragbarkeit der Empfehlungen auf lokale Gegebenheiten.

7. Gültigkeitsdauer und Aktualisierungsverfahren

Die Leitlinie ist bis mindestens Mai 2026, d.h. bis vier Jahre nach der Verabschiedung der Leitlinie, gültig. Verantwortlich für die kontinuierliche Fortschreibung, Aktualisierung und Bekanntmachung der S3-Leitlinie ist die Deutsche Gesellschaft für Psychiatrie, Psychotherapie, Psychosomatik und Nervenheilkunde (DGPPN e. V.; leitlinien@dgppn.de). Sofern schon früher neue wissenschaftliche Erkenntnisse bekannt werden, die wichtige Änderungen in einzelnen Empfehlungen zur Folge haben würden, kann auch schon vorzeitig ein partielles Aktualisierungsverfahren eingeleitet bzw. ein Addendum erstellt werden. Kommentare und Hinweise für den Aktualisierungsprozess sind ausdrücklich erwünscht und können an das Leitliniensekretariat gesendet werden.

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9. Anhänge

9.1 Anhang 1: Übersicht der Fragestellungen und Empfehlungen

Frage Nr.[1]	Übersetzung/Adaption	Empfehlungen[2]
	Erkennen und Beurteilen der BPS	
1.	Wie können Behandelnde Merkmale der BPS (bei jungen Menschen) identifizieren?	E 1-5
2.	Sollen standardisierte Testverfahren eingesetzt werden? Falls ja, welche?	E 6-7
ADD1[3]	Nach welchen psychischen und somatischen Komorbiditäten soll gesucht werden?	-
ADD2	Welche differenzialdiagnostische Abklärung soll erfolgen?	-
	Management von Risikofaktoren und Prävention	
3.	Welche Risikofaktoren für BPS sind bekannt?	-
4.	Welche präventiven Maßnahmen gibt es zur Reduktion der Inzidenz einer BPS (als primärem oder sekundärem Outcome)?	-
	Management der BPS	
5.	Durch welche Interventionen und Behandlungsprozesse kann bei Jugendlichen unter 18 Jahren, die die diagnostischen Kriterien einer BPS (außer dem Alterskriterium) erfüllen, der Entwicklungsverlauf positiv beeinflusst oder das Behandlungsergebnis verbessert werden[4]?	E 14-17
6.	Welche Behandlungs- und Versorgungsmöglichkeiten für Betroffene mit BPS führen zu Verbesserungen der konsentierten Ergebnisvariablen[3] und weisen dabei ein günstiges Nutzen-Schaden-Profil auf?	E 8-11
7.	Welche Psychotherapien sind wirksam? (Fokus auf grundsätzlicher Wirksamkeit, explizit kein Vergleich zwischen verschiedenen Methoden)	E 8-11
8.	Welche psychosozialen Interventionen sind wirksam[3]?	E 8-11
9.	Welche medikamentösen Interventionen/Behandlungsmöglichkeiten weisen, insbesondere bei Vorliegen bestimmter Komorbiditäten, ein günstiges Nutzen-Schaden-Profil auf?	E 18-27
10.	Sind multimodale Therapien (medikamentös, psychotherapeutisch, Gruppeninterventionen, teil- oder vollstationäre Programme, Familientherapie, Systemische Therapie, therapeutische Gemeinschaften) effektiver als unimodale Therapien bezüglich der definierten Ergebnisvariablen?	E 12.1, E13, E28

[1] Nummerierung analog der NHMRC-Leitlinien[26]

[2] Die Empfehlungen sind analog ihres chronoligeschen Erscheinens im Leitlineintext fortlaufend durchnummeriert.

[3] Präfix „ADD“: neue, ergänzende Fragestellungen der S3-LL, die in den NHMRC-Leitlinien nicht behandelt wurden

[4] Primäre Endpunkte (untereinander gleichwertig): Selbst- und fremdgefährdendes Verhalten („Life-threatening behaviour“), Psychopathologie, einschließlich selbstverletzenden Verhaltens („psychopathology“, „self-injury“), psychosoziales Funktionsniveau („Functioning“), Lebensqualität; sekundäre Endpunkte (untereinander gleichwertig): Kosten, Unerwünschte Wirkungen

Frage Nr.[1]	Übersetzung/Adaption	Empfehlungen[2]
11.	Welche Interventionen sind bei Menschen mit BPS und komorbiden psychischen und somatischen Erkrankungen wirksam bezüglich der definierten Ergebnisvariablen?	E 29-31
13.	Müssen anderweitige psychische Störungen, die gleichzeitig mit einer BPS vorliegen, anders als üblich behandelt werden? Falls ja, wie?	E 29-31
	Organisation spezifisch ausgerichteter Behandlugnsangebote für von BPS Betroffene	
15.	Welche Versorgungsstrukturen/Therapiesettings sollten angeboten werden (ambulant, stationär, tagesklinisch, therapeutische Wohngruppen, aufsuchende Behandlung, ASP, stepped care, „case management“)?	E32
16.	Welchen Stellenwert haben stationäre Behandlungsangebote im Rahmen forensischer/gesicherter Settings (ambulante und stationäre forensische Settings, geschlossene Wohnheime)?	E 33
20.	Was sollen Behandler anderer Fachbereiche als der Psychiatrie und Psychotherapie im Umgang mit Menschen mit BPS beachten (Hausärztinnen und -ärzte, Notaufnahmen, Intensivtstationen)?	E 34
22.	Wie können Menschen, die mit der Versorgung und Behandlung von Menschen mit BPS befasst sind, unterstützt werden (Supervision, Fortbildung, zugeordnete Fallzahlen etc.)?	E 35-36
ADD3	Wie sollen Behandlungsmöglichkeiten und deren Koordination im Transitionsbereich adaptiert werden?	E 37
	Unterstützung für Angehörige und Betreuende	
23.	Benötigen Familien und Angehörige (insbesondere Kinder) von Menschen mit BPS besondere Unterstützung?	E 47
24.	Falls ja, welche spezifischen Angebote sollen angeboten werden?	E 42-44, E 46, E 48
25.	Können Familien und Angehörige durch Ihr Verhalten oder ihre Beziehungsgestaltung den Verlauf der BPS (im klinischen und sozialen Outcome und im Wohlergehen der von BPS Betroffenen) beeinflussen?	-
26.	Falls ja, welche Interventionen sollen angeboten werden?	E 38-41
	Spezielle Gruppen mit BPS	
	Wie sollen Behandlungsmöglichkeiten und deren Koordination adaptiert werden für…	
ADD5[5]	…Menschen mit intellektuellen Entwicklungsstörungen? Welche Rolle spielt deren Schweregrad?	E 50-53
ADD6[6]	…Angehörige ethnisch diverser Gruppen?	E 49

[5] NICE-Fragestellung Nr. 13

[6] NICE-Fragestellung Nr. 14

Frage Nr.[1]	Übersetzung/Adaption	Empfehlungen[2]
ADD7[7]	…von BPS Betroffene, die eine Elternschaft planen, Eltern werden oder sind?	E 45
ADD8	…mit genderspezifischen Besonderheiten?	E 54
ADD9	…im höheren Lebensalter	-

9.2 Anhang 2: Suchstrategien

9.2.1 Fragestellung 1

A Medline – Ovid interface (September 07, 2021)

1. borderline personality disorder.mp. or Borderline Personality Disorder/
2. Borderline Personality Disorder/ or borderline personality symptom$.mp.
3. Personality disorder$.sh. or PD$1.ti. or personaltit$.sh. or Personality.sh. or personality disorder$.sh. or personality disorders.sh.
4. personality dysfunction.mp.
5. Personality Disorders/ or cluster c personality disorder$.mp.
6. (Borderline or borderline person$ or borderline state or borderline$).sh.
7. borderline patient$.mp.
8. or/1-7
9. young people.m_titl.
10. young adults.m_titl.
11. young people.mp.
12. or/9-11
13. risk factors.mp. or Risk Factors/
14. 8 and 12 and 13
15. limit 14 to yr=”2011 - current”

B PsycINFO – Ovid interface

1. borderline personality disorder.mp. or Borderline Personality Disorder/
2. (Borderline or borderline person$ or borderline state or borderline$).sh.
3. borderline patient$.mp.
4. Borderline Personality Disorder/ or borderline personality symptom$.mp.
5. Personality Disorders/ or cluster c personality disorder$.mp.
6. borderline personality disorder {Including Related Terms}
7. or/1-6
8. young people.m_titl.
9. young adults.m_titl.
10. young people.mp.
11. or/8-10
12. assessment.m_titl.

[7] NICE-Fragestellung Nr. 15

13. assessment.mp.
14. or/12-13
15. 7 and 11 and 14
16. limit 15 to yr="2011 - current"

9.2.2 Fragestellung 2

A Medline – Ovid interface (September 07, 2021)

1. borderline personality disorder.mp. or Borderline Personality Disorder/
2. Borderline Personality Disorder/ or borderline personality symptom$.mp.
3. Personality disorder$.sh. or PD$1.ti. or personaltit$.sh. or Personality.sh. or personality disorder$.sh. or personality disorders.sh.
4. personality dysfunction.mp.
5. Personality Disorders/ or cluster c personality disorder$.mp.
6. (Borderline or borderline person$ or borderline state or borderline$).sh.
7. borderline patient$.mp.
8. or/1-7
9. RCT or randomized control trials {No Related Terms}
10. randomised control trials {No Related Terms}
11. random allocation or random assignment or random sample or random sampling {No Related Terms}
12. random or randomization {No Related Terms}
13. randomized controlled trial or randomized control trials {No Related Terms}
14. randomised controlled trial or randomised control trials {No Related Terms}
15. double blind method or double blind procedure or double blind study or double blind studies or doubleblind or double {No Related Terms}
16. single blind procure or single blind method or single blind study or single blind studies or single or single blind or single blind method {No Related Terms}
17. crossover or crossover design or crossover procedure or cross over studies {No Related Terms}
18. clinical or clinical trial or clinical trials {No Related Terms}
19. controlled clinical trial or controlled clinical trials {No Related Terms}
20. or/9-19
21. "assessment*".m_titl.
22. assessment*.mp.
23. (assessment adj3 screening).m_titl.
24. (assessment adj3 screening).mp. [mp=protocol supplementary concept, rare disease supplementary concept, title, original title, abstract, name of substance word, subject heading word, unique identifier]
25. (assessment adj6 mental health).m_titl.
26. (assessment adj6 mental health).mp. [mp=protocol supplementary concept, rare disease supplementary concept, title, original title, abstract, name of substance word, subject heading word, unique identifier]
27. (assessment adj6 tools).mp. [mp=protocol supplementary concept, rare disease supplementary concept, title, original title, abstract, name of substance word, subject heading word, unique identifier]
28. (assessment adj6 tools).m_titl.
29. or/21-28

30. 8 and 20 and 29
31. limit 30 to yr="2011 - current"

B PsycINFO – Ovid interface (September 07, 2021)

1. borderline personality disorder.mp. or Borderline Personality Disorder/
2. (Borderline or borderline person$ or borderline state or borderline$).sh.
3. borderline patient$.mp.
4. Borderline Personality Disorder/ or borderline personality symptom$.mp
5. Personality Disorders/ or cluster c personality disorder$.mp.
6. borderline personality disorder {Including Related Terms}
7. or/1-6
8. randomised control trials {No Related Terms}
9. RCT {Including Related Terms}
10. random allocation or random assignment or random sample or random sampling {No Related Terms}
11. random allocation or random assignment or random sample or random sampling {Including Related Terms}
12. randomized control trials {No Related Terms}
13. random or randomization {No Related Terms}
14. randomized controlled trial or randomized control trials {Including Related Terms}
15. randomised controlled trial or randomised control trials {Including Related Terms}
16. double blind method.mp.
17. double blind procedure.mp.
18. double blind study.mp.
19. double blind studies.mp.
20. (single blind procedure or single blind method or single blind study or single blind studies or single blind).ab.
21. crossover or crossover design or crossover procedure or cross over studies {No Related Terms}
22. clinical or clinical trial or clinical trials {No Related Terms}
23. controlled clinical trial or controlled clinical trials {No Related Terms}
24. or/8-23
25. "assessment*".m_titl.
26. Psychological Assessment/ or assessment*.mp. or Cognitive Assessment/
27. (assessment adj3 screening).m_titl.
28. (assessment adj3 screening).mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures]
29. (assessment adj6 mental health).m_titl.
30. (assessment adj6 mental health).mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures]
31. (assessment adj6 tools).m_titl.
32. (assessment adj6 tools).mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures]
33. or/25-32
34. 7 and 24 and 33
35. limit 34 to yr="2008 - current"

C EMBASE- Ovid interface (September 07, 2021)

1. 'borderline state'/exp/mj OR 'borderline state'/exp OR 'personality disorder'/exp
2. 'randomised controlled trial'/exp OR 'systematic review'/exp OR 'meta analysis'/exp OR 'randomization'/exp OR 'random sample'/exp OR 'double blind procedure'/exp OR 'single blind procedure'/exp OR 'crossover procedure'/exp OR 'clinical trial'/exp
3. 'psychologic assessment'/exp OR 'clinical assessment tool'/exp OR 'clinical assessment'/
4. exp #1 AND #2 AND #3
5. #1 AND #2 AND #3 AND [2008-2018]/py

9.2.3 Fragestellung 3

A Medline – Ovid interface (August 26, 2021)

SEARCH (ADDITIONAL STRING SEARCH Q3)

1. RCT or randomized control trials {No Related Terms}
2. randomised control trials {No Related Terms}
3. random allocation or random assignment or random sample or random sampling {No Related Terms}
4. random or randomization {No Related Terms}
5. randomized controlled trial or randomized control trials {No Related Terms}
6. randomised controlled trial or randomised control trials {No Related Terms}
7. double blind method or double blind procedure or double blind study or double blind studies or doubleblind or double {No Related Terms}
8. single blind procedure or single blind method or single blind study or single blind studies or single or single blind or single blind method {No Related Terms}
9. crossover or crossover design or crossover procedure or cross over studies {No Related Terms}
10. clinical or clinical trial or clinical trials {No Related Terms}
11. controlled clinical trial or controlled clinical trials {No Related Terms}
12. or/1-11
13. borderline personality disorder.mp. or Borderline Personality Disorder/
14. Borderline Personality Disorder/ or borderline personality symptom$.mp.
15. Personality disorder$.sh. or PD$1.ti. or personaltit$.sh. or Personality.sh. or personality disorder$.sh. or personality disorders.sh.
16. personality dysfunction.mp.
17. Personality Disorders/ or cluster c personality disorder$.mp.
18. (Borderline or borderline person$ or borderline state or borderline$).sh.
19. borderline patient$.mp.
20. or/13-19
21. risk factors.mp. or Risk Factors/
22. prevention.mp.
23. 12 and 20 and 21
24. limit 23 to yr="2011 - current"

SEARCH (BPD AND RISK FACTORS Q3 REPEAT SEARCH)

1. borderline personality disorder.mp. or Borderline Personality Disorder/

2. Borderline Personality Disorder/ or borderline personality symptom$.mp.
3. Personality disorder$.sh. or PD$1.ti. or personaltit$.sh. or Personality.sh. or personality disorder$.sh. or personality disorders.sh.
4. personality dysfunction.mp.
5. Personality Disorders/ or cluster c personality disorder$.mp.
6. (Borderline or borderline person$ or borderline state or borderline$).sh.
7. borderline patient$.mp.
8. or/1-7
9. RCT or randomized control trials {No Related Terms}
10. randomised control trials {No Related Terms}
11. random allocation or random assignment or random sample or random sampling {No Related Terms}
12. random or randomization {No Related Terms}
13. randomized controlled trial or randomized control trials {No Related Terms}
14. randomised controlled trial or randomised control trials {No Related Terms}
15. double blind method or double blind procedure or double blind study or double blind studies or double blind or double {No Related Terms}
16. single blind procedure or single blind method or single blind study or single blind studies or single or single blind or single blind method {No Related Terms}
17. crossover or crossover design or crossover procedure or cross over studies {No Related Terms}
18. clinical or clinical trial or clinical trials {No Related Terms}
19. controlled clinical trial or controlled clinical trials {No Related Terms}
20. or/9-19
21. Risk Factors/ or risk factor*.mp.
22. "risk factor*".m_titl.
23. or/21-22
24. Prospective Studies {No Related Terms}
25. cohort studies {No Related Terms}
26. case control studies {No Related Terms}
27. prospective cohort study {No Related Terms}
28. retrospective cohort study {No Related Terms}
29. case-control study.m_titl.
30. correlational study {No Related Terms}
31. comparative study {No Related Terms}
32. or/24-31
33. 8 and 23 and 32
34. limit 33 to „yr=2011 to current"

B. PsycINFO – Ovid interface

SEARCH (ADDITIONAL STRING SEARCH Q3)

1. borderline personality disorder.mp. or Borderline Personality Disorder/
2. (Borderline or borderline person$ or borderline state or borderline$).sh.
3. borderline patient$.mp.
4. Borderline Personality Disorder/ or borderline personality symptom$.mp.
5. Personality Disorders/ or cluster c personality disorder$.mp.
6. borderline personality disorder {Including Related Terms}

7. or/1-6
8. risk factors.mp. or Risk Factors/
9. prevention.m_titl.
10. Prevention/
11. or/8-10
12. 7 and 11
13. randomised control trials {No Related Terms}
14. RCT {Including Related Terms}
15. random allocation or random assignment or random sample or random sampling {No Related Terms}
16. random allocation or random assignment or random sample or random sampling {Including Related Terms}
17. randomized control trials {No Related Terms}
18. random or randomization {No Related Terms}
19. randomized controlled trial or randomized control trials {Including Related Terms}
20. randomised controlled trial or randomised control trials {Including Related Terms}
21. double blind method.mp.
22. double blind procedure.mp.
23. double blind study.mp.
24. double blind studies.mp.
25. (single blind procedure or single blind method or single blind study or single blind studies or single blind).ab.
26. crossover or crossover design or crossover procedure or cross over studies {No Related Terms}
27. clinical or clinical trial or clinical trials {No Related Terms}
28. controlled clinical trial or controlled clinical trials {No Related Terms}
29. or/13-28
30. 12 and 29
31. limit 31 to yr="2011 - current"

C EMBASE - Ovid interface (September 07, 2021)

1. 'borderline state'/exp/mj OR 'borderline state'/exp OR 'personality disorder'/exp
2. 'randomised controlled trial'/exp OR 'systematic review'/exp OR 'meta analysis'/exp OR 'randomization'/exp OR 'random sample'/exp OR 'double blind procedure'/exp OR 'single blind procedure'/exp OR 'crossover procedure'/exp OR 'clinical trial'/exp
3. 'risk factor'/exp
4. 'case control study'/exp OR 'prospective study'/exp OR 'cohort analysis'/exp OR 'comparative
study'/exp OR 'retrospective study'/exp OR 'correlational study'/exp
5. #1 AND #3 AND #4
6. #1 AND #3 AND #4 AND [2011-2021]/py

9.2.4 Fragestellung 4

A Medline – Ovid Interface (August 27, 2021)

SEARCH (BPD, RCT AND PREVENTION INTERVENTION Q4 REPEAT SEARCH)
1. borderline personality disorder.mp. or Borderline Personality Disorder/

2. Borderline Personality Disorder/ or borderline personality symptom$.mp.
3. Personality disorder$.sh. or PD$1.ti. or personaltit$.sh. or Personality.sh. or personality disorder$.sh. or personality disorders.sh.
4. personality dysfunction.mp.
5. Personality Disorders/ or cluster c personality disorder$.mp.
6. (Borderline or borderline person$ or borderline state or borderline$).sh.
7. borderline patient$.mp.
8. or/1-7
9. RCT or randomized control trials {No Related Terms}
10. randomised control trials {No Related Terms}
11. random allocation or random assignment or random sample or random sampling {No Related Terms}
12. random or randomization {No Related Terms}
13. randomized controlled trial or randomized control trials {No Related Terms}
14. randomised controlled trial or randomised control trials {No Related Terms}
15. double blind method or double blind procedure or double blind study or double blind studies or doubleblind or double {No Related Terms}
16. single blind procedure or single blind method or single blind study or single blind studies or single or single blind or single blind method {No Related Terms}
17. crossover or crossover design or crossover procedure or cross over studies {No Related Terms}
18. clinical or clinical trial or clinical trials {No Related Terms}
19. controlled clinical trial or controlled clinical trials {No Related Terms}
20. or/9-19
21. Prospective Studies {No Related Terms}
22. cohort studies {No Related Terms}
23. case control studies {No Related Terms}
24. prospective cohort study {No Related Terms}
25. retrospective cohort study {No Related Terms}
26. case-control study.m_titl.
27. correlational study {No Related Terms}
28. comparative study {No Related Terms}
29. or/21-28
30. (prevent* adj6 intervention*).m_titl.
31. (prevent* adj6 intervention*).mp. [mp=protocol supplementary concept, rare disease supplementary concept, title, original title, abstract, name of substance word, subject heading word, unique identifier]
32. or/30-31
33. 8 and 20 and 32
34. limit 33 to yr=”2011 - current”

B PsycINFO – Ovid interface (September 07, 2021)

1. borderline personality disorder.mp. or Borderline Personality Disorder/
2. (Borderline or borderline person$ or borderline state or borderline$).sh.
3. borderline patient$.mp.
4. Borderline Personality Disorder/ or borderline personality symptom$.mp
5. Personality Disorders/ or cluster c personality disorder$.mp.
6. borderline personality disorder {Including Related Terms}
7. or/1-6

8. randomised control trials {No Related Terms}
9. RCT {Including Related Terms}
10. random allocation or random assignment or random sample or random sampling {No Related Terms}
11. random allocation or random assignment or random sample or random sampling {Including Related Terms}
12. randomized control trials {No Related Terms}
13. random or randomization {No Related Terms}
14. randomized controlled trial or randomized control trials {Including Related Terms}
15. randomised controlled trial or randomised control trials {Including Related Terms}
16. double blind method.mp.
17. double blind procedure.mp.
18. double blind study.mp.
19. double blind studies.mp.
20. (single blind procedure or single blind method or single blind study or single blind studies or single blind).ab.
21. crossover or crossover design or crossover procedure or cross over studies {No Related Terms}
22. clinical or clinical trial or clinical trials {No Related Terms}
23. controlled clinical trial or controlled clinical trials {No Related Terms}
24. or/8-23
25. Prospective Studies/
26. cohort studies.mp.
27. case control studies.mp.
28. prospective cohort study.mp.
29. retrospective cohort study.mp.
30. case-control study.m_titl.
31. correlational study.mp.
32. comparative study.mp.
33. or/25-32
34. (prevent* adj6 intervention*).m_titl.
35. (prevent* adj6 intervention*).mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures]
36. Intervention/ or prevention intervention*.mp.
37. prevention.mp. or Prevention/
38. or/34-37
39. 7 and 24 and 38

C EMBASE- Ovid interface (September 07, 2021)

1. 'borderline state'/exp/mj OR 'borderline state'/exp OR 'personality disorder'/exp
2. 'randomised controlled trial'/exp OR 'systematic review'/exp OR 'meta analysis'/exp OR 'randomization'/exp OR 'random sample'/exp OR 'double blind procedure'/exp OR 'single blind procedure'/exp OR 'crossover procedure'/exp OR 'clinical trial'/exp
3. 'prevention study'/exp OR 'intervention study'/exp
4. 'borderline state'/exp/mj OR 'borderline state'/exp OR 'personality disorder'/exp AND ('randomised controlled trial'/exp OR 'systematic review'/exp OR 'meta analysis'/exp OR 'randomization'/exp OR 'random sample'/exp OR 'double blind procedure'/exp OR 'single blind procedure'/exp OR 'crossover procedure'/exp OR 'clinical trial'/exp) AND ('prevention study'/exp OR 'intervention study'/exp)

9.2.5 Fragestellung 5

A Medline – Ovid interface (September 06, 2021)

1. borderline personality disorder.mp. or Borderline Personality Disorder/
2. Borderline Personality Disorder/ or borderline personality symptom$.mp.
3. Personality disorder$.sh. or PD$1.ti. or personaltit$.sh. or Personality.sh. or personality disorder$.sh. or personality disorders.sh.
4. personality dysfunction.mp.
5. Personality Disorders/ or cluster c personality disorder$.mp.
6. (Borderline or borderline person$ or borderline state or borderline$).sh.
7. borderline patient$.mp.
8. or/1-7
9. young people.m_titl.
10. young adults.m_titl.
11. young people.mp.
12. or/9-11
13. Intervention Studies/ or intervention*.mp.
14. “intervention*”.m_titl.
15. or/13-14
16. and 12 and 15
17. limit 16 to yr=”2008 - 2011”
18. “care process*”.m_titl.
19. and 12 and 18
20. and 12
21. limit 20 to yr=”2008 - current”

B PsycINFO – Ovid interface (September 06, 2021)

1. borderline personality disorder.mp. or Borderline Personality Disorder/
2. (Borderline or borderline person$ or borderline state or borderline$).sh.
3. borderline patient$.mp.
4. Borderline Personality Disorder/ or borderline personality symptom$.mp.
5. Personality Disorders/ or cluster c personality disorder$.mp.
6. borderline personality disorder
7. or/1-6
8. young people.m_titl.
9. young adults.m_titl.
10. young people.mp.
11. or/8-10
12. putative borderline personality disorder.mp.
13. intervention*.mp.
14. "intervention*".m_titl.
15. or/13-14
16. 7 and 11 and 15
17. (care adj2 process$).mp.
18. 7 and 11 and 17
19. 16 or 18
20. limit 16 to yr="2011-2019"

C EMBASE- Ovid interface (September 06, 2021)

1. borderline state'/exp/mj OR 'borderline state'/exp OR 'personality disorder'/exp
2. 'randomised controlled trial'/exp OR 'systematic review'/exp OR 'meta analysis'/exp OR 'randomization'/exp OR 'random sample'/exp OR 'double blind procedure'/exp OR 'single blind procedure'/exp OR 'crossover procedure'/exp OR 'clinical trial'/exp
3. 'youth'/exp OR young NEAR/2 people OR young NEAR/2 adults OR 'adolescent'/exp
4. #1 AND #2 AND #3
5. #1 AND #2 AND #3 AND [2011-2021]/py
6. intervention OR interventions
7. #5 AND #6

9.2.6 Fragestellung 6

A Medline – Ovid interface (September 06, 2021)

Medline-Suche 6.1

1. borderline personality disorder.mp. or Borderline Personality Disorder/
2. Borderline Personality Disorder/ or borderline personality symptom$.mp.
3. Personality disorder$.sh. or PD$1.ti. or personaltit$.sh. or Personality.sh. or personality disorder$.sh. or personality disorders.sh.
4. personality dysfunction.mp.
5. Personality Disorders/ or cluster c personality disorder$.mp.
6. (Borderline or borderline person$ or borderline state or borderline$).sh.
7. borderline patient$.mp.
8. or/1-7
9. RCT or randomized control trials {No Related Terms}
10. randomised control trials {No Related Terms}
11. random allocation or random assignment or random sample or random sampling {No Related Terms}
12. random or randomization {No Related Terms}
13. randomized controlled trial or randomized control trials {No Related Terms}
14. randomised controlled trial or randomised control trials {No Related Terms}
15. double blind method or double blind procedure or double blind study or double blind studies or doubleblind or double {No Related Terms}
16. single blind procedure or single blind method or single blind study or single blind studies or single or single blind or single blind method {No Related Terms}
17. crossover or crossover design or crossover procedure or cross over studies {No Related Terms}
18. clinical or clinical trial or clinical trials {No Related Terms}
19. controlled clinical trial or controlled clinical trials {No Related Terms}
20. or/9-19
21. Treatment Outcome/ or treatment*.mp.
22. "treatment*".m_titl.
23. or/21-22
24. 8 and 20 and 23
25. limit 24 to yr="2008 - 2021"

Medline-Suche 6.2

1. borderline personality disorder.mp. or Borderline Personality Disorder/
2. Borderline Personality Disorder/ or borderline personality symptom$.mp.
3. Personality disorder$.sh. or PD$1.ti. or personaltit$.sh. or Personality.sh. or personality disorder$.sh. or personality disorders.sh.
4. personality dysfunction.mp.
5. Personality Disorders/ or cluster c personality disorder$.mp.
6. (Borderline or borderline person$ or borderline state or borderline$).sh.
7. borderline patient$.mp.
8. or/1-7
9. RCT or randomized control trials {No Related Terms}
10. randomised control trials {No Related Terms}
11. random allocation or random assignment or random sample or random sampling {No Related Terms}
12. random or randomization {No Related Terms}
13. randomized controlled trial or randomized control trials {No Related Terms}
14. randomised controlled trial or randomised control trials {No Related Terms}
15. double blind method or double blind procedure or double blind study or double blind studies or doubleblind or double {No Related Terms}
16. single blind procedure or single blind method or single blind study or single blind studies or single or single blind or single blind method {No Related Terms}
17. crossover or crossover design or crossover procedure or cross over studies {No Related Terms}
18. clinical or clinical trial or clinical trials {No Related Terms}
19. controlled clinical trial or controlled clinical trials {No Related Terms}
20. or/9-19
21. quality of life.mp. or “Quality of Life”/
22. 8 and 20 and 21
23. limit 22 to yr=”2011 - 2021”
24. from 23 keep 1-8
25. self-harm.mp.
26. 8 and 20 and 25
27. limit 26 to yr=”2011 - 2021”
28. “service*”.m_titl.
29. 8 and 20 and 28
30. (risk adj6 behavio$r).m_titl.
31. 8 and 20 and 30
32. Risk-Taking/ or risk-related behavio$r.mp.
33. 8 and 20 and 32
34. (social adj6 function*).mp. [mp=protocol supplementary concept, rare disease supplementary concept, title, original title, abstract, name of substance word, subject heading word, unique identifier]
35. 8 and 20 and 34
36. limit 35 to yr=”2011-2021”
37. (personal adj6 function*).mp. [mp=protocol supplementary concept, rare disease supplementary concept, title, original title, abstract, name of substance word, subject heading word, unique identifier]
38 8 and 20 and 37
39. (harm* adj6 minimis*).mp. [mp=protocol supplementary concept, rare disease supplementary concept, title, original title, abstract, name of substance word, subject

heading word, unique identifier]
40. 8 and 20 and 39
41. 23 or 27 or 36

B. PsycINFO – Ovid interface (September 06, 2021)

PsycINFO-Suche 6.1

1 borderline personality disorder.mp. or Borderline Personality Disorder/
2 (Borderline or borderline person$ or borderline state or borderline$).sh.
3 borderline patient$.mp.
4 Borderline Personality Disorder/ or borderline personality symptom$.mp.
5 Personality Disorders/ or cluster c personality disorder$.mp.
6 borderline personality disorder {Including Related Terms}
7 or/1-6
8 randomised control trials {No Related Terms}
9 RCT {Including Related Terms}
10 random allocation or random assignment or random sample or random sampling {No Related Terms}
11 random allocation or random assignment or random sample or random sampling {Including Related Terms}
12 randomized control trials {No Related Terms}
13 random or randomization {No Related Terms}
14 randomized controlled trial or randomized control trials {Including Related Terms}
15 randomised controlled trial or randomised control trials {Including Related Terms}
16 double blind method.mp.
17 double blind procedure.mp.
18 double blind study.mp.
19 double blind studies.mp.
20 (single blind procedure or single blind method or single blind study or single blind studies or single blind).ab.
21 crossover or crossover design or crossover procedure or cross over studies {No Related Terms}
22 clinical or clinical trial or clinical trials {No Related Terms}
23 controlled clinical trial or controlled clinical trials {No Related Terms}
24 or/8-23
25 treatment*.mp.
26 "treatment*".m_titl.
27 or/25-26
28 7 and 24 and 27
29 limit 28 to yr="2011 - 2021"

PsycINFO-Suche 6.2

1 borderline personality disorder.mp. or Borderline Personality Disorder/
2 (Borderline or borderline person$ or borderline state or borderline$).sh.
3 borderline patient$.mp.
4 Borderline Personality Disorder/ or borderline personality symptom$.mp.
5 Personality Disorders/ or cluster c personality disorder$.mp.

6 borderline personality disorder {Including Related Terms}
7 or/1-6
8 randomised control trials {No Related Terms}
9 RCT {Including Related Terms}
10 random allocation or random assignment or random sample or random sampling {No Related Terms}
11 random allocation or random assignment or random sample or random sampling {Including Related Terms}
12 randomized control trials {No Related Terms}
13 random or randomization {No Related Terms}
14 randomized controlled trial or randomized control trials {Including Related Terms}
15 randomised controlled trial or randomised control trials {Including Related Terms}
16 double blind method.mp.
17 double blind procedure.mp.
18 double blind study.mp.
19 double blind studies.mp.
20 (single blind procedure or single blind method or single blind study or single blind studies or single blind).ab.
21 crossover or crossover design or crossover procedure or cross over studies {No Related Terms}
22 clinical or clinical trial or clinical trials {No Related Terms}
23 controlled clinical trial or controlled clinical trials {No Related Terms}
24 or/8-23
25. quality of life.mp. or "Quality of Life"/
26. 7 and 24 and 25
27. limit 26 to yr="2011 - 2021"
28. self-harm.mp.
29. service*.mp.
30. 7 and 24 and 29
31. limit 30 to yr="2011 - 2019"
32. (risk adj6 behavio$r).m_titl.
33. 7 and 24 and 32
34. Risk-Taking/ or risk-related behavio$r.mp.
35. 7 and 24 and 34
36. (social adj6 function*).m_titl.
37. 7 and 24 and 36
38. limit 37 to yr="2011 - 2019"
39. (personal adj6 function*).m_titl.
40. 7 and 24 and 39
41. (harm* adj6 minimis*).mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures]
42. 7 and 24 and 41
43. 27 or 31

C. EMBASE- Ovid interface (September 06, 2021)

1. 'borderline state'/exp/mj OR 'borderline state'/exp OR 'personality disorder'/exp
2. 'randomised controlled trial'/exp OR 'systematic review'/exp OR 'meta analysis'/exp OR 'randomization'/exp OR 'random sample'/exp OR 'double blind procedure'/exp OR 'single blind
procedure'/exp OR 'crossover procedure'/exp OR 'clinical trial'/exp

3. ‘therapy’/exp OR ‘quality of life’/exp OR ‘health care utilization’/exp OR ‘high risk behavior’/exp
OR ‘social interaction’/exp
4. #1 AND #2 AND #3
5. #1 AND #2 AND #3 AND [2011-2021]/py

9.2.7 Fragestellung 7

A Medline – Ovid interface (September 06, 2021)

1. borderline personality disorder.mp. or Borderline Personality Disorder/
2. Borderline Personality Disorder/ or borderline personality symptom$.mp.
3. Personality disorder$.sh. or PD$1.ti. or personaltit$.sh. or Personality.sh. or personality disorder$.sh. or personality disorders.sh.
4. personality dysfunction.mp.
5. Personality Disorders/ or cluster c personality disorder$.mp.
6. (Borderline or borderline person$ or borderline state or borderline$).sh.
7. borderline patient$.mp.
8. or/1-7
9. RCT or randomized control trials {No Related Terms}
10. randomised control trials {No Related Terms}
11. random allocation or random assignment or random sample or random sampling {No Related Terms}
12. random or randomization {No Related Terms}
13. randomized controlled trial or randomized control trials {No Related Terms}
14. randomised controlled trial or randomised control trials {No Related Terms}
15. double blind method or double blind procedure or double blind study or double blind studies or doubleblind or double {No Related Terms}
16. single blind procedure or single blind method or single blind study or single blind studies or single or single blind or single blind method {No Related Terms}
17. crossover or crossover design or crossover procedure or cross over studies {No Related Terms}
18. clinical or clinical trial or clinical trials {No Related Terms}
19. controlled clinical trial or controlled clinical trials {No Related Terms}
20. or/9-19
21. “psychological therap*”.m_titl.
22. (psychological adj6 therap*).mp. [mp=protocol supplementary concept, rare disease supplementary concept, title, original title, abstract, name of substance word, subject heading word, unique identifier]
23. CBT.m_titl.
24. cognit* behavio?r therapy.mp.
25. mentalisation.mp.
26. mentalisation.m_titl.
27. (behavio?r adj3 therap*).mp. [mp=protocol supplementary concept, rare disease supplementary
concept, title, original title, abstract, name of substance word, subject
heading word, unique identifier]
28. (behavio?r adj3 therap*).m_titl.
29. psychodynamic.mp.
30. Psychodynamic interpersonal therapy.m_titl.

31. Psychodynamic psychotherapy.m_titl.
32. Cognitive analytic therapy.m_titl.
33. Cognitive analytic therapy.mp.
34. (group adj6 therapy).mp. [mp=protocol supplementary concept, rare disease supplementary
concept, title, original title, abstract, name of substance word, subject heading word, unique identifier]
35. family therapy.m_titl.
36. (family adj3 therapy).mp. [mp=protocol supplementary concept, rare disease supplementary
concept, title, original title, abstract, name of substance word, subject heading word, unique identifier]
37. schema-focused therapy.m_titl.
38. schema-focused therapy.mp.
39. transference-focused.m_titl.
40. (transference adj3 therapy).mp. [mp=protocol supplementary concept, rare disease supplementary concept, title, original title, abstract, name of substance word, subject heading word, unique identifier]
41. DBT.m_titl.
42. Dialectical Behavior Therapy.mp.
43. or/21-42
44. 8 and 20 and 43
45. limit 44 to yr="2011 - 2021"

B PsycINFO – Ovid interface (September 06, 2021)

1. borderline personality disorder.mp. or Borderline Personality Disorder/
2. (Borderline or borderline person$ or borderline state or borderline$).sh.
3. borderline patient$.mp.
4. Borderline Personality Disorder/ or borderline personality symptom$.mp.
5. Personality Disorders/ or cluster c personality disorder$.mp.
6. borderline personality disorder
7. or/1-6
8. randomised control trials
9. RCT
10. random allocation or random assignment or random sample or random sampling
11. random allocation or random assignment or random sample or random sampling
12. randomized control trials
13. random or randomization
14. randomized controlled trial or randomized control trials
15. randomised controlled trial or randomised control trials
16. double blind method.mp.
17. double blind procedure.mp.
18. double blind study.mp.
19. double blind studies.mp.
20. (single blind procedure or single blind method or single blind study or single blind studies or single blind).ab.
21. crossover or crossover design or crossover procedure or cross over studies
22. clinical or clinical trial or clinical trials
23. controlled clinical trial or controlled clinical trials
24. or/8-23

25. (psychological adj6 therap*).mp.
26. "psychological therap*".m_titl.
27. CBT.m_titl.
28. cognit* behavio?r therapy.mp.
29. mentalisation.m_titl.
30. mentalisation.mp.
31. behavio?r therapy.mp. or Behavior Therapy/
32. Psychodynamic psychotherapy.m_titl.
33. psychodynamic.mp. or Psychodynamics/
34. (group adj6 therapy).mp.
35. schema-focused therapy.m_titl.
36. schema-focused therapy.mp.
37. Cognitive analytic therapy.m_titl.
38. Cognitive analytic therapy.mp.
39. family therapy.m_titl.
40. family therapy.mp. or Family Therapy/
41. transference-focused.m_titl.
42. (transference adj3 therapy).mp.
43. DBT.m_titl.
44. Dialectical Behavior Therapy/ or DBT.mp.
45. or/25-44
46. 7 and 24 and 45
47. limit 46 to yr="2011 - 2021"

C EMBASE- Ovid interface (September 06, 2021)

1. 'borderline state'/exp/mj OR 'borderline state'/exp OR 'personality disorder'/exp
2. 'randomised controlled trial'/exp OR 'systematic review'/exp OR 'meta analysis'/exp OR 'randomization'/exp OR 'random sample'/exp OR 'double blind procedure'/exp OR 'single blind procedure'/exp OR 'crossover procedure'/exp OR 'clinical trial'/exp
3. 'cognitive therapy'/exp OR 'behavior therapy'/exp OR 'group therapy'/exp OR 'family therapy'/exp OR 'transference'/exp OR 'psychotherapy'/exp
4. #1 AND #2 AND #3
5. #1 AND #2 AND #3 AND [2011-2019]/py

9.2.8 Fragestellung 8

A Medline – Ovid interface (September 06, 2021)

1. borderline personality disorder.mp. or Borderline Personality Disorder/
2. Borderline Personality Disorder/ or borderline personality symptom$.mp.
3. Personality disorder$.sh. or PD$1.ti. or personaltit$.sh. or Personality.sh. or personality disorder$.sh. or personality disorders.sh.
4. personality dysfunction.mp.
5. Personality Disorders/ or cluster c personality disorder$.mp.
6. (Borderline or borderline person$ or borderline state or borderline$).sh.
7. borderline patient$.mp.
8. or/1-7
9. RCT or randomized control trials {No Related Terms}

10. randomised control trials {No Related Terms}
11. random allocation or random assignment or random sample or random sampling {No Related Terms}
12. random or randomization {No Related Terms}
13. randomized controlled trial or randomized control trials {No Related Terms}
14. randomised controlled trial or randomised control trials {No Related Terms}
15. double blind method or double blind procedure or double blind study or double blind studies or doubleblind or double {No Related Terms}
16. single blind procedure or single blind method or single blind study or single blind studies or single or single blind or single blind method {No Related Terms}
17. crossover or crossover design or crossover procedure or cross over studies {No Related Terms}
18. clinical or clinical trial or clinical trials {No Related Terms}
19. controlled clinical trial or controlled clinical trials {No Related Terms}
20. or/9-19
21. "psychosocial treatment*".m_titl.
22. psychosocial treatment*.mp.
23. psychosocial therapy.m_titl.
24. psychosocial therapy.mp.
25. (psychosocial adj6 therap*).mp. [mp=protocol supplementary concept, rare disease supplementary concept, title, original title, abstract, name of substance word, subject heading word, unique identifier]
26. psychosocial.mp.
27. or/21-26
28. 8 and 20 and 27
29. limit 28 to yr="2011 - 2021"

B PsycINFO – Ovid interface (September 06, 2021)

1. borderline personality disorder.mp. or Borderline Personality Disorder/
2. (Borderline or borderline person$ or borderline state or borderline$).sh.
3. borderline patient$.mp.
4. Borderline Personality Disorder/ or borderline personality symptom$.mp.
5. Personality Disorders/ or cluster c personality disorder$.mp.
6. borderline personality disorder
7. or/1-6
8. randomised control trials
9. RCT
10. random allocation or random assignment or random sample or random sampling
11. random allocation or random assignment or random sample or random sampling
12. randomized control trials
13. random or randomization
14. randomized controlled trial or randomized control trials
15. randomised controlled trial or randomised control trials
16. double blind method.mp.
17. double blind procedure.mp.
18. double blind study.mp.
19. double blind studies.mp.
20. (single blind procedure or single blind method or single blind study or single blind studies or single blind).ab.
21. crossover or crossover design or crossover procedure or cross over studies

22. clinical or clinical trial or clinical trials
23. controlled clinical trial or controlled clinical trials
24. or/8-23
25. "psychosocial treatment*".m_titl.
26. Psychosocial Factors/ or psychosocial treatment.mp.
27. psychosocial therapy.m_titl.
28. Psychosocial Rehabilitation/
29. psychosocial therapy.mp.
30. (psychosocial adj6 therap*).mp.
31. psychosocial.mp.
32. or/25-31
33. 7 and 24 and 32
34. limit 33 to yr="2011 -2021"

C EMBASE- Ovid interface (September 06, 2021)

1. 'borderline state'/exp/mj OR 'borderline state'/exp OR 'personality disorder'/exp
2. 'randomised controlled trial'/exp OR 'systematic review'/exp OR 'meta analysis'/exp OR 'randomization'/exp OR 'random sample'/exp OR 'double blind procedure'/exp OR 'single blind procedure'/exp OR 'crossover procedure'/exp OR 'clinical trial'/exp
3. 'psychosocial care'/exp
4. #1 AND #2 AND #3
5. #1 AND #2 AND #3 AND [2011-2021]/py

9.2.9 Fragestellung 9

A Medline – Ovid interface (September 06, 2021)

1 borderline personality disorder.mp. or Borderline Personality Disorder/
2 Borderline Personality Disorder/ or borderline personality symptom$.mp.
3 Personality disorder$.sh. or PD$1.ti. or personaltit$.sh. or Personality.sh. or personality disorder$.sh. or personality disorders.sh.
4 personality dysfunction.mp.
5 Personality Disorders/ or cluster c personality disorder$.mp.
6 (Borderline or borderline person$ or borderline state or borderline$).sh.
7 borderline patient$.mp.
8 or/1-7
9 RCT or randomized control trials {No Related Terms}
10 randomised control trials {No Related Terms}
11 random allocation or random assignment or random sample or random sampling {No Related Terms}
12 random or randomization {No Related Terms}
13 randomized controlled trial or randomized control trials {No Related Terms}
14 randomised controlled trial or randomised control trials {No Related Terms}
15 double blind method or double blind procedure or double blind study or double blind studies or doubleblind or double {No Related Terms}
16 single blind procedure or single blind method or single blind study or single blind studies or single or single blind or single blind method {No Related Terms}

17 crossover OR crossover design OR crossover procedure OR cross over studies {No Related Terms}
18 clinical or clinical trial or clinical trials {No Related Terms}
19 controlled clinical trial or controlled clinical trials {No Related Terms}
20 or/9-19
21 "pharmacological intervention*".m_titl.
22 pharmacological intervention*.mp.
23 Pharmacology/ or pharmacological intervention*.mp.
24 pharmacological treatment.m_titl.
25 "pharmacological treatment*".m_titl.
26 pharmacological treatment*.mp.
27 (pharmacological adj6 therap*).m_titl.
28 (pharmacological adj6 therap*).mp.
29 pharmacology.mp. or Pharmacology/
30 or/21-29
31 8 and 20 and 30
32 limit 31 to yr="2011 -2021"

B PsycINFO – Ovid interface (September 06, 2021)

1. borderline personality disorder.mp. or Borderline Personality Disorder/
2. (Borderline or borderline person$ or borderline state or borderline$).sh.
3. borderline patient$.mp.
4. Borderline Personality Disorder/ or borderline personality symptom$.mp.
5. Personality Disorders/ or cluster c personality disorder$.mp.
6. borderline personality disorder
7. or/1-6
8. randomised control trials
9. RCT
10. random allocation or random assignment or random sample or random sampling
11. random allocation or random assignment or random sample or random sampling
12. randomized control trials
13. random or randomization
14. randomized controlled trial or randomized control trials
15. randomised controlled trial or randomised control trials
16. double blind method.mp.
17. double blind procedure.mp.
18. double blind study.mp.
19. double blind studies.mp.
20. (single blind procedure or single blind method or single blind study or single blind studies or single blind).ab.
21. crossover or crossover design or crossover procedure or cross over studies
22. clinical or clinical trial or clinical trials
23. controlled clinical trial or controlled clinical trials
24. or/8-23
25. "pharmacological intervention*".m_titl.
26. Pharmacology/ or pharmacological intervention*.mp.
27. pharmacological treatment.m_titl.
28. "pharmacological treatment*".m_titl.
29. (pharmacological adj6 therap*).mp.

30. (pharmacological adj6 therap*).m_titl.
31. pharmacology.mp. or Pharmacology/
32. or/25-31
33. 7 and 24 and 32
34. limit 33 to yr="2011 -2021"

C EMBASE – Ovid interface (September 06, 2021)

1. 'borderline state'/exp/mj OR 'borderline state'/exp OR 'personality disorder'/exp
2. 'randomised controlled trial'/exp OR 'systematic review'/exp OR 'meta analysis'/exp OR 'randomization'/exp OR 'random sample'/exp OR 'double blind procedure'/exp OR 'single blind procedure'/exp OR 'crossover procedure'/exp OR 'clinical trial'/exp
3. 'pharmacology'/exp OR 'clinical pharmacology'/exp OR 'drug therapy'/exp
4. #1 AND #2 AND #3
5. #1 AND #2 AND #3 AND [embase]/lim AND [2011-2021]/py

9.2.10 Fragestellung 10

A Medline – Ovid interface (September 06, 2021)

1 borderline personality disorder.mp. or Borderline Personality Disorder/
2 Borderline Personality Disorder/ or borderline personality symptom$.mp.
3 Personality disorder$.sh. or PD$1.ti. or personaltit$.sh. or Personality.sh. or personality disorder$.sh. or personality disorders.sh.
4 personality dysfunction.mp.
5 Personality Disorders/ or cluster c personality disorder$.mp.
6 (Borderline or borderline person$ or borderline state or borderline$).sh.
7 borderline patient$.mp.
8 or/1-7
9 RCT or randomized control trials {No Related Terms}
10 randomised control trials {No Related Terms}
11 random allocation or random assignment or random sample or random sampling {No Related Terms}
12 random or randomization {No Related Terms}
13 randomized controlled trial or randomized control trials {No Related Terms}
14 randomised controlled trial or randomised control trials {No Related Terms}
15 double blind method or double blind procedure or double blind study or double blind studies or doubleblind or double {No Related Terms}
16 single blind procedure or single blind method or single blind study or single blind studies or single or single blind or single blind method {No Related Terms}
17 crossover OR crossover design OR crossover procedure OR cross over studies {No Related Terms}
18 clinical or clinical trial or clinical trials {No Related Terms}
19 controlled clinical trial or controlled clinical trials {No Related Terms}
20 or/9-19
21. "multimodal therap*".m_titl.
22. multimodal therapy.mp.
23. (multimodal adj6 therapy).mp. [mp=protocol supplementary concept, rare disease supplementary concept, title, original title, abstract, name of substance word, subject heading word, unique identifier]

24. or/21-23
25. 8 and 20 and 24
26. 8 and 24
27. limit 26 to yr="2011 -2021"

B PsycINFO – Ovid interface (September 06, 2021)

1. borderline personality disorder.mp. or Borderline Personality Disorder/
2. (Borderline or borderline person$ or borderline state or borderline$).sh.
3. borderline patient$.mp.
4. Borderline Personality Disorder/ or borderline personality symptom$.mp
5. Personality Disorders/ or cluster c personality disorder$.mp.
6. borderline personality disorder {Including Related Terms}
7. or/1-6
8. randomised control trials {No Related Terms}
9. RCT {Including Related Terms}
10. random allocation or random assignment or random sample or random sampling {No Related Terms}
11. random allocation or random assignment or random sample or random sampling {Including Related Terms}
12. randomized control trials {No Related Terms}
13. random or randomization {No Related Terms}
14. randomized controlled trial or randomized control trials {Including Related Terms}
15. randomised controlled trial or randomised control trials {Including Related Terms}
16. double blind method.mp.
17. double blind procedure.mp.
18. double blind study.mp.
19. double blind studies.mp.
20. (single blind procedure or single blind method or single blind study or single blind studies or single blind).ab.
21. crossover or crossover design or crossover procedure or cross over studies {No Related Terms}
22. clinical or clinical trial or clinical trials {No Related Terms}
23. controlled clinical trial or controlled clinical trials {No Related Terms}
24. or/8-23
25. “multimodal therap* “.m_titl.
26. (multimodal adj6 therapy).mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures]
27. or/25-26
28. 7 and 24 and 27
29. 7 and 27
30. limit 29 to yr=”2011 - 2021”

C Embase – Ovid Interface

No search completed on Embase[26]

9.2.11 Fragestellung 11

A Medline – Ovid interface (September 06, 2021)

1 borderline personality disorder.mp. or Borderline Personality Disorder/
2 Borderline Personality Disorder/ or borderline personality symptom$.mp.
3 Personality disorder$.sh. or PD$1.ti. or personaltit$.sh. or Personality.sh. or personality disorder$.sh. or personality disorders.sh.
4 personality dysfunction.mp.
5 Personality Disorders/ or cluster c personality disorder$.mp.
6 (Borderline or borderline person$ or borderline state or borderline$).sh.
7 borderline patient$.mp.
8 or/1-7
9 RCT or randomized control trials {No Related Terms}
10 randomised control trials {No Related Terms}
11 random allocation or random assignment or random sample or random sampling {No Related Terms}
12 random or randomization {No Related Terms}
13 randomized controlled trial or randomized control trials {No Related Terms}
14 randomised controlled trial or randomised control trials {No Related Terms}
15 double blind method or double blind procedure or double blind study or double blind studies or doubleblind or double {No Related Terms}
16 single blind procedure or single blind method or single blind study or single blind studies or single or single blind or single blind method {No Related Terms}
17 crossover OR crossover design OR crossover procedure OR cross over studies {No Related Terms}
18 clinical or clinical trial or clinical trials {No Related Terms}
19 controlled clinical trial or controlled clinical trials {No Related Terms}
20 or/9-19
21. AIDS.mp. or Acquired Immunodeficiency Syndrome/
22. diabetes.mp.
23. Pain/ or chronic pain.mp.
24. Obesity/ or obesity.mp.
25. Fatigue Syndrome, Chronic/ or chronic fatigue.mp.
26. eating disorders.mp. or Eating Disorders/
27. intellectual disability.mp. or Mental Retardation/
28. or/21-27
29. 8 and 20 and 28
30. limit 29 to yr=”2011 - 2021”

B PsycINFO – Ovid interface (September 06, 2021)

1. borderline personality disorder.mp. or Borderline Personality Disorder/
2. (Borderline or borderline person$ or borderline state or borderline$).sh.
3. borderline patient$.mp.
4. Borderline Personality Disorder/ or borderline personality symptom$.mp
5. Personality Disorders/ or cluster c personality disorder$.mp.
6. borderline personality disorder {Including Related Terms}
7. or/1-6
8. randomised control trials {No Related Terms}
9. RCT {Including Related Terms}

10. random allocation or random assignment or random sample or random sampling {No Related Terms}
11. random allocation or random assignment or random sample or random sampling {Including Related Terms}
12. randomized control trials {No Related Terms}
13. random or randomization {No Related Terms}
14. randomized controlled trial or randomized control trials {Including Related Terms}
15. randomised controlled trial or randomised control trials {Including Related Terms}
16. double blind method.mp.
17. double blind procedure.mp.
18. double blind study.mp.
19. double blind studies.mp.
20. (single blind procedure or single blind method or single blind study or single blind studies or single blind).ab.
21. crossover or crossover design or crossover procedure or cross over studies {No Related Terms}
22. clinical or clinical trial or clinical trials {No Related Terms}
23. controlled clinical trial or controlled clinical trials {No Related Terms}
24. or/8-23
25. AIDS.mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures]
26. AIDS.mp. or AIDS/
27. diabetes.mp. or Diabetes/
28. Chronic Pain/ or Pain/ or Pain.mp.
29. Obesity/ or obesity.mp.
30. Chronic Fatigue Syndrome/ or chronic fatigue.mp.
31. eating disorders.mp. or Eating Disorders/
32. Mental Retardation/ or intellectual disability.mp.
33. Learning Disabilities/
34. or/25-33
35. 7 and 24 and 34
36. limit 35 to yr="2011 - 2021"

C Embase – Ovid Interface

No search completed on Embase[26]

9.2.12 Fragestellung 13

A Medline – Ovid interface (September 06, 2021)

1 borderline personality disorder.mp. or Borderline Personality Disorder/
2 Borderline Personality Disorder/ or borderline personality symptom$.mp.
3 Personality disorder$.sh. or PD$1.ti. or personaltit$.sh. or Personality.sh. or personality disorder$.sh. or personality disorders.sh.
4 personality dysfunction.mp.
5 Personality Disorders/ or cluster c personality disorder$.mp.
6 (Borderline or borderline person$ or borderline state or borderline$).sh.
7 borderline patient$.mp.

8 or/1-7
9 RCT or randomized control trials {No Related Terms}
10 randomised control trials {No Related Terms}
11 random allocation or random assignment or random sample or random sampling {No Related Terms}
12 random or randomization {No Related Terms}
13 randomized controlled trial or randomized control trials {No Related Terms}
14 randomised controlled trial or randomised control trials {No Related Terms}
15 double blind method or double blind procedure or double blind study or double blind studies or doubleblind or double {No Related Terms}
16 single blind procedure or single blind method or single blind study or single blind studies or single or single blind or single blind method {No Related Terms}
17 crossover OR crossover design OR crossover procedure OR cross over studies {No Related Terms}
18 clinical or clinical trial or clinical trials {No Related Terms}
19 controlled clinical trial or controlled clinical trials {No Related Terms}
20 or/9-19
21. axis II disorder*.mp.
22. "axis II disorder*".m_titl.
23. Depression/ or depression.mp.
24. anxiety.mp. or Anxiety/ or Anxiety Disorders/
25. Bipolar Disorder/ or bipolar.mp.
26. Substance-Related Disorders/ or Substance-Related Disorder*.mp.
27. comorbidity.mp. or Comorbidity/
28. or/21-27
29. treatment*.mp.
30. "treatment*".m_titl.
31. or/29-30
32. 20 and 28 and 31
33. 8 and 32
34. limit 33 to yr="2011 to 2021"

B PsycINFO – Ovid interface (September 06, 2021)

1. borderline personality disorder.mp. or Borderline Personality Disorder/
2. (Borderline or borderline person$ or borderline state or borderline$).sh.
3. borderline patient$.mp.
4. Borderline Personality Disorder/ or borderline personality symptom$.mp
5. Personality Disorders/ or cluster c personality disorder$.mp.
6. borderline personality disorder {Including Related Terms}
7. or/1-6
8. randomised control trials {No Related Terms}
9. RCT {Including Related Terms}
10. random allocation or random assignment or random sample or random sampling {No Related Terms}
11. random allocation or random assignment or random sample or random sampling {Including Related Terms}
12. randomized control trials {No Related Terms}
13. random or randomization {No Related Terms}

14. randomized controlled trial or randomized control trials {Including Related Terms}
15. randomised controlled trial or randomised control trials {Including Related Terms}
16. double blind method.mp.
17. double blind procedure.mp.
18. double blind study.mp.
19. double blind studies.mp.
20. (single blind procedure or single blind method or single blind study or single blind studies or single blind).ab.
21. crossover or crossover design or crossover procedure or cross over studies {No Related Terms}
22. clinical or clinical trial or clinical trials {No Related Terms}
23. controlled clinical trial or controlled clinical trials {No Related Terms}
24. or/8-23
25. “axis II disorder*”.m_titl.
26. axis II disorder*.mp.
27. depression.m_titl.
28. Major Depression/ or depression.mp.
29. “anxiety disorder*”.m_titl.
30. Anxiety Disorders/ or Anxiety/ or anxiety disorder*.mp.
31. Psychosis/ or psychosis.mp.
32. bipolar.m_titl.
33. Bipolar Disorder/ or bipolar disorder*.mp.
34. Substance-Related Disorder*.mp.
35. “Substance-Related Disorder*”.m_titl.
36. Comorbidity/ or comorbidit*.mp.
37. or/25-36
38. treatment*.mp. or Treatment/
39. “treatment*”.m_titl.
40. or/38-39
41. 24 and 37 and 40
42. 7 and 41
43. limit 42 to yr=”2011 - 2021”

C Embase – Ovid Interface (September 07, 2021)

1. ‘borderline state’/exp/mj OR ‘borderline state’/exp OR ‘personality disorder’/exp
2. ‘randomised controlled trial’/exp OR ‘systematic review’/exp OR ‘meta analysis’/exp OR ‘randomization’/exp OR ‘random sample’/exp OR ‘double blind procedure’/exp OR ‘single blind procedure’/exp OR ‘crossover procedure’/exp OR ‘clinical trial’/exp
3. ‘depression’/exp OR ‘generalized anxiety disorder’/exp OR ‘psychosis’/exp OR ‘bipolar disorder’/exp OR ‘substance abuse’/exp
4. #1 AND #2
5. #3 AND #4
6. #3 AND #4 AND [2011-2021]/py
7. ‘treatment’ AND [2011-2021]/py
8. #6 AND #7

9.2.13 Fragestellung 15

A Medline – Ovid Interface (September 6, 2021)

1 borderline personality disorder.mp. or Borderline Personality Disorder/
2 Borderline Personality Disorder/ or borderline personality symptom$.mp.
3 Personality disorder$.sh. or PD$1.ti. or personaltit$.sh. or Personality.sh. or personality disorder$.sh. or personality disorders.sh.
4 personality dysfunction.mp.
5 Personality Disorders/ or cluster c personality disorder$.mp.
6 (Borderline or borderline person$ or borderline state or borderline$).sh.
7 borderline patient$.mp.
8 or/1-7
9 RCT or randomized control trials {No Related Terms}
10 randomised control trials {No Related Terms}
11 random allocation or random assignment or random sample or random sampling {No Related Terms}
12 random or randomization {No Related Terms}
13 randomized controlled trial or randomized control trials {No Related Terms}
14 randomised controlled trial or randomised control trials {No Related Terms}
15 double blind method or double blind procedure or double blind study or double blind studies or doubleblind or double {No Related Terms}
16 single blind procedure or single blind method or single blind study or single blind studies or single or single blind or single blind method {No Related Terms}
17 crossover OR crossover design OR crossover procedure OR cross over studies {No Related Terms}
18 clinical or clinical trial or clinical trials {No Related Terms}
19 controlled clinical trial or controlled clinical trials {No Related Terms}
20 or/9-19
21. day hospital.mp.
22. inpatient.m_titl.
23. therapeutic community.mp. or Therapeutic Community/
24. enhanced care program$.m_titl.
25. enhanced care.m_titl.
26. enhanced care programming.mp.
27. team-based care.mp.
28. individual-based care.mp.
29. individual-based care.m_titl.
30. (partial hospitalisation or partial hospitalisation).m_titl.
31. or/21-30
32. 8 and 20 and 31

B PsycINFO – Ovid interface (September 06, 2021)

1. borderline personality disorder.mp. or Borderline Personality Disorder/
2. (Borderline or borderline person$ or borderline state or borderline$).sh.
3. borderline patient$.mp.
4. Borderline Personality Disorder/ or borderline personality symptom$.mp
5. Personality Disorders/ or cluster c personality disorder$.mp.
6. borderline personality disorder {Including Related Terms}

7. or/1-6
8. randomised control trials {No Related Terms}
9. RCT {Including Related Terms}
10. random allocation or random assignment or random sample or random sampling {No Related Terms}
11. random allocation or random assignment or random sample or random sampling {Including Related Terms}
12. randomized control trials {No Related Terms}
13. random or randomization {No Related Terms}
14. randomized controlled trial or randomized control trials {Including Related Terms}
15. randomised controlled trial or randomised control trials {Including Related Terms}
16. double blind method.mp.
17. double blind procedure.mp.
18. double blind study.mp.
19. double blind studies.mp.
20. (single blind procedure or single blind method or single blind study or single blind studies or single blind).ab.
21. crossover or crossover design or crossover procedure or cross over studies {No Related Terms}
22. clinical or clinical trial or clinical trials {No Related Terms}
23. controlled clinical trial or controlled clinical trials {No Related Terms}
24. or/8-23
26. day hospital or day hospitlization or day hospitlisation).m_titl.
27. inpatient care.mp.
28. therapeutic community.mp. or Therapeutic Community/
29. enhanced care programming.mp.
30. enhanced care programming.m_titl.
31. (team-based care or team based care).mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures]
32. (team based care or team-based care).m_titl.
33. (individual -based care or individual based care).mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures]
34. (individual -based care or individual based care).m_titl.
35. (partial hospitlisation or partial hospitilization).mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures]
36. (partial hospitlisation or partial hospitilization).m_titl.
37. or/25-36
38. 7 and 24 and 37
39. limit 38 to yr="2011 - 2021"

C EMBASE - Ovid interface (September 07, 2021)

1. 'borderline state'/exp/mj OR 'borderline state'/exp OR 'personality disorder'/exp
2. 'randomised controlled trial'/exp OR 'systematic review'/exp OR 'meta analysis'/exp OR 'randomization'/exp OR 'random sample'/exp OR 'double blind procedure'/exp OR 'single blind procedure'/exp OR 'crossover procedure'/exp OR 'clinical trial'/exp
3. 'randomization'/exp OR 'random sample'/exp
4. 'double blind procedure'/exp OR 'single blind procedure'/exp OR 'crossover procedure'/exp
5. 'clinical trial'/exp
6. #1 OR #2 OR #3 OR #4 OR #5

7. ‘borderline state’/exp/mj OR ‘borderline state’/exp OR ‘personality disorder’/exp
8. ‘therapeutic community’/exp
9. team AND ‘based’/exp AND care
10. individual AND ‘based’/exp AND care
11. day AND ‘hospital’/exp
12. ‘inpatient’/exp
13. partial AND ‘hospitalization’/exp
14. enhanced AND care AND programming
15. #7 OR #8 OR #9 OR #10 OR #11 OR #12 OR #13
16. #6 AND #7 AND #15
17. #6 AND #7 AND #15 AND [2011-2021]/py

9.2.14 Fragestellung 16

A Medline – Ovid Interface (September 6, 2021)

1 borderline personality disorder.mp. or Borderline Personality Disorder/
2 Borderline Personality Disorder/ or borderline personality symptom$.mp.
3 Personality disorder$.sh. or PD$1.ti. or personaltit$.sh. or Personality.sh. or personality disorder$.sh. or personality disorders.sh.
4 personality dysfunction.mp.
5 Personality Disorders/ or cluster c personality disorder$.mp.
6 (Borderline or borderline person$ or borderline state or borderline$).sh.
7 borderline patient$.mp.
8 or/1-7
9 RCT or randomized control trials {No Related Terms}
10 randomised control trials {No Related Terms}
11 random allocation or random assignment or random sample or random sampling {No Related Terms}
12 random or randomization {No Related Terms}
13 randomized controlled trial or randomized control trials {No Related Terms}
14 randomised controlled trial or randomised control trials {No Related Terms}
15 double blind method or double blind procedure or double blind study or double blind studies or doubleblind or double {No Related Terms}
16 single blind procedure or single blind method or single blind study or single blind studies or single or single blind or single blind method {No Related Terms}
17 crossover OR crossover design OR crossover procedure OR cross over studies {No Related Terms}
18 clinical or clinical trial or clinical trials {No Related Terms}
19 controlled clinical trial or controlled clinical trials {No Related Terms}
20 or/9-19
21. Hospitalization/ or Inpatients/ or inpatient care.mp.
22. inpatient care.m_titl.
23. acute care.mp.
24. acute care.m_titl.
25. forensic care.mp.
26. or/21-25
27. 8 and 20 and 26

B PsycINFO – Ovid interface (September 06, 2021)

1. borderline personality disorder.mp. or Borderline Personality Disorder/
2. (Borderline or borderline person$ or borderline state or borderline$).sh.
3. borderline patient$.mp.
4. Borderline Personality Disorder/ or borderline personality symptom$.mp
5. Personality Disorders/ or cluster c personality disorder$.mp.
6. borderline personality disorder {Including Related Terms}
7. or/1-6
8. randomised control trials {No Related Terms}
9. RCT {Including Related Terms}
10. random allocation or random assignment or random sample or random sampling {No Related Terms}
11. random allocation or random assignment or random sample or random sampling {Including Related Terms}
12. randomized control trials {No Related Terms}
13. random or randomization {No Related Terms}
14. randomized controlled trial or randomized control trials {Including Related Terms}
15. randomised controlled trial or randomised control trials {Including Related Terms}
16. double blind method.mp.
17. double blind procedure.mp.
18. double blind study.mp.
19. double blind studies.mp.
20. (single blind procedure or single blind method or single blind study or single blind studies or single blind).ab.
21. crossover or crossover design or crossover procedure or cross over studies {No Related Terms}
22. clinical or clinical trial or clinical trials {No Related Terms}
23. controlled clinical trial or controlled clinical trials {No Related Terms}
24. or/8-23
25. Hospitalization/ or Hospitalized Patients/ or inpatient care.mp.
26. acute care.mp.
27. acute care.m_titl.
28. forensic care.mp.
29. forensic care.m_titl.
30. inpatient care.m_titl.
31. or/25-30
32. 7 and 24 and 31
33. limit 32 to yr=”2011 - 2021”

C Embase – Ovid Interface (September 7, 2021)

1. ‘borderline state’/exp/mj OR ‘borderline state’/exp OR ‘personality disorder’/exp
2. ‘randomised controlled trial’/exp OR ‘systematic review’/exp OR ‘meta analysis’/exp OR ‘randomization’/exp OR ‘random sample’/exp OR ‘double blind procedure’/exp OR ‘single blind procedure’/exp OR ‘crossover procedure’/exp OR ‘clinical trial’/exp
3. ‘randomization’/exp OR ‘random sample’/exp
4. ‘double blind procedure’/exp OR ‘single blind procedure’/exp OR ‘crossover procedure’/exp
5. ‘clinical trial’/exp
6. #1 OR #2 OR #3 OR #4 OR #5

7. ‘borderline state’/exp/mj OR ‘borderline state’/exp OR ‘personality disorder’/exp
8. ‘hospitalization’/exp AND care OR ‘inpatients’/exp OR ‘inpatient’/exp AND care OR acute AND care OR forensic AND care
9. #6 AND #7 AND #8
10. #6 AND #7 AND #8 AND [2011-2021]/py

9.2.15 Fragestellung 20

A Medline – Ovid Interface (September 6, 2021)

SEARCH (ADDITIONAL STRING SEARCH Q20)

1 borderline personality disorder.mp. or Borderline Personality Disorder/
2 Borderline Personality Disorder/ or borderline personality symptom$.mp.
3 Personality disorder$.sh. or PD$1.ti. or personaltit$.sh. or Personality.sh. or personality disorder$.sh. or personality disorders.sh.
4 personality dysfunction.mp.
5 Personality Disorders/ or cluster c personality disorder$.mp.
6 (Borderline or borderline person$ or borderline state or borderline$).sh.
7 borderline patient$.mp.
8 or/1-7
9 RCT or randomized control trials {No Related Terms}
10 randomised control trials {No Related Terms}
11 random allocation or random assignment or random sample or random sampling {No Related Terms}
12 random or randomization {No Related Terms}
13 randomized controlled trial or randomized control trials {No Related Terms}
14 randomised controlled trial or randomised control trials {No Related Terms}
15 double blind method or double blind procedure or double blind study or double blind studies or doubleblind or double {No Related Terms}
16 single blind procedure or single blind method or single blind study or single blind studies or single or single blind or single blind method {No Related Terms}
17 crossover OR crossover design OR crossover procedure OR cross over studies {No Related Terms}
18 clinical or clinical trial or clinical trials {No Related Terms}
19 controlled clinical trial or controlled clinical trials {No Related Terms}
20 or/9-19
21. primary care.mp. or Primary Health Care/
22. (accident and emergency).m_titl.
23. emergency.mp. or Emergencies/
24. crisis intervention.m_titl.
25. crisis intervention.mp. or Crisis Intervention/
26. crisis service.m_titl.
27. crisis service$.mp.
28. crisis housing.mp.
29. crisis housing.m_titl.
30. acute care.m_titl.
31. or/21-30
32. 8 and 20 and 31
33. limit 32 to yr=”2011 - 2021”

SEARCH (BPD, RCT AND HEALTH CARE Q20A REPEAT SEARCH

1 borderline personality disorder.mp. or Borderline Personality Disorder/
2 Borderline Personality Disorder/ or borderline personality symptom$.mp.
3 Personality disorder$.sh. or PD$1.ti. or personaltit$.sh. or Personality.sh. or personality disorder$.sh. or personality disorders.sh.
4 personality dysfunction.mp.
5 Personality Disorders/ or cluster c personality disorder$.mp.
6 (Borderline or borderline person$ or borderline state or borderline$).sh.
7 borderline patient$.mp.
8 or/1-7
9 RCT or randomized control trials {No Related Terms}
10 randomised control trials {No Related Terms}
11 random allocation or random assignment or random sample or random sampling {No Related Terms}
12 random or randomization {No Related Terms}
13 randomized controlled trial or randomized control trials {No Related Terms}
14 randomised controlled trial or randomised control trials {No Related Terms}
15 double blind method or double blind procedure or double blind study or double blind studies or doubleblind or double {No Related Terms}
16 single blind procedure or single blind method or single blind study or single blind studies or single or single blind or single blind method {No Related Terms}
17 crossover OR crossover design OR crossover procedure OR cross over studies {No Related Terms}
18 clinical or clinical trial or clinical trials {No Related Terms}
19 controlled clinical trial or controlled clinical trials {No Related Terms}
20 or/9-19
21. (alcohol adj6 drug service*).m_titl.
22. (alcohol adj6 drug service*).mp. [mp=protocol supplementary concept, rare disease supplementary concept, title, original title, abstract, name of substance word, subject heading word, unique identifier]
23. primary care.m_titl.
24. emergency care.m_titl.
25. (emergency adj6 care).mp. [mp=protocol supplementary concept, rare disease supplementary concept, title, original title, abstract, name of substance word, subject heading word, unique identifier]
26. “crisis service*”.m_titl.
27. (crisis adj6 service*).mp. [mp=protocol supplementary concept, rare disease supplementary concept, title, original title, abstract, name of substance word, subject heading word, unique identifier]
28. (refugee* adj6 service*).m_titl.
29. (refugee* adj6 service*).mp. [mp=protocol supplementary concept, rare disease supplementary concept, title, original title, abstract, name of substance word, subject heading word, unique identifier]
30. (Aboriginal adj6 health).m_titl.
31. (Aboriginal adj6 health).mp. [mp=protocol supplementary concept, rare disease supplementary concept, title, original title, abstract, name of substance word, subject heading word, unique identifier]
32. “aboriginal health service*”.m_titl.

33. aboriginal health service*.mp.
34. Health Services, Indigenous/ or aboriginal health service*.mp.
35. supported accomodation.m_titl.
36. supported accomodation.mp.
37. Eating Disorders/ or eating disorder*.mp.
38. disability.mp.
39. (disability adj6 service*).mp. [mp=protocol supplementary concept, rare disease supplementary concept, title, original title, abstract, name of substance word, subject heading word, unique identifier
40. or/21-39
41. 8 and 20 and 40
42. limit 41 to yr="2011 - 2021"

B PsycINFO – Ovid interface (September 06, 2021)

1. borderline personality disorder.mp. or Borderline Personality Disorder/
2. (Borderline or borderline person$ or borderline state or borderline$).sh.
3. borderline patient$.mp.
4. Borderline Personality Disorder/ or borderline personality symptom$.mp
5. Personality Disorders/ or cluster c personality disorder$.mp.
6. borderline personality disorder {Including Related Terms}
7. or/1-6
8. randomised control trials {No Related Terms}
9. RCT {Including Related Terms}
10. random allocation or random assignment or random sample or random sampling {No Related Terms}
11. random allocation or random assignment or random sample or random sampling {Including Related Terms}
12. randomized control trials {No Related Terms}
13. random or randomization {No Related Terms}
14. randomized controlled trial or randomized control trials {Including Related Terms}
15. randomised controlled trial or randomised control trials {Including Related Terms}
16. double blind method.mp.
17. double blind procedure.mp.
18. double blind study.mp.
19. double blind studies.mp.
20. (single blind procedure or single blind method or single blind study or single blind studies or single blind).ab.
21. crossover or crossover design or crossover procedure or cross over studies {No Related Terms}
22. clinical or clinical trial or clinical trials {No Related Terms}
23. controlled clinical trial or controlled clinical trials {No Related Terms}
24. or/8-23
25. day hospital.mp. or Partial Hospitalization/
25. primary care.mp. or Primary Health Care/
26. (accident and emergency).m_titl.
27. emergency.mp. or Emergencies/
28. Crisis Intervention/ or crisis.mp.
29. "crisis service*".m_titl.
30. crisis housing.m_titl.

31. acute care.m_titl.
32. or/25-31
33. 7 and 24 and 32
34. limit 33 to yr="2011 - 2021"

C Embase – Ovid interface (September 07, 2021)

ADDITIONAL STRING SEARCH Q20

1. 'borderline state'/exp/mj OR 'borderline state'/exp OR 'personality disorder'/exp
2. 'randomised controlled trial'/exp OR 'systematic review'/exp OR 'meta analysis'/exp OR 'randomization'/exp OR 'random sample'/exp OR 'double blind procedure'/exp OR 'single blind procedure'/exp OR 'crossover procedure'/exp OR 'clinical trial'/exp
3. 'primary health care'/exp OR 'primary medical care'/exp
4. 'emergency health service'/exp OR 'emergency care'/exp OR 'emergency'/exp
5. 'emergency care'/exp
6. crisis AND ('housing'/exp OR housing
7. crisis AND services
8. crisis AND care
9. #3 OR #4 OR #5 OR #6 OR #7 OR #8
10. #1 AND #2 AND #9
11. #1 AND #2 AND #9 AND [2011-2021]/py

BPD, RCT AND HEALTH CARE Q20 REPEAT SEARCH

1. 'borderline state'/exp/mj OR 'borderline state'/exp OR 'personality disorder'/exp
2. 'randomised controlled trial'/exp OR 'systematic review'/exp OR 'meta analysis'/exp OR 'randomization'/exp OR 'random sample'/exp OR 'double blind procedure'/exp OR 'single blind procedure'/exp OR 'crossover procedure'/exp OR 'clinical trial'/exp
3. 'drug dependence treatment'/exp OR 'primary health care'/exp OR 'emergency care'/exp OR 'refugee'/exp OR 'health service'/exp OR 'binge eating disorder'/exp OR 'disability'/exp
4. #1 AND #2 AND #3
5. #1 AND #2 AND #3 AND [2011-2021]/py

9.2.16 Fragestellung 22

A Medline – Ovid interface (September 06, 2021)

1 borderline personality disorder.mp. or Borderline Personality Disorder/
2 Borderline Personality Disorder/ or borderline personality symptom$.mp.
3 Personality disorder$.sh. or PD$1.ti. or personaltit$.sh. or Personality.sh. or personality disorder$.sh. or personality disorders.sh.
4 personality dysfunction.mp.
5 Personality Disorders/ or cluster c personality disorder$.mp.
6 (Borderline or borderline person$ or borderline state or borderline$).sh.
7 borderline patient$.mp.
8 or/1-7
9 RCT or randomized control trials {No Related Terms}

10 randomised control trials {No Related Terms}
11 random allocation or random assignment or random sample or random sampling {No Related Terms}
12 random or randomization {No Related Terms}
13 randomized controlled trial or randomized control trials {No Related Terms}
14 randomised controlled trial or randomised control trials {No Related Terms}
15 double blind method or double blind procedure or double blind study or double blind studies or doubleblind or double {No Related Terms}
16 single blind procedure or single blind method or single blind study or single blind studies or single or single blind or single blind method {No Related Terms}
17 crossover OR crossover design OR crossover procedure OR cross over studies {No Related Terms}
18 clinical or clinical trial or clinical trials {No Related Terms}
19 controlled clinical trial or controlled clinical trials {No Related Terms}
20 or/9-19
21. health care professional$.m_titl.
22. (clinical supervision or supervison).m_titl.
23. clinical supervision.mp.
24. clinical training.mp.
25. clinical training.m_titl.
26. clinical case load.mp.
27. case load.m_titl.
28. or/21-27
29. 8 and 20 and 28
30. 8 and 21
31. or/22-23
32. 8 and 31
33. or/24-25
34. 8 and 33
35. 8 and 27
36. 30 or 32 or 34
37. limit 36 to yr="2011 - 2021"

B PsycINFO – Ovid interface (September 06, 2021)

1. borderline personality disorder.mp. or Borderline Personality Disorder/
2. (Borderline or borderline person$ or borderline state or borderline$).sh.
3. borderline patient$.mp.
4. Borderline Personality Disorder/ or borderline personality symptom$.mp
5. Personality Disorders/ or cluster c personality disorder$.mp.
6. borderline personality disorder {Including Related Terms}
7. or/1-6
8. randomised control trials {No Related Terms}
9. RCT {Including Related Terms}
10. random allocation or random assignment or random sample or random sampling {No Related Terms}
11. random allocation or random assignment or random sample or random sampling {Including Related Terms}
12. randomized control trials {No Related Terms}

13. random or randomization {No Related Terms}
14. randomized controlled trial or randomized control trials {Including Related Terms}
15. randomised controlled trial or randomised control trials {Including Related Terms}
16. double blind method.mp.
17. double blind procedure.mp.
18. double blind study.mp.
19. double blind studies.mp.
20. (single blind procedure or single blind method or single blind study or single blind studies or single blind).ab.
21. crossover or crossover design or crossover procedure or cross over studies {No Related Terms}
22. clinical or clinical trial or clinical trials {No Related Terms}
23. controlled clinical trial or controlled clinical trials {No Related Terms}
24. or/8-23
25. clinical training.m_titl.
26. clinical case load.mp.
27. case load.m_titl.
28. or/21-27
29. 8 and 20 and 28
30. 8 and 21
31. or/22-23
32. 8 and 31
33. or/24-25
34. 8 and 33
35. 8 and 27
36. 30 or 32 or 34
37. limit 36 to yr="2011 - 2021"

C Embase – Ovid interface (September 07, 2021)

1. 'borderline state'/exp/mj OR 'borderline state'/exp OR 'personality disorder'/exp
2. 'randomised controlled trial'/exp OR 'systematic review'/exp OR 'meta analysis'/exp OR 'randomization'/exp OR 'random sample'/exp OR 'double blind procedure'/exp OR 'single blind procedure'/exp OR 'crossover procedure'/exp OR 'clinical trial'/exp
3. 'health care personnel'/exp(
4. clinical AND supervision OR clinical AND 'training'/exp OR clinical AND case AND load
5. #3 OR #4
6. #1 AND #2 AND #5
7. #1 AND #2 AND #5 AND [2011-2021]/py

9.2.17 Fragestellung 23

A Medline – Ovid interface (September 06, 2021)

1 borderline personality disorder.mp. or Borderline Personality Disorder/
2 Borderline Personality Disorder/ or borderline personality symptom$.mp.
3 Personality disorder$.sh. or PD$1.ti. or personaltit$.sh. or Personality.sh. or personality disorder$.sh. or personality disorders.sh.

4 personality dysfunction.mp.
5 Personality Disorders/ or cluster c personality disorder$.mp.
6 (Borderline or borderline person$ or borderline state or borderline$).sh.
7 borderline patient$.mp.
8 or/1-7
9 RCT or randomized control trials {No Related Terms}
10 randomised control trials {No Related Terms}
11 random allocation or random assignment or random sample or random sampling {No Related Terms}
12 random or randomization {No Related Terms}
13 randomized controlled trial or randomized control trials {No Related Terms}
14 randomised controlled trial or randomised control trials {No Related Terms}
15 double blind method or double blind procedure or double blind study or double blind studies or doubleblind or double {No Related Terms}
16 single blind procedure or single blind method or single blind study or single blind studies or single or single blind or single blind method {No Related Terms}
17 crossover OR crossover design OR crossover procedure OR cross over studies {No Related Terms}
18 clinical or clinical trial or clinical trials {No Related Terms}
19 controlled clinical trial or controlled clinical trials {No Related Terms}
20 or/9-19
22. family care needs.m_titl.
23. (burden or stigma).m_titl.
24. depression.m_titl.
25. general mental health.m_titl.
26. family interventions.mp.
27. carers.m_titl
28. or/21-27
29. 8 and 20 and 28
30. limit 29 to yr=”2011 - 2021”

B PsycINFO – Ovid interface (September 06, 2021)

1. borderline personality disorder.mp. or Borderline Personality Disorder/
2. (Borderline or borderline person$ or borderline state or borderline$).sh.
3. borderline patient$.mp.
4. Borderline Personality Disorder/ or borderline personality symptom$.mp
5. Personality Disorders/ or cluster c personality disorder$.mp.
6. borderline personality disorder {Including Related Terms}
7. or/1-6
8. randomised control trials {No Related Terms}
9. RCT {Including Related Terms}
10. random allocation or random assignment or random sample or random sampling {No Related Terms}
11. random allocation or random assignment or random sample or random sampling {Including Related Terms}
12. randomized control trials {No Related Terms}
13. random or randomization {No Related Terms}
14. randomized controlled trial or randomized control trials {Including Related Terms}

15. randomised controlled trial or randomised control trials {Including Related Terms}
16. double blind method.mp.
17. double blind procedure.mp.
18. double blind study.mp.
19. double blind studies.mp.
20. (single blind procedure or single blind method or single blind study or single blind studies or single blind).ab.
21. crossover or crossover design or crossover procedure or cross over studies {No Related Terms}
22. clinical or clinical trial or clinical trials {No Related Terms}
23. controlled clinical trial or controlled clinical trials {No Related Terms}
24. or/8-23
25. health care professional.m_titl.
26. “health care professional*”.m_titl.
27. or/25-26
28. clinical supervision.m_titl.
29. clinical training.m_titl.
30. clinical case load.m_titl.
31. or/28-30
32. 7 and 24 and 27
33. 7 and 27
34. 7 and 24 and 31
35. 7 and 31
36. 33 or 35
37. from 36 keep 1-3

C Embase – Ovid interface (September 07, 2021)

1. ‘borderline state’/exp/mj OR ‘borderline state’/exp OR ‘personality disorder’/exp
2. ‘randomised controlled trial’/exp OR ‘systematic review’/exp OR ‘meta analysis’/exp OR ‘randomization’/exp OR ‘random sample’/exp OR ‘double blind procedure’/exp OR ‘single blind procedure’/exp OR ‘crossover procedure’/exp OR ‘clinical trial’/exp
3. ‘family’/exp AND care AND needs
4. burden OR ‘stigma’/exp
5. ‘depression’/exp
6. general AND mental AND ‘health’/exp
7. ‘family’/exp AND intervention OR ‘family’/exp AND interventions
8. carer OR carers
9. #2 OR #3 OR #4 OR #5 OR #6 OR #7
10. ‘randomised controlled trial’/exp
11. #1 AND #8 AND #10
12. #1 AND #8 AND #10 AND [2011-2021]/py

9.2.18 Fragestellung 24

A Medline – Ovid interface

s. Fragestellung 23

B PsycINFO – Ovid interface

s. Fragestellung 23

C EMBASE – Ovid interface

s. Fragestellung 23

9.2.19 Fragestellung 25

A Medline – Ovid interface (September 06, 2021)

1 borderline personality disorder.mp. or Borderline Personality Disorder/
2 Borderline Personality Disorder/ or borderline personality symptom$.mp.
3 Personality disorder$.sh. or PD$1.ti. or personaltit$.sh. or Personality.sh. or personality disorder$.sh. or personality disorders.sh.
4 personality dysfunction.mp.
5 Personality Disorders/ or cluster c personality disorder$.mp.
6 (Borderline or borderline person$ or borderline state or borderline$).sh.
7 borderline patient$.mp.
8 or/1-7
9 RCT or randomized control trials {No Related Terms}
10 randomised control trials {No Related Terms}
11 random allocation or random assignment or random sample or random sampling {No Related Terms}
12 random or randomization {No Related Terms}
13 randomized controlled trial or randomized control trials {No Related Terms}
14 randomised controlled trial or randomised control trials {No Related Terms}
15 double blind method or double blind procedure or double blind study or double blind studies or doubleblind or double {No Related Terms}
16 single blind procedure or single blind method or single blind study or single blind studies or single or single blind or single blind method {No Related Terms}
17 crossover OR crossover design OR crossover procedure OR cross over studies {No Related Terms}
18 clinical or clinical trial or clinical trials {No Related Terms}
19 controlled clinical trial or controlled clinical trials {No Related Terms}
20 or/9-19
21. family intervention.mp.
22. Family/ or family.mp.
23. families.mp. or Family/
24. or/21-23
25. expressed emotion.m_titl.
26. 24 and 25
27. 8 and 26
28. limit 27 to yr=”2011 - 2021”

B PsycINFO – Ovid interface (September 07, 2021)

1. borderline personality disorder.mp. or Borderline Personality Disorder/
2. (Borderline or borderline person$ or borderline state or borderline$).sh.
3. borderline patient$.mp.
4. Borderline Personality Disorder/ or borderline personality symptom$.mp
5. Personality Disorders/ or cluster c personality disorder$.mp.
6. borderline personality disorder {Including Related Terms}
7. or/1-6
8. randomised control trials {No Related Terms}
9. RCT {Including Related Terms}
10. random allocation or random assignment or random sample or random sampling {No Related Terms}
11. random allocation or random assignment or random sample or random sampling {Including Related Terms}
12. randomized control trials {No Related Terms}
13. random or randomization {No Related Terms}
14. randomized controlled trial or randomized control trials {Including Related Terms}
15. randomised controlled trial or randomised control trials {Including Related Terms}
16. double blind method.mp.
17. double blind procedure.mp.
18. double blind study.mp.
19. double blind studies.mp.
20. (single blind procedure or single blind method or single blind study or single blind studies or single blind).ab.
21. crossover or crossover design or crossover procedure or cross over studies {No Related Terms}
22. clinical or clinical trial or clinical trials {No Related Terms}
23. controlled clinical trial or controlled clinical trials {No Related Terms}
24. or/8-23
25. family intervention$.mp. or Family Intervention/
26. famil$.mp.
27. or/25-26
28. expressed emotion.mp. or Expressed Emotion/
29. 27 and 28
30. 7 and 29
31. limit 30 to yr=”2011 - 2021”

C Embase – Ovid interface (September 07, 2021)

No search completed on Embase[26]

9.2.20 Fragestellung 26

A Medline – Ovid interface

s. Fragestellung 25

B PsycINFO – Ovid interface

s. Fragestellung 25

C EMBASE – Ovid interface

No search completed on Embase[26], s. Fragestellung 25

9.3 Anhang 3: Evidenzhierarchie

NHMRC Evidence hierarchy: designations of 'levels of evidence' according to type of research question

Level	Intervention	Diagnostic accuracy	Prognosis	Aetiology	Screening Intervention
I	A systematic review of level II studies	A systematic review of level II studies	A systematic review of level II studies	A systematic review of level II studies	A systematic review of level II studies
II	A randomised controlled trial	A study of test accuracy with: an independent, blinded comparison with a valid reference standard, among consecutive persons with a defined clinical presentation	A prospective cohort study	A prospective cohort study	A randomised controlled trial
III-1	A pseudorandomised controlled trial (i.e. alternate allocation or some other method)	A study of test accuracy with: an independent, blinded comparison with a valid reference standard, among non-consecutive persons with a defined clinical presentation	All or none	All or none	A pseudorandomised controlled trial (i.e. alternate allocation or some other method)
III-2	A comparative study with concurrent controls: ▪ Non-randomised, experimental trial ▪ Cohort study ▪ Case-control study ▪ Interrupted time series with a control group	A comparison with reference standard that does not meet the criteria required for Level II and III-1 evidence	Analysis of prognostic factors amongst persons in a single arm of a randomised controlled trial	A retrospective cohort study	A comparative study with concurrent controls: ▪ Non-randomised, experimental trial ▪ Cohort study ▪ Case-control study
III-3	A comparative study without concurrent controls: ▪ Historical control study ▪ Two or more single arm study ▪ Interrupted time series without a parallel control group	Diagnostic case-control study	A retrospective cohort study	A case-control study	A comparative study without concurrent controls: ▪ Historical control study ▪ Two or more single arm study
IV	Case series with either post-test or pre-test/post-test outcomes	Study of diagnostic yield (no reference standard)	Case series, or cohort study of persons at different stages of disease	A cross-sectional study or case series	Case series

Source: NHMRC Levels of evidence and grades for recommendations for developers of guidelines 2009

9.4 Anhang 4: Evidenztabellen

Die folgenden Evidenztabellen enthalten die Evidenz, die jeweils im Zuge der Aktualisierungssuchen für den Zeitraum 2011 bis September 2021 identifziert wurde.

9.4.1 Evidenztabellen Fragestellung 1

Level I

Full reference Country	Study Design/ Level of Evidence	N (n)	Participants Age Gender Diagnosis Other	Intervention	Comparison	Outcomes	Measure/s	Length of follow-up	Effect Size	Comments
Winsper C, Lereya ST, Marwaha S, Thompson A, Eyden J & Singh SP (2016). The aetiological and psychopathological validity of borderline personality disorder in youth: A systematic review and meta-analysis. *Clinical Psychology Review, 44*: 13-24	SR of prospective (CAVE: but also retrospective and cross-sectional!) studies providing information on aetiological or psychopathological associations of adolescent (<19 years) BPD	N=61 studies	Clinical or community samples, aged 19 or under	n.a.	n.a.	Association of risk factors and psychopathological features to BPD pathology	n.a.	n.a.	criteria. Statistically significant pooled associations with youth (19 years of age and under) BPD were observed for sexual abuse (all youth: odds ratio = 4.88; 95% confidence interval = 3.30, 7.21; children: OR = 3.97; 95% CI = 1.51, 10.41; adolescents: OR = 5.41; 95% CI = 3.43, 8.53); physical abuse	adult and youth BPD share common aetiological and psychopathological correlates. This offers some support for the diagnostic validity of youth BPD and indicates the need for clinical recognition in this age group

									(all youth: 2.79 [2.03, 3.84]; children: 2.86 [1.98, 4.13]; adolescents: 2.60 [1.38, 4.90]); maternal hostility/verbal abuse (all youth: 3.28 [2.67, 4.03]; children: 3.15 [2.55, 3.88]; adolescents: 4.71 [1.77, 12.53]); and neglect (all youth: 3.40 [2.27, 5.11]; children: 2.87 [1.73, 4.73]; adolescents: 4.87 [2.24, 10.59]). Several psychopathological features were also associated with youth BPD, including comorbid mood (3.21 [2.13, 4.83]), anxiety (2.30 [1.44, 3.70]) and substance use (2.92 [1.60, 5.31]) disorders; self-harm (2.81 [1.61, 4.90]); suicide ideation (all youth: 2.02 [1.23, 3.32]; children:	

									6.00 [1.81, 19.84]; adoles-cents: 1.75 [1.20; 2.54]) and suicide attempt (2.10 [1.21, 3.66]).	

Level II

ull reference Country	Study Level of Evidence Design/	N (n)	Participants Age Gender Diagnosis Other	Intervention	Comparison	Outcomes	Measure/s	Length of follow-up	Effect Size	Comments
Wolke D., Schreier A., Zanarini M.C., und Winsper C. „Bullied by peers in childhood and borderline personality symptoms at 11 years of age: a prospective study". *Journal of child psychology and psychiatry, and allied disciplines* 53, Nr. 8 (2012): 846–55. **UK**	II (prospective cohort study)	N=6050	Children in the community born between April 1991 and December 1992 Mean age at interview: 11.8 years	n.a.		Associations between peer victimisation and presence of BPD symptoms; impact of kind of victimization (overt/relational), chronicity, severity on BPD severity. Controlled for known confounders such as sexual abuse, maladaptive parenting, family adversity	via child report, at 8 and 10 years of age, with the Bullying and Friendship Interview Schedule Parent and teacher report: 1 item from the Strengths and Difficulties Questionnaire (Goodman, 1997): 'Picked on or bullied by other children in the past 6 months' was used.	6 months	Accounting for known confounders, victims of peer bullying had an increased risk of BPD symptoms according to self-report (OR, 2.82; 95% CI, 2.13–3.72); mother report (OR, 2.43; 95% CI, 1.86–3.16); and teacher report (OR, 1.95; 95% CI, 1.34–2.83). Children who reported being chronically bullied (OR, 5.44; 95% CI, 3.86–7.66) or experienced combined relational and overt victimisation (OR, 7.10; 95% CI, 4.79–10.51) had	Intentional harm inflicted by peers is a precursor or marker on the trajectory towards the development of BPD symptoms in childhood. Clinicians should ask users of mental health services routinely about adverse experiences with peers

									highly increased odds of developing BPD symptoms. Children exposed to chronic victimisation according to mother report were also at heightened risk of developing BPD symptoms (OR, 3.24; 95% CI, 2.24–4.68)	

9.4.2 Evidenztabellen Fragestellung 2

Level I

Full reference Country	Study Design/ Level of Evidence	N (n)	Participants Age Gender Diagnosis Other	Intervention	Comparison	Outcomes	Measure/s	Length of follow-up	Effect Size	Comments
Carcone, D., Tokarz, V. L. and Ruocco, A. C. (2015). A Systematic Review on the Reliability and Validity of Semistructured Diagnostic Interviews for Borderline Personality Disorder. *Canadian psychology/Psychologie Canadienne 56*, No. 2, 208–226	LEVEL I (SR OF LEVEL II STUDIES)	N=53 STUDIES	STUDIES EXAMINING RELIABILITY AND VALIDITY OF DIAGNOSTIC INTERVIEWS FOR BPD		SCID-II, IPDE, DIB-R, SIDP, DIPD	RELIABILTY AND VALIDITY	INTERRATER RELIABILITY, TEST-RETEST RELIABILITY, INTERNAL CONSISTENCY, CONVERGENT VALIDITY (HERE: ONLY CATEGORIALLY REPORTED)	TEST-RE-TEST-RELIABILITY: UP TO 6 MONTHS	SCID-II: INTERRATER RELIABILITY $\kappa \geq .89$, TEST-RETEST RELIABILITY (2 DAYS) $\kappa \geq .87$, INTERNAL CONSISTENCY CRONBACH'S A=.74; BPD ITEMS MODERATELY TO STRONG CORRELATED WITH SELF-REPORT INVENTORIES ASSESSING BPD (*RS* .37 TO .69) DIPD: INTERRATER RELIABILITY MEAN	MOST STUDIED: SCID-II; ALL INTERVIEWS HAVE HIGH TO MODERATE INTERRATER RELIABILITY, ALL HAVE MODERATE TO HIGH TEST-RETEST RELIABILITY (ESP. SHORT-TERM), CONVERGENT VALIDITY HIGHER FOR DIMENSIONAL ASSESSMENTS FOR BPD THAN CATEGORIAL ONES)

									κ =.87, HIGH TEST-RETEST RELIABILITY (κ = .80), GOOD INTERNAL CONSISTENCY (CRONBACH'S A=.84), CONVERGENT VALIDITY: GOOD WITH PDQ-4 (κ = .53) IPDE: INTERRATER RELIABILITY κ=.80, TEST-RETEST-RELIABILITY (6 MONTHS) κ =.70, CONVERGENT VALIDITY WEAK (MCMI: κ =.30, PDQ κ=.16) DIB-R: INTERRATER RELIABILITY κ=.94, TEST-RETEST RELIABILITY (7-10 DAYS) κ=.91, MODERATE CONVERGENT	

									VALIDITY WITH ZAN-BPD SEVERITY ($r_S \geq .45$) SIDP: INTERRATER RELIABILITY κ .85 TO .94, NO DATA ON RETEST RELIABILITY AVAILABLE, INTERNAL CONSISTENCY HIGH (CRONBACHS' α=.85), CONVERGENT VALIDITY, NO AGREEMENT WITH MCMI CATEGORIAL ASSESSMENT	

Level II

Full reference Country	Study Design/ Level of Evidence	N (n)	Participants Age Gender Diagnosis Other	Intervention	Comparison	Outcomes	Measure/s	Length of follow-up	Effect Size	Comments
Germans S, van Heck GL & Hodiament PPG. Results of the search for personality disorder screening tools: clinical implications. *The Journal of Clinical Psychiatry 73* (2): 165-73. **The Netherlands**	Diagnostic accuracy Level II (independent, blinded comparison with a valid reference, random sample from consecutive admissions)	The paper reports on three equivalent studies (different periods of patient recruitment, but same study site and roughly same methods: prospective, observational test validation studies), including N=195, N=79 and	Adult psychiatric outpatients referred to a community mental health care center; mean age 32.7, 34.3 and 33.7 years, resp.; 57.4%, 57.0% and 59.8% female, resp.	Application of different self-report questionnaires and informant-based interviews	Value of 8 questionnaires for predicting PD; 3 questionnaires thereof with capacity to diagnose BPD specifically (SCID-II-PQ with adjusted cut-off score by +3; PAS-Q and SAP)	SCID-II interview as gold standard		n.a.	Instruments capable of screening for BPD: PAS-Q sensitivity 80%, specifity 82%; SAP sensitivity 69%, specifity 76%, SCID-II-PQ with adjusted score sensitivity 78 to 100%, specifity 27 to 78%	Of PD screening instruments capable to screen for specific PDs, PAS-Q has best sensitivity and specifity, raising the odds that a patient in a psychiatric outpatient population will receive a personality disorder diagnosis from 50% to 81%

		N=102 patients								
Van Alebeek, A., van der Heijden, P.T., Hessels, C., Thong, M.S.Y. & van Aken, M. (2017). Comparison of Three Questionnaires to Screen for Borderline Personality Disorder in Adolescents and Young Adults. *European Journal of Psychological Assessment* 33, no. 2: 123–28. https://doi.org/10.1027/1015-5759/a000279. **The Netherlands**	Diagnostic accuracy Level II (independent, blinded comparison with a valid reference standard, among consecutive persons with a defined clinical presentation)	N=53	Dutch-speaking adolescents and young adults, between the ages of 16 and 25 years, with a mean age of 19.2 years (SD = 1.86, seeking help at a center for adolescent psychiatry	n.a.	Diagnostic accuracy of MSI, PDQ-4 and SCID-II-PQ BPD	BPD as diagnosed by use of SCID-II interview (reference standard)	MSI PDQ-4 SCID-II-PQ BPD	n.a.	Internal consistency (Cronbach's α) acceptable for MSI (.79) and SCID-II-PQ BPD (.85), poor for PDQ-4 (.68). Strong correlation between questionnaires (r [[PDQ-4, MSI] = .87; r [SCID-II PQ, PDQ-4] = .86 and r [MSI, SCID-II PQ] = .87) All questionnaires correlated substantially with BPD according to SCID-II (r [MSI] = .62, p < .001; r [PDQ-4] = .64, p < .001;	MSI-BPD and the SCID-II PQ BPD demonstrate an acceptable reliability. Strong correlations were found between all the questionnaires and the BPD criteria of the SCID-II. Using more questionnaires at the same time does not add to the explained variance in the SCID-II BPD All the questionnaires had acceptable levels of sensitivity and specificity. Based on the assumption that

									r [SCID-II-PQ] = .65, p < .001) no differences in correlations with the SCID-II between the three screening instruments (.14 ≤ Z ≤ .56, p>.28) sensitivity and specificity in predicting five or more BPD criteria in the SCID-II: MSI (cut-off 5) sensitivity of .94 and specificity of .73; PDQ-4 (cut-off 6) sensitivity of .88 and a specificity of .81; SCID-II-PQ BPD sensitivity of .94 and	sensitivity is more important than specificity in early detection of BPD, the MSI-BPD and the SCID-II-PQ BPD slightly outperformed the PDQ-4 BP. Considering the number of items of these screening instruments (i.e., 10 items for the MSI-BPD vs. 15 items for the SCID-II-PQ BPD) the MSI-BPD seems to be favorable in clinical practice

									a specificity of .84	

9.4.3 Evidenztabellen Fragestellung 5

Level I

Full reference Country	Study Design/ Level of Evidence	N (n)	Participants Age Gender Diagnosis Other	Intervention	Comparison	Outcomes	Measure/s	Length of follow-up	Effect Size	Comments
Jørgensen, MS, Storebø OJ, Stoffers-Winterling JM, Faltinsen E, Todorovac A, Simonsen E. Psychological Therapies for Adolescents with Borderline Personality Disorder (BPD) or BPD Features-A Systematic Review of Randomized Clinical Trials with Meta-Analysis and Trial Sequential Analysis". *PloS One* 16, Nr. 1 (2021): e0245331. https://doi.org/10.1371/journal.pone.0245331.	Level I/meta-analysis	N=10 RCTs (775 participants)	adolescent individuals with a BPD diagnosis or subthreshold BPD, any gender	well-defined, theory-driven psychotherapeutic treatments	control interventions, alternate specific psychotherapeutic interventions	BPD severity impulsivity (including self-harm, non-suicidal self-injury, suicide attempts, externalizing behaviours psychosocial functioning quality of life		post treatment	only meta-analytic statistical significant finding: DBT-A vs. control: Self-harm OR=0.45, 95% CI 0.26 to 0.76, 2 RCTs, 212 participants, I^2=0%	maximum 2 RCTs per comparison and outcome, meta-analytic pooling only feasible for CAT, DBT-A, ERT, MBT,

Wong J, Bahji A, Khalid-Khan S. Systematic Review and Meta-Analyses of Psychotherapies for Adolescents with Subclinical and Borderline Personality Disorder: A systematic review and meta-analysis. Can J Psychiatry. 2020 May;65(1):5-15 CANADA[35]	Level I/meta-analysis	N=7 RCTs (643 participants)	adolescents with minimum 2 BPD symptoms	psychotherapy	control	severity of symptoms externalizing symptoms internalising symptoms functioning treatment retention NSSI suicide attempts	-	post-treatment	hedge's *g*=-0.89 (-1.75, -0.02) n.s. n.s. n.s. n.s. n.s. n.s.	small number of primary studies, large effect of symptom reduction post-treatment, not sustained at follow-up

Level II

Full reference Country	Study Design/ Level of Evidence	N (n)	Participants Age Gender Diagnosis Other	Intervention	Com-parison	Outcomes	Measure/s	Length of follow-up	Effect Size	Comments
Beck E, Bo S, Jørgensen MS, Gondan M, Poulsen S, Storebø OJ, Fjellerad Andersen C, Folmo E, Sharp C, Pedersen J, Simonsen E. Mentalization-based treatment in groups for adolescents with borderline personality disorder: a randomized controlled trial. J Child Psychol Psychiatry. 2020 May;61(5):594-604. doi: 10.1111/jcpp.13152. Epub 2019 Nov 8. PMID: 31702058. Denmark	II/RCT	N=112	adolescents with minimum 4 BPD criteria (96% full BPD)	MBT-group	TAU	primary: BPD severity (self-rated) secondary: self-harm depression externalizing and internalizing symptoms caregiver reports social functioning BPS symptoms rated by blinded clinician	BPFSC-C RTSHIA BDI-Y YSR BPFS-P, CBCL C-GAS ZAN-BPD	1 year	MD -0.4 (p=.91) effect sizes n.s. for all outcomes	no sig. group differences at end of treatment for any outcome Robust TAU treatment: at least 12 individual supportive sessions, one per month; psychoeducation, counseling, if needed ad hoc crisis management and sessions with caregivers higher attrition in MBT-G (29% completed less than half of the sessions)

										as compared to TAU (7%)
Gleeson JFM, Chanen A, Cotton SM, Pearce T, Newman B, McCutcheon L (2012). Treating co-occurring first-episode psychosis and borderline personality: a pilot RCT. Early Intervention in Psychiatry, 6: 21-9 **Australia**	Level II/RCT	N=16	People aged 15 to 25 years meeting 4 or more BPD criteria (**75% full BPD**) with 1 week or more of psychotic symptoms and less than 6 months of previous antipsychotic medication; mean age 18.4 years, 81.2% females	SFET (description s. comparison treatment) + HYPE: rigorous personality pathology diagnosis, individual cognitive analytic therapy (CAT), development of a collaborative model of the individual's difficulties; 16 weekly sessions of individual therapy	SFET: Routine treatment at the Early Psychosis prevention and intervention centre, possibly including youth assessment, acute home treatment, outpatient case management, medical follow-u, family work, inpatient	Depression Overall burden Neg. symptoms Suicidality Aggression Substance use functioning	MADRS BPRS SANS AIAQ OAS-M ASSIST AUDIT SOFAS	16 weeks	Descriptive data reported only due to small sample size; HYPE+SEFT: fewer positive psychotic and negative symptoms, less anhedonia, less depression, better functioning, less irritable, more likely to be adherent, higher levels of alcohol misuse	Very small study with high dropouts (7 out of 16 participants involved)

					treatment, assertive outreach, psychosocial recovery programme					
McCauley E, Berk MS, Asarnow JR, Adrian M, Cohen J et al. (2018). Efficacy of dialectical behavior therapy for adolescents at high risk for suicide – a randomized clinical trial. JAMA Psychiatry, 75(8): 777-85 **USA**	Level II/RCT	N=173	Adolescents aged 12-18 years (mean age 14.89 years) with at least one lifetime suicide attempt, elevated past-month suicidal ideation, 3 or more BPD criteria (**53.2% full BPD**),	DBT: weekly individual psychotherapy, multifamily group skills training, youth and parent telephone coaching, weekly therapist team consultation. Parents offered 1 to 7 family sessions	Individual and Group supportive Therapy (CCT-based: acceptance, validation, connectedness/belonging); individual plus group therapy	Suicide attempts NSSI Self-harm Suicidal ideation	SASII SIQ-JR	6 months	Sig. less suicide attempts (OR 0.30; 95% CI 0.10, 0.91), NSSI episodes (OR 0.32, 95% CI 0.13, 0.77), self-harm episodes (OR 0.33, 95% CI 0.14, 0.78) in DBT- treated persons	
Mehlum L, Tørmoen AJ,	Level II/RCT	N=77	adolescents (12-18 years) with	Dialectical Behaviour Therapy	enhanced	self-harm episodes	self-report SIQ-JR	19 weeks	between-group	full diagnosis of BPD and

Ramberg M, Haga E, Diep LM, Laberg S, Larsson BS, Stanley BH, Miller AL, Sund AM, Grøholt B. Dialectical behavior therapy for adolescents with repeated suicidal and self-harming behavior: a randomized trial. J Am Acad Child Adolesc Psychiatry. 2014 Oct;53(10):1082-91. doi: 10.1016/j.jaac.2014.07.003. Epub 2014 Jul 22. PMID: 25245352. NORWAY			recent and repetitive self-harm and at least 2 criteria of DSM-IV BPD (plus the self-destructive criterion), or, alternatively, at least 1 criterion of DSM-IV BPD plus at least 2 subthreshold-level criteria, 87% female sex, 21% full BPD	adapted for adolescents (DBT-A)	usual care	suicidal ideation depression hopelessness BPD symptoms	SMFQ MADRS BHS BSL		difference in self-harm frequency was statistically significant (Δ slope=-0.92, 95% CI -1.69 to -0.15, *p*=0.21), also suicidal ideation (Δ slope=-0.62 per week, *p*=.010)	high baseline depression predict higher depression at trial completion; DBT-A predictive of lowever depression at completion of the trial[36]
Rossouw & Fonagy (2012). Mentalization-based treatment for self-harm in adolescents: a randomized controlled trial. J Am Acad Child Adolesc Psychiatry, 51(12): 1304-13 UK	Level II/RCT	N=80	Adolescents presenting after self-harm, 12 to 17 years of age, **73% with BPD**, 97% with MDD, 85% females, mean age 15.1 years	MBT-A: MBT for adolescents, weekly individual and monthly family sessions with focus on impulsivity and affect regulation	TAU: routine care by community-based aservices	Self-harm Depression Risk taking BPD	RTSHI (Risk Taking and Self-harm Inventory) Mood and Feelings Questionnaire RTSHI CI-BPD, BPFS-C	12 months	Sig. group differences at post-treatment for self-harm (OR 0.24, p<.01) and depression (OR 0.21, p<.05), BPD features (OR 0.07, p<.05 and OR -0.29, p<.05)	MBT-A may be helpful in reducing both depression and BPD symptoms in adolescents with both disorders

Salzer S, Cropp C, Jaeger U, Masuhr O, Streeck-Fischer A (2014). Psychodynamic therapy for adolescents suffering from co-morbid disorders of conduct and emotions in an in-patient setting: a randomized controlled trial. Psychological Medicine, 44: 2213-22 **Germany**	Level II	N=66, N=39 with full BPD	adolescents aged 14-19 years (mean 16.5 years), with mixed disorder of conduct and emotions (F92 according to ICD-10), **59.1% full BPD**	Psychodynamic Therapy based on the psychoanalytic-interactional method (PiM)	Waiting List/TAU	Remission (not meeting F92 criteria anymore) General psychopathology Mental health	SCID DISYPS-KJ SCL-90R/GSI SDQ (Strenghts an Difficulties Questionnaire	Post-treatment: mean 34.15 weeks (PiM)	Remission: OR=26.41 (95% CI 6.42-108.55) SDQ: Between-group effect *d*=0.38 (no CI reported) SCL-90-R/GSI: between-group effect *d*=0.18 (no CI reported)	
Santisteban DA, Mena MP, Muir J, McCabe BE, Abalo C, Cummings AM (2015). The efficacy of two adolescent substance use treatments and the impact of comorbid depression: results of a small randomized controlled trial. Psychiatric Rehabilitation Journal, 38(1); 55-64	Level II	N=25	Adolescents ages 14 to 17 years (mean 15.8 years), 37,5% females, all fulfilled criteria for substance abuse; recent use (30 days): 85% marijuana, 56% alcohol	I-BAFT: individual intervention, skills training modules from DBT and family interventions from structural family therapy Weekly family session and skills training or individual session with the adolescent	IDC Individual drug counseling according to 12-step philosophy; 2 session/week	BPD diagnosis Therapeutic alliance BPD behavior Depression Substance use	DIB-R WAI MACI (Millon adolescent clinical inventory) DPS (Diagnostic Interview Schedule for Children- Predictive Scales) Timeline Followback (TLFB)	12 months	No sig differences in conditions in working alliance, total number of sessions, BPD behavior, substance use	Unable to use data for effect size calculation

USA							Urine samples			
Schuppert, H.M., Giesen-Bloo, J., van Gemert, T.G., Wiersema, H.M., Minderaa, R.B., Emmelkamp, P.M.G., & Nauta, M.H.(2009). Effectiveness of an emotion regulation group training for adolescents- -a randomized controlled pilot study. Psychology & Psychotherapy, 16(6), 467-478. **The Netherlands**	Level II	N=43 ERT+ TAU = 23 TAU= 20	Age ERT+TAU=16.23 years TAU=15.9 years Gender ERT+TAU=95.6% FM TAU=80% FM	Emotion Regulation Training: 17 sessions, one systems meeting and two booster sessions. The main goal of the training is to introduce alternative ways of coping with affective instability, daily stressors and psychological vulnerability. Reducing selfharm or harm to others is another important issue. The adolescents learn that they can take more responsibility for their behaviour and realize they have a choice in how to (re)act when emotionally distressed.	Treatment as usual (TAU): medication, individual psychotherapy, system-based therapy, inpatient psychiatric care and emergency services in case of self-harm or suicidal behaviour.	Summary: Repeated measure ANOVAs indicate improvement over time, measured by the total score of the BPDSI-IV. The other primary outcome measures demonstrated no significant improvement over time. Detail: Repeated measure ANOVAs on the BPDSI-IV showed that there was no significant level of change between groups for both the total and the subscale affective stability of the BPDSI-IV (BPDSI-IV total score F [1,29] = 0.07; p = 0.79; BPDSI-IV subscale affect regulation F [1,29] = 0.24; p = 0.63). With regard to our other primary	BPDSI-IV to assess current severity and frequency of DSM-IV BPD symptoms. The Multidimensional Emotion Regulation Locus of Control (MERLC) The Youth Self Report (YSR)	post treatment	BPDSI-IV total score = 0.27 BPDSI-IV affective stability=0.33 MERLC subscale internal locus of control=-.49 YSR subscale internalizing g =0.04 YSR subscale externalizing = 0.15	

						outcome measure, we found a significant interaction effect on the adolescents' MERLC subscale internal locus of control (F [1, 24] = 9.16; p = 0.006). Adolescents in the ERT group reported an improvement in their feeling of having control over their emotions, whereas the adolescents in the TAU alone group reported a decrease of internal locus of control. The secondary outcome measures for the adolescents showed no significant effect between groups, measured by the YSR, internalizing and externalizing subscales (YSRintern F [1, 23] = 0.32; p = 0.58; YSRextern F [1,				

						24] = 0.06; p = 0.82).				
Schuppert HM, Timmerman ME, Bloo J, van Gemert TG, Wiersema HM et al. (2012). Emotion regulation training for adolescents with BPD traits: a randomized controlled trial. J Am Acad Child Adolesc Psychiatry, 51 (12): 1314-23. **The Netherlands**	Level II	N=109	Adolescents aged 14-19 years (mean 15.98 years) with emotion regulation problems/BPD feature, minimum two BPD criteria fulfilled; **73% full BPD**, 95% female	Emotion Regulation Training (ERT): add-on group training, adaption of STEPPS for adolescents, DBT- and CBT-based; 17 weekly sessions plus two booster sessions 6 and 12 weeks after the weekly course	TAU: no restrictions (pharmacotherapy, individual therapy, counseling, family therapi, inpatient or emergency care)	BPD severity Quality of life Emotional dysregulation Locus of control Depression ADHD, oppositional-defiant disorder symptoms	BPDSI-IV-ado Youth Quality of life- research version Life Problems Inventory, subscale emotional dysregulation Multidimensional Health Locus of Control Children's Depression Inventory Swanson, Nolan, and Pelham Rating Scale	29 weeks	No sig. differences between groups on any measurement	Both groups improved equally on severity of BPD symptoms, general psychopathology, and quality of life

Level III

Full reference Country	Study Design/ Level of Evidence	N (n)	Participants Age Gender Diagnosis Other	Intervention	Com-parison	Outcomes	Measure/s	Length of follow-up	Effect Size	Comments
*Chanen, A.M., Jackson, H.J., McCutcheon, L.K., Jovev, M., Dudgeon, P., Yuen, H.P., Germano, D., Nistico, H., McDougall, E., Weinstein, C., Clarkson, V., McGorry, P.D. (2009). Early intervention for adolescents with borderline personality disorder: Quasiexperimental comparison with treatment as usual. Australian &New Zealand Journal of Psychiatry, 43(5), 397-408.	Partial quasiexperimental design with historical cohort control Level III-1	N=110 TAU=32 CAT=41 GCC=37	CAT participants same as Chanen t al. 2008 Fulfilled two to nine DSM–IV criteria for borderline personality disorder Age CAT=16.3yo GCC=16.6yo TAU=16.2yo Gender CAT 2.9% M GCC 67.6% FM TAU 71.9% FM	Cognitive Analytic Therapy (CAT)	GCC as in Chanen et al 2008 Historical TAU Summary: At 24 month follow up: (i) HYPE + CAT had lower standardized levels of,	Summary: At 24 month follow up: (i) HYPE + CAT had lower standardized levels of, and a significantly faster standardized rate of improvement in, internalizing and externalizing psychopathology, compared with H-TAU; and (ii) HYPE + GCC had lower standardized levels of internalizing psychopathology and a faster rate of improvement in global functioning than HTAU. HYPE + CAT yielded the greatest median improvement on the four continuous outcome measures over 24	Psycho-pathology (SCID–II borderline personality disorder dimen-sional score) Internalising and exter-nalising psycho-pathology scores were de-rived from the Youth Self-Report (YSR) ques-tionnaire or the Young Adult Self-Report (YASR) Par-asuicidal behaviour	24 months		TAU not ran-domised

						months. No adverse effects were shown with any of the treatments.	was assessed by semistructured interview Global functioning was assessed using the widely used Social and Occupational Functioning Assessment Scale (SOFAS).			

9.4.4 Evidenztabellen Fragestellung 6, 7 und 8

Search last updated: 27 August 2021
Includes meta-analyses with the following characteristics:

- involving three or more relevant level-I-studies (inclusion criteria: RCT, ≥70% participants with BPD, adults, reporting on at least one of the pre-defined outcomes, comparing active treatment to controls)
- analysing between-group differences (data not included if only one RCT arm of was analysed, e.g., pre-post outcomes of control arms of RCTs)

Level I

Full reference Country	Study Design/ Level of Evidence	N (n)	Participants Age Gender Diagnosis Other	Intervention	Com-parison	Outcomes	Measure/s	Length of follow-up	Effect Size	Comments
Calati, Raffaella, und Philippe Courtet. „Is Psychotherapy Effective for Reducing Suicide Attempt and Non-Suicidal Self-Injury Rates? Meta-Analysis and Meta-Regression of Literature Data". *Journal of Psychiatric Research* 79 (August 2016): 8–20. https://doi.org/10.1016/j.jpsychires.2016.04.003.	Level I/meta-analysis of RCTs	N=32 included RCTs overall	self-harming and/or with suicidal behavior N=8 RCTs focusing on BPD or sub-threshold (3 or more criteria) BPD	Psychotherapy or treatment with substantial psychotherapeutic component	TAU	Suicide attempts, non-suicidal self-injury rate	diverse	12 to 18 months	Sig. risk reduction of suicide attempts within BPD samples (p <.00001) and non-suicidal self-injury (p=0.002)	

Full reference Country	Study Design/ Level of Evidence	N (n)	Participants Age Gender Diagnosis Other	Intervention	Comparison	Outcomes	Measure/s	Length of follow-up	Effect Size	Comments
Cristea, Ioana A., Claudio Gentili, Carmen D. Cotet, Daniela Palomba, Corrado Barbui, und Pim Cuijpers. „Efficacy of Psychotherapies for Borderline Personality Disorder: A Systematic Review and Meta-Analysis". *JAMA Psychiatry* 74, Nr. 4 (1. April 2017): 319–28. https://doi.org/10.1001/jamapsychiatry.2016.4287.	Level I/meta-analysis of RCTs	N=33 RCTs, N=28 RCTs available for effect size calculation	N=2256 adult patients with BPD	Psychotherapy (any); categorized as stand-alone (experimental group received full course of BPD psychotherapy, control TAU or another therapy not specific for BPD) or add-on (both groups received TAU and experimental group an additional BPD therapy)	Control; not eligible: alternate psychotherapy specifically developed for BPD	Borderline-relevant outcomes (including BPD symptoms, slef-harm, parasuicidal behavior, suicide), composite of all borderline-relevant outcomes defined above, health service use, general psychopathology	diverse		Main effect at post-test for all designs: Hedges' g = 0.35; 95% CI 0.20-0.50 (27 trials); Stand-alone designs: sig. effects for all outcomes with hedges *g* ranging from 0.31 to 0.44; add-on treatments no sig. effects for self-harm/parasuicidal behavior and health service use, remaining effects ranging from Hedges *g* 0.35 to 0.40 Subgroup analyses: DBT (*g=0.34*, 95% CI 0.15 to 0.53; 9 trials) and	

Full reference Country	Study Design/ Level of Evidence	N (n)	Participants Age Gender Diagnosis Other	Intervention	Comparison	Outcomes	Measure/s	Length of follow-up	Effect Size	Comments
									psychodynamic approaches (including MBT, TFP, Short Adlerian Therapy and Deconstructive Psychotherapy; *g*= 0.41, 95% CI 0.12 to 0.69, 7 trials)	
Keefe, John R, Shelley F McMain, Kevin S McCarthy, Sigal Zilcha-Mano, Ulrike Dinger, Zeynep Sahin, Kathryn Graham, und Jacques P Barber. „A meta-analysis of psychodynamic treatments for borderline and cluster C personality disorders.“ *Personality disorders* 11, Nr. 3 (2020): 157–69. https://doi.org/1	Level I/meta-analysis of RCTs in individuals with BPD or Cluster C personality disorders	N=16 RCTs, n=10 RCTs there of including persons with BPD	n=1207 BPD participants	Psychodynamic therapies (PDT)	control condition intended and expected to underperform against any uniquely therapeutic treatment (e.g., waitlist, non-bona	BPD symptoms, suicidality, axis-I symptomatology, interpersonal problems, psychosocial functioning, dropout, diagnostic remission	SCID-II-criteria counts, PD specific measures; SCL-90-R, BDI, BAI, IIP, GAF, SAS, treatment dropout, remission from PD per a structured interview	post treatment	PDT stat. sig. superior to control treatments regarding general psychiatric symptoms (Hedge's *g*=-0.38, 95% CI -0.68 to-0.08, *p*=0.19) psychosocial functioning (Hedge's *g*=-0.66, 95% CI -1.01 to -0.32, *p*=0.03) no stat. sig. differences	Concrete studies and numbers of studies/participants included in corresponding analyses not specified

Full reference Country	Study Design/ Level of Evidence	N (n)	Participants Age Gender Diagnosis Other	Intervention	Com-parison	Outcomes	Measure/s	Length of follow-up	Effect Size	Comments
0.1037/per0000382.					fide sup-portive coun-seling, TAU)				between PDT and control groups re-garding core PD symptoms (Hedge's *g*=-0.25, 95% CI -0.82 to 0.31, *p*=.279), sui-cidality (Hedge's *g*=-045, 95% CI -1.31 to 0.40, *p*=.217), inter-personal problems (Hedge's *g*=-1.25, 95% CI -3.22 to 0.71, *p*=.111)	
McLaughlin, Ste-phanie P. B., Sa-rah Barkowski, Gary M. Bur-lingame, Bernard Strauss, und Jenny Rosendahl. „Group Psycho-therapy for Bor-derline Personal-ity Disorder: A Meta-Analysis of	meta-analysis of RCTs	24 RCTs	BPD patients	Group therapies	TAU	BPD symptoms, suicidality/para-suicidality, general mental health, de-pression, anxiety, emergency visits, hospitalizations			Effect of group treatments on BPD symp-toms: *g*=0.72, p<.001; sui-cidality/para-suicidality: *g*=0.46, p<.001; anxi-ety/depres-sion *g*=.46, p<.001;	

Full reference Country	Study Design/ Level of Evidence	N (n)	Participants Age Gender Diagnosis Other	Intervention	Com-parison	Outcomes	Measure/s	Length of follow-up	Effect Size	Comments
Randomized-Controlled Trials“. *Psychotherapy (Chicago, Ill.)* 56, Nr. 2 (Juni 2019): 260–73. https://doi.org/10.1037/pst0000211. USA									general mental healt: *g*=0.28, p<.001; no sig. differences re hospitalizations or emergency visits	
Meuldijk D, McCarthy A, Bourke ME, Grenyer BF. The value of psychological treatment for borderline personality disorder: Systematic review and cost offset analysis of economic evaluations. PLoS One. 2017 Mar 1;12(3):e0171592. doi: 10.1371/journal.pone.0171592. PMID: 28249032;	meta-analysis of controlled trials (RCTs, quasi-experimental controls, or historical controls)	15 studies comparing psychother. Interventions to TAU	individuals with BPD	psychotherapeutic intervention	TAU	direct costs, indirect costs, intervention costs, cost offset psychotherapy vs. TAU		12 weeks to 3 years	cost offset PT vs. TAU: additional weithed mean cost-savings of PT: $1,551.37 USD per person per year (SD=$6,574.17, range $83 to $29,392 per year)	includes one study with historical controls (Berrino 2011[37]), several quasi-experimental trials (Pasieczny 2011[38]) and a pre-post comparative study (Richter 2014[39]); several primary studies doubly considered in analyses (Bateman 2003[40]=Bateman 1999[41];

Full reference Country	Study Design/ Level of Evidence	N (n)	Participants Age Gender Diagnosis Other	Intervention	Com-parison	Outcomes	Measure/s	Length of follow-up	Effect Size	Comments
PMCID: PMC5332029.										Linehan 1991[42]=Heard 2000[43], Davidson 2010[44]=Palmer 2006[45])
Oud M, Arntz A, Hermens MLM, Verhoef R, Kendall T. Specialized psychotherpaies for adults with BPD: a systematic review and meta-analysis. Australian & New Zealand Journal of Psychiatry, 52(10), 949-61	Level I	N=RCTs	Samples of adult people with BPD (minimum 66% of overall sample)	DBT, MBT, TFP, ST	Specialized BPD psychotherapies, control groups (e.g., TAU, waiting list, attention control, CTBE)	BPD severity Single BPD symptoms Dropout		Minimum 16 weeks	Specialized psychotherapies vs. TAU: <u>BPD severity</u>: **total** *k=4*; n=151; SMD -0.75 (-1.30, -0.19); **DBT-PTSD** SMD-0.85 (-1.57, -0.13); **SFT-Group**: SMD -1.66 (-2.54, -0.78) <u>self-injury:</u> **total** *k*=7,n=314, SMD =-0.33, 95% CI -0.57, -0.09; **DBT** *k*=5, SMD=-0.40 (-0.66,-0.13); **MBT-PH** RR=0.44 (0.24, 0.81);	

Full reference Country	Study Design/ Level of Evidence	N (n)	Participants Age Gender Diagnosis Other	Intervention	Com-parison	Outcomes	Measure/s	Length of follow-up	Effect Size	Comments
									Specialized psychothera-pies vs. CTBE: <u>BPD severity</u> **total** *k*=2, SMD=-0.47, 95% CI -0.78, -0.16; **TFP** SMD=-0.55 (-0.95, -0.16), <u>drop-out</u> **total** RR = 0.62, 95% CI 0.39, 0.99 Specialized psychothera-pies vs. proto-colized psy-chological treatment (MBT vs. standardized CM, DBT vs. CCT, DBT vs. GPM, DBT vs. TFP vs. SFT) <u>Self-injury</u> **DBT vs. CCT** SMD=-1.28 (-2.17, -0.38); **MBT-PH vs.**	

Full reference Country	Study Design/ Level of Evidence	N (n)	Participants Age Gender Diagnosis Other	Intervention	Com-parison	Outcomes	Measure/s	Length of follow-up	Effect Size	Comments
									SCM RR=0.56 (0.34, 0.92) DBT vs. TFP <u>Dropout</u> RR=2.07 (1.04, 4.10), fav. DBT SFT vs. TFP <u>BPD severity</u> SMD=-0.45 (-0.87, -0.02), <u>dropout</u> RR=0.52 (0.30, 0.92) No evidence of sig. effects for compari-sons SFT vs. SFT+therapist telephone availability,; DBT vs. DBT+DBT pro-longed-expo-sure, DBT vs. DBT-skills training+case management, DBT vs. DBT	

Full reference Country	Study Design/ Level of Evidence	N (n)	Participants Age Gender Diagnosis Other	Intervention	Com-parison	Outcomes	Measure/s	Length of follow-up	Effect Size	Comments
									individual therapy+activ-ities group, DBT skills training+case management vs. DBT indi-vidual ther-apy+activities group	
Storebø O.J., Stoffers-Winter-ling J.M., Vollm B.A., Kongerslev M.T., Mattivi J.T., Jorgensen M.S., Faltinsen E., u. a. „Psychological Therapies for People with Bor-derline Personal-ity Disorder". *Cochrane Data-base of System-atic Reviews* 2020, Nr. 5 (2020): CD012955. https://doi.org/10.1002/14651858.CD012955.pub2.	Level I	N=75 RCTs	Adolescent and adult people with BPD	Psychotherapies	Con-trols or active	BPD severity, self-harm, suicidality, functionining, BPD symptoms, depression, attri-tion, adverse events	diverse	Post-treat-mentand follow-up	**Psychother-apy (any) vs. TAU** BPD SEVERITY: SMD -0.52, 95% CI -0.70 to -0.33, 22 trials, 1244 participants, moderate-quality evi-dence SELF-HARM: SMD -0.32, 95% CI -0.49 to -0.14, 13 trials, 616 par-ticipants SUICIDE-RE-LATED	

Full reference Country	Study Design/ Level of Evidence	N (n)	Participants Age Gender Diagnosis Other	Intervention	Com-parison	Outcomes	Measure/s	Length of follow-up	Effect Size	Comments
									SMD -0.34, 95% CI -0.57 to -0.11, 13 trials, 666 participants PSYCHOSOCIAL FUNCTIONING SMD -0.45, 95% CI -0.68 to -0.22, 22 trials, 1314 participants **DBT vs. TAU** BPD SEVERITY SMD -0.60, 95% CI-1.05 to -0.14, 3 trials, 149 participatns PSYCHOSOCIAL FUNCTIONING SMD -0.36, 95% CI -0.69 to -0.03, 6 trials, 225 participants	

Full reference Country	Study Design/ Level of Evidence	N (n)	Participants Age Gender Diagnosis Other	Intervention	Comparison	Outcomes	Measure/s	Length of follow-up	Effect Size	Comments
									MBT vs. TAU SELF-HARM RR 0.62, 95% CI 0.49 to 0.80, 3 trials, 252 participants SUICIDALITY RR 0.10, 95% CI 0.04 to 0.30, 3 trials, 218 participants	
Zahediabghari, Soheil, Philippe Boursiquot, und Paul Links. „Impact of Psychotherapy on Psychosocial Functioning in Borderline Personality Disorder Patients.“ *International journal of environmental research and public health* 17, Nr. 12 (2020). https://doi.org/1	Level I/Meta-analysis of level-II studies	N= 10 RCTs, n= 880 participants	adults, either gender, BPD diagnosis	BPD-specifically-designed psychotherapy	non-specific psychotherapies (TAU, clinical management, standard treatment, community	psychosocial functioning	GAF IIP SAS	post-treatment (8 weeks to 18 months)	stat. sig. higher psychosocial functioning in participants who had received BPD-specific psychotherapies as compared to control groups (Hedes *g*=-0.41, 95% CI 0.09 to 0.73)	primary studies identified from reference list of Cristea 2017[28]

Full reference Country	Study Design/ Level of Evidence	N (n)	Participants Age Gender Diagnosis Other	Intervention	Com-parison	Outcomes	Measure/s	Length of follow-up	Effect Size	Comments
0.3390/ijerph17124610.					treat-ment by ex-perts)					

Level II

Studies meeting the following inclusion criteria:

- identified in update searches (January 2011 – August 2021; for Level I studies previously identified and included into the NHMRC guidelines s. Leitlinie, section 4.1., table 10 and evidence tables in NHMRC guidelines[26])
- RCT
- ≥70% participants with BPD
- reporting on at least one of the pre-defined guideline outcomes
- comparing active treatment to controls
- analysing between-group differences (within-group comparisons are not included)

Full reference Country	Study Design/ Level of Evidence	N (n)	Participants Age Gender Diagnosis Other	Intervention	Comparison	Outcomes	Measure/s	Length of follow-up	Effect Size	Comments
Amianto et al. 2011[46] **Italy**	Level II/RCT	N=35 (n=33)	Adults with BPD and heavy use of mental health services throughout the prior year. 20-50 years of age. Mean age: 39.5 years. 49% female. 100% with BPD	Supervised team management (STM) + sequential brief Adlerian psychodynamic psychotherapy (SB-APP)	STM only	Primary: Self-harm; Suicide-related outcomes; psychosocial functioning.	Number of self-harm incidents reported CGI-BPD, (Clinical Global Impression – Modified), Glocal Assessment of Functioning	12 months	"SB-APP treatment seemed more effective than STM on four CGI-M items at T6 and T12 (Table 3): disturbed relationships (p < .040), impulsivity (p < .025), self-damaging behaviors (p < .019), and chronic feelings of emptiness (p <	"Independently of treatment group, patients were found to overall improve in terms of general symptoms and clinical severity (SCL-90-R; CGI; CGI-M 9 items), global functioning (GAF), and control of anger expression

Full reference Country	Study Design/ Level of Evidence	N (n)	Participants Age Gender Diagnosis Other	Intervention	Com-parison	Outcomes	Meas-ure/s	Length of follow-up	Effect Size	Comments
									.009)." (Amianto et al. 2011, p. 7)	(STAXI) at T6 and T12." (Amianto et al. 2011, p. 7 Risk of affiliation bias (developer of experimental treatment is first author)
Andreoli et al. 2016[47] **Switzerland**	Level II/RCT	N=170 (n=151)	Consecutive patients admitted to the psychiatric crisis unit after suicide attempt , mean age: 31.9 years. 84.1% female. 10.6% substance abuse, 4.1% alcohol dependence, 21.8% alcohol abuse. 100% BPD, 100% comorbid major depressive disorder	abandonment psychotherapy (AP-P), or abandonment psychotherapy delivered by nurses (AP-N),	intensive community treatment-as-usual	Primary: Suicide-related outcomes, psychosocial functioning Secondary: adverse effects	Number of suicidal ideations	3 months	"Those patients assigned to AP had lower numbers on repeat suicide attempt, but the between-group differences did not reach significance. […] participants who received either form of AP had fewer episodes of suicidal relapse (AP-P vs.	No difference was observed for this short-term intervention being delivered by nurses or psychotherapists. Findings may be compromised by concurrent antidepressive medication that was part of of the treatment regimen (exact medication not specified).

Full reference Country	Study Design/ Level of Evidence	N (n)	Participants Age Gender Diagnosis Other	Intervention	Com-parison	Outcomes	Meas-ure/s	Length of follow-up	Effect Size	Comments
									TAU: Pearson $\chi2 = 8.09$, *df* = 1, *p* = .004; AP-N vs. TAU: Pearson $\chi2 = 9.33$, *df* = 1, *p* = .002). […] they all also had increased survival to suicidal crisis relapse compared to patients assigned to TAU (AP-P vs. TAU log-rank test: Mantel $\chi2 = 7.63$, *df* = 1, *p* = .006; AP-N vs. TAU log-rank test: Mantel $\chi2 = 9.87$, *df* = 1, *p* = .002). Participants who received psychotherapy also showed [..] a greater improvement	High risk of attention bias (substantially more attention paid to active groups than control group).

Full reference Country	Study Design/ Level of Evidence	N (n)	Participants Age Gender Diagnosis Other	Intervention	Com-parison	Outcomes	Meas-ure/s	Length of follow-up	Effect Size	Comments
									in terms of suicidal idea-tion compared to patients re-ceiving TAU (AP-P: sepa-rate variances *t* test = 2.84, *df* = 37.7, *p* = .007; AP-N: separate vari-ances *t* test = 3.44, *df* = 33.3, *p* = .002). No dif-ferences were found on sui-cidality measures when we compared AP-P and AP-N." (Andreoli et al. 2016, p. 281) "The analyses of variance for repeated measures dis-closed a	

Full reference Country	Study Design/ Level of Evidence	N (n)	Participants Age Gender Diagnosis Other	Intervention	Com-parison	Outcomes	Meas-ure/s	Length of follow-up	Effect Size	Comments
									marked positive effect of time on global functioning and symptom severity in all treatment cells as well as a significant positive time/treatment effect on the variability of GAS scores (AP-P vs. TAU: *F*[1, 98] = 6.09, *p* = .015; AP-N vs. TAU: *F*[1, 98] = 6.65, *p* = .011), CGI scores (AP-P vs. TAU: F[1, 98] = 9.63, *p* = .003; AP-N vs. TAU: *F*[1, 98] = 10.24, *p* = .002), […]	

Full reference Country	Study Design/ Level of Evidence	N (n)	Participants Age Gender Diagnosis Other	Intervention	Comparison	Outcomes	Measure/s	Length of follow-up	Effect Size	Comments
									(Andreoli et al., p. 282)	
Antonsen et al., 2017 [48] **Norway**	Level II / RCT	N=117 (n=52 with BPD)	women and men with BPD (85% women), mean age 29.0 years (SD 6.7)	Long-term combination program (18 weeks) day-hospital treatment (combination of psychodynamic and cognitive-behavioural group therapies; CP) followed by outpatient combined group (weekly) and individual psychotherapy (weekly); OIP)	Outpatient individual therapy (therapists in private practice; treatment according to their own preferred method and practice	primary outcomes: Psychosocial functioning Quality of life Self-harm, suicidal thoughts, suicide attempts	GAF 10-point Likert scale SIPP-118 Self-report/record	Average duration: combined: 28 months, maximum 4 years Average duration outpatient: 24 months	stat. sig. interaction group x time > 36 months for GAF (LMM estimate -0.31, 95% CI -0.60,-0.05) no statistical sig. difference between treatment groups in quality of life (p=.14) "GLMM analyses did not reveal any significant differences in longitudinal outcome between treatment conditions regarding the proportion of patients who	"…patients in the CP continued to improve in psychosocial function during the threeto six-year period, while patients in the OIP showed a decline in psychosocial functioning over this same period […] Both treatment conditions had a BPD diagnostic remission rate of over 90% at the six-year follow-up." (Antonsen et al. 2017, p. 56)

Full reference Country	Study Design/ Level of Evidence	N (n)	Participants Age Gender Diagnosis Other	Intervention	Com-parison	Outcomes	Meas-ure/s	Length of follow-up	Effect Size	Comments
									had been self-harming (p = .56), made suicidal attempts (p = .14), or experienced suicidal thoughts (p = .43). There were no significant differences between treatment conditions in the proportion of patients who had experienced suicidal thoughts during the last seven days (p = .98)." (Antonsen et al. 2017, p. 56-57)	Treatment adherence:DHP: "However, there was no formal training for the therapists, nor did the guidelines serve as a standard for treatment adherence." (p.72). OIP: "The researchers gave no instructions to the OIP therapists regarding the duration and intensity of psychotherapy, nor did they interfere with any treatment decisions in the OIP conditions." (p.72) Allegieance bias:Low risk of bias

Full reference Country	Study Design/ Level of Evidence	N (n)	Participants Age Gender Diagnosis Other	Intervention	Com-parison	Outcomes	Meas-ure/s	Length of follow-up	Effect Size	Comments
										Attention bias: Similar total length. Frequency of therapy from once a month to three times a week in OIP. Frequency of therapy in groups were different. (Not reported in Arnevik, 2009[49]). There was an obvious difference in the amount of therapy received. CP patients received 18 weeks' intensive day hospital treatment followed by conjoint treatment, while in OIP, most patients attended

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										therapy once a week. The mean number of received therapy sessions at 18 months in OIP was 40. (Arnevik, 2010, p. 199)
Bianchini et al. 2019[50] **Italy**	Level II/RCT	N=21 (n=21)	men with BPD and a history of violence who were patients in three high intensity therapeutic facilities, mean age 41.79 years (SD 8.14), 100% BPD	DBT (once-weekly individual therapy (60 minutes), once-weekly group sessions (120 minutes)) +TAU	Treatment as usual (pharmacotherapy, social skills, cognitive remediation)	secondary: impulsivity emotion regulation	BIS DERS	12 months	"There was a tendency for all scale scores to be slightly lower at the end of the study period than at the beginning, but there was a significant reduction in total impulsivity scores in the DBT-treated group alone [BIS-11 total score p=0.05] […] there was an overall reduction in	small sample size; between-group effects not reported

Full reference Country	Study Design/ Level of Evidence	N (n)	Participants Age Gender Diagnosis Other	Intervention	Com-parison	Outcomes	Meas-ure/s	Length of follow-up	Effect Size	Comments
									difficulties with emo-tional regula-tion in the DBT-treated group, [DERS total p=0.04)" (Bianchini et al., 2019, p. 6)	
Bohus et al. 2013[51] **Germany**		N=74 (n=74), N=33 there of with full BPD (≥5 DSM crite-ria)	female partici-pants with a diag-nosis of post-trau-matic stress disor-der (PTSD) and at least 4 criteria of DSM-IV-BPD after childhood sexual abuse mean age 32.9 years	inpatient DBT for patients with PTSD after childhood sex-ual abuse (DBT-PTSD); including: modified DBT skills training group (1 session of 90 minutes duration per week, modules: mindfulness, inter-personal skills, emotion regulation, stress tolerance; but less attention on interpersonal and detention skills as in standard DBT skills group); indi-vidual cognitive trauma therapy, ex-posure and discrim-ination training (2	Waiting list: contin-uation of al-ready ongo-ing treat-ments for 6 months , inpa-tient DBT-PTSD treat-ment after-wards; points of	secondary: BPD severity psychosocial func-tioning dissociation adverse events in terms of worsen-ing, suicide at-tempts, NSSI be-haviours	BSL GAF DES	3 months	Hedges' g be-tween groups: BSL 0.52, GAF 1.02, DES 0.50; time x group interac-tion stat. sig. for GAF (0.503, p<.001) but not BSL or DES; no worseining of PTSD symp-toms ob-served in any group,	large be-tween-group effects regard-ing reduction of PTSD; BPD severity at in-take was not related to treatment outcome

Full reference Country	Study Design/ Level of Evidence	N (n)	Participants Age Gender Diagnosis Other	Intervention	Com-parison	Outcomes	Meas-ure/s	Length of follow-up	Effect Size	Comments
				sessions of 45 minutes duration per week); psy-choeducation group concerning PTSD aetiology and treat-ment; additional group training in mindfulness- and acceptance-based techniques (three sessions of 20 minutes duration per week); partici-pation in music, arts and exercise ther-apy DBT skills train-ing (DBT-ST), includ-ing DBT original skills for interper-sonal effectiveness, emotional regula-tion, mindfulness and distress toler-ance; 13 psycho-therapy sessions of 120 min each, con-ducted by 2 thera-pists (a male and a female) for each group, in groups of 9-11 participants	meas-ure-ment: base-line, 3 months, 4.5 months and 6 months after study inclu-sion					

Full reference Country	Study Design/ Level of Evidence	N (n)	Participants Age Gender Diagnosis Other	Intervention	Comparison	Outcomes	Measure/s	Length of follow-up	Effect Size	Comments
Borschmann 2013[52] **United Kingdom**	Level II/RCT	N=88 (n=73)	adult patients under ongoing care of community mental health team, 100% BPD, 80.7% female gender, mean age 35.8 years	Joint crisis plans plus TAU (joint elaboration of a list of topics to be considered for inclusion in the individuals crisis plan, care coordinators and significant others involved)	TAU	primary outcomes: Social functioning quality of life self-harm	WSAS EQ-5D unpublished questionnaire	6 months	"no significant difference in the proportion reporting self-harm between the JCP + TAU and TAU arms (OR = 1.9, 95% CI 0.53–6.5, P= 0.33)." (Borschmann et al. 2013, p. 360) "no significant differences between the groups on any of the secondary outcomes [WSAS, EQ-5D]" (Borschmann et al. 2013, p. 361)	proportion of participants reporting self-harm fell in both groups, no sig. differences on any outcome, including health and social care costs.
Bozzatello et al. 2020[53] **Italy**	RCT/Level II	N=43 (n=36)	adult outpatients with BPD (100%), 66.7% female gender, mean age 35.4 years	Interpersonal Psychotherapy adapted for BPD (IPT-BPD), including included an intervention for patients'	Waiting List+clinical management	primary BPD symptoms psychosocial functioning impulsivity aggression	BPDSI-IV SOFAS BIS MOAS	10 months	"A significant effect between subjects (treatment modality) was	

Full reference Country	Study Design/ Level of Evidence	N (n)	Participants Age Gender Diagnosis Other	Intervention	Com-parison	Outcomes	Meas-ure/s	Length of follow-up	Effect Size	Comments
				family members in order to help them to under-stand and deal with the disorder of their relative		self-harm	DSHI		found for CGI-S (P = 0.009); for SOFAS (P = 0.02); for BIS-11 total score (P = 0.031) and subscale " non-planning impulsivity" (P = 0.042); for BPDSI total score (P = 0.01) and items " interpersonal relationships" (P = 0.001), " impulsivity" (P = 0.03), " identity" (P = 0.014)." (Boz-zatello et al. 2020, p. 11)	
Davidson et al. 2014[54]	Level II/RCT	N=20 (n=15)	patients admitted to the medical re-ceiving ward after	Manual-assisted cognitive therapy	TAU	primary: suicidal ideation	BSS Acts DSH	3 months	stat. sig. lower suicidal idea-tion in MACT	sample poorly described (gender, age)

Full reference Country	Study Design/ Level of Evidence	N (n)	Participants Age Gender Diagnosis Other	Intervention	Com-parison	Outcomes	Meas-ure/s	Length of follow-up	Effect Size	Comments
United Kingdom			an episode of self-harm, 85% BPD, gender n.s., mean age n.s.	(MACT) + TAU, 6 weekly sessions		acts of deliberate self-harm			group (BSS: *t*=-3.64, *p*=0.004), no stat. sig. difference between groups regarding number of non-suicidal self-harm episodes	
Feigenbaum et al. 2012[55] **United Kingdom**	Level II/RCT	N=42 (n=41)	Cluster B PD patients from secondary and tertiary care services, 73% females, 93% BPD, mean age 35.1 years	Standard DBT as delivered by staff of the UK NHS service	TAU	primary functioning self-harm/ suicide attempts aggression anger dissociation	CORE-OM SASII OAS STAXI DES	12 months	stat. sig. between-group differences favouring DBT regarding self-harm (F=8.4, *p*=0.001), anger (STAXI F=7.5, *p*=.001) no stat. sig. differences between groups regarding functioning (CORE-OM F=2.8, *p*=0.71), aggression (OAS F<1.0, *p* n.s.), dissociation	slightly greater decrease also of PTSD symptom severity in DBT group; feasibility study indicating that DBT is feasible in routine care,

Full reference Country	Study Design/ Level of Evidence	N (n)	Participants Age Gender Diagnosis Other	Intervention	Com-parison	Outcomes	Meas-ure/s	Length of follow-up	Effect Size	Comments
									(DES F<1.0, *p* n.s.)	
Gleeson et al. 2012[56] **Australia**	Level II/RCT	N=16	People aged 15 to 25 years meeting 4 or more BPD criteria (75% full BPD) with 1 week or more of psychotic symptoms and less than 6 months of previous antipsychotic medication; mean age 18.4 years, 81.2% females	SFET (description s. comparison treatment) + HYPE: rigorous personality pathology diagnosis, individual cognitive analytic therapy (CAT), development of a collaborative model of the individual's difficulties; 16 weekly sessions of individual therapy	SFET: Routine treatment at the Early Psychosis prevention and intervention centre, possibly including youth assessment, acute home treatment, outpatient case management, medical	Depression Overall burden Neg. symptoms Suicidality Aggression Substance use functioning	MADRS BPRS SANS AIAQ OAS-M ASSIST AUDIT SOFAS	16 weeks	Descriptive data reported only due to small sample size; HYPE+SEFT: fewer positive psychotic and negative symptoms, less anhedonia, less depression, better functioning, less irritable, more likely to be adherent, higher levels of alcohol misuse	Very small study with high dropouts (7 out of 16 participants involved)

Full reference Country	Study Design/ Level of Evidence	N (n)	Participants Age Gender Diagnosis Other	Intervention	Com-parison	Outcomes	Meas-ure/s	Length of follow-up	Effect Size	Comments
					follow-u, fam-ily work , inpa-tient treat-ment, asser-tive out-reach, psycho-social recov-ery pro-gramm e					
Gratz et al. 2014[57] **USA**	Level II/RCT	N=61 (n=61)	female outpa-tients with sub-threshold or full BPD and repeated self-harm, 89% full BPD, mean age 33.2 years	Emotion Regulation Group Therapy (ERGT; ACT- and DBT-based) + ongo-ing outpatient ther-apy	waiting list + ongo-ing out-patient therapy	primary deliberate self-harm BPD pathology BPD severity interpersonal problems psychosocial func-tioning quality of life emotion regula-tion	SHI, DSHI Zan-BPD BEST IIP-BPD SDS QOLI DERS	6 months	"The results revealed sig-nificant ef-fects (accompanied by medium to large effect sizes) of ERGT on DSH and other self-destruc-tive behav-iors, emotion dysregulation	investigates the effects of an adjunct group pro-gram deliv-ered in addi-tion to ongo-ing individual therapy or case manage-ment

Full reference Country	Study Design/ Level of Evidence	N (n)	Participants Age Gender Diagnosis Other	Intervention	Com-parison	Outcomes	Meas-ure/s	Length of follow-up	Effect Size	Comments
									(overall and across the dimensions of emotional non-acceptance, difficulties engaging in goal-directed behaviors when distressed, and lack of access to effective regulation strategies), BPD symptoms on the ZAN-BPD, depression and stress symptoms on the DASS, and quality of life." (Gratz et al. 2015, p. 2105)	
Haeyen et al. 2014[58], BPD subsample data	Level II/RCT	N=76 people with	participants were recruited from a waiting list of patients targeted for	art therapy (aimed at improving mindfulness, self-validation, emotion	waiting list	primary: psychosocial functioning	OQ45-functioning	10 weeks	stat. sig. better functioning (SMD	risk of affiliation bias (treatment developed by

Full reference Country	Study Design/ Level of Evidence	N (n)	Participants Age Gender Diagnosis Other	Intervention	Comparison	Outcomes	Measure/s	Length of follow-up	Effect Size	Comments
taken from Storebø et al. 2020 [30] The Netherlands		any Cluster B/C PD, n= 26 thereof (34%) with full BPD; data on subsample with full BPD available from Storebø et al. 2020 [30]	PD treatment in a specialized outpatient treatment unit for personality disorders	regulation skills, interpersonal functioning and insight, and comprehension […]The utilized art assignments consisted of individual, dual, and group components. Each session started with some minutes for tuning in and explaining the experiential assignment and the goals for the session. The sessions ended with discussion and reflection with the therapist together with the whole group, based on the art process and art product. This art therapy protocol made use of theoretical elements of dialectical behavior therapy (DBT)		interpersonal problems	OQ45-interpersonal		-1.34, 95% CI -2.21, -0.47) and interpersonal problems (SMD -1.11, 95% CI -1.96, -0.27) in active group (subsample data for participants with full BPD, quoted from Storebø et al. 2020 [30])	primary author) and attention bias (substantially more attention spent to active group)

Full reference Country	Study Design/ Level of Evidence	N (n)	Participants Age Gender Diagnosis Other	Intervention	Com-parison	Outcomes	Meas-ure/s	Length of follow-up	Effect Size	Comments
				(Linehan, 1996), schema-focused therapy (SFT) (Young, 1994; Young et al., 2003), gestalt art therapy (Rhyne, 1970, 1973a, 1973b), creative problem solving (Osborn, 2011), and the expressive therapies continuum (Hinz, 2009; Schweizer et al., 2009).“ (Haeyen et al. 2017, p. 316)						
Harned et al. 2014[59] **USA**	Level II/RCT	N=26	Women with BPD + PTSD, mean age 32.6 years	Standard DBT with DBT-PE protocol (+ Prolonged Exposure according to Foa et al., 2007)	One year of standard DBT 0.6 and 0.7(weekly individual therapy, weekly group skills training)	PTSD severity Self-injury Dissociation Trauma-related guilt inventory Shame General psychopathology Depression anxiety	PSS-I SASII DES Trauma-related guilt inventory Experience of Shame Scale ESS SCL-90-R-GSI HRSD HRSA	12 months	Hedges’ *g* at post-treatment (between groups) for ITT sample (no p values reported): trauma-related guilt 1.0, suicide attempts 0.7, depression 0.5, shame 0.4, anxiety 0.3, dissociation 0.3, PTSD	Large pre-post effects (g>1; ITT samples) in both conditions for PTSD severity, shame, depression, global psychopathology

Full reference Country	Study Design/ Level of Evidence	N (n)	Participants Age Gender Diagnosis Other	Intervention	Com-parison	Outcomes	Meas-ure/s	Length of follow-up	Effect Size	Comments
									0.0, non-suicidal self-injury acts 0.0 Large pre-post effects in both groups for PTSD (DBT+DBT PE (ITT) *g*=1.8; DBT (ITT) *g*=1.3) and non-suicidal self-injury in both groups (DBT+DBT PE (ITT) *g*=1.0, DBT (ITT) *g*=0.8) PTSD remission: DBT+DBT PE 80%, DBT 40%	
Jahangard et al. 2012[60] **Iran**	Level II/RCT	N=30	Inpatients with BPD and depressive disorder; 53% females, mean age 24.2	Emotional intelligence training, 12 sessions over 4 weeks	Any other care as received on ward (including	Depression Emotional intelligence	Ham-D Emotional Quotient inventory (EQ-I)	4 weeks	Sig. time x group interactions for emotional intelligence (F=10.12, p<.05) and depression (F=20.21, p<.001)	control group poorly described, very short observation period, all participants received SSRIs concomitantly and benzodeziapines in

Full reference Country	Study Design/ Level of Evidence	N (n)	Participants Age Gender Diagnosis Other	Intervention	Com-parison	Outcomes	Meas-ure/s	Length of follow-up	Effect Size	Comments
					phar-maco-logical treat-ment)					case of sleep problems
Jochems et al. 2015[61] BPD subsample data taken from Storebø et al. 2020 [30] **The Netherlands**	Level II/RCT	N=294 of over-all sam-ple (in-clud-ing psy-chic or psy-chotic disor-ders) n=38 with diag-nosis of BPD	outpatients of as-sertive commu-nity mental health care, mean age overall sample 45.0 years, 60.9 % male gender (overall sample)	Motivation feed-back (monthly as-sessments of level and type of the pa-tient's treatment motivation) as-sessed and pro-vided to clinicians + TAU	TAU	primary: psychosocial func-tioning	HoNOS	12 months	SMD -0.42 (95% CI-4.23, 3.39) (BPD subsam-ple data taken from Storebø et al. 2020 [30])	comparatively old and male sample
Jørgensen et al. 2013[62]	Level II/RCT	N=111	adult outpatients (100% BPD), 95.5% female,	intensive MBT: twice weekly	less in-tensive	primary: psychosocial func-tioning	SAS-SR, GAF	24 months	"Pre-post ef-fect sizes (Cohen_s d)	high risk of at-tention bias (substantially

Full reference Country	Study Design/ Level of Evidence	N (n)	Participants Age Gender Diagnosis Other	Intervention	Com-parison	Outcomes	Meas-ure/s	Length of follow-up	Effect Size	Comments
Denmark		(n=58)	mean age 29.1 years	combined individual and group MBT	(bi-weekly) supportive group therapy	interpersonal problems			were calculated based on those patients who started treatment. In both groups, a large or very large (0.5–2.1) and in most cases highly significant (all Ps < 0.01, in the MBT group most Ps < 0.00005) effect sizes on all measures of outcome were found“ […] For self-report measures of depression,	less attention spent to control group), high attrition rate (45% of ITT group)

Full reference Country	Study Design/ Level of Evidence	N (n)	Participants Age Gender Diagnosis Other	Intervention	Com-parison	Outcomes	Meas-ure/s	Length of follow-up	Effect Size	Comments
									anxiety, so-cial functioning, interpersonal function and general level of func-tioning, we found no sta-tistically significant differences between the two groups (all Fs < 2.9, all Ps > 0.13) […] Only thera-pistrated global level of function-ing showed statistically significant differences between the two groups. Com-pared with	

Full reference Country	Study Design/ Level of Evidence	N (n)	Participants Age Gender Diagnosis Other	Intervention	Com-parison	Outcomes	Meas-ure/s	Length of follow-up	Effect Size	Comments
									patients in supportive group treat-ment, changes on both GAF-S and GAF-F were significantly higher in the MBT group (GAF-F: F = 8.0, P = 0.005; GAF-S: F = 12.7, P = 0.0004).“ (Jorgensen et al. 2013, p. 313)	
Kamalabadi et al. 2012[63] **Iran**	Level II/RCT	N=30 cou-ples	Males 18-50 years with their part-ners, at least one partner with BPD	14 weekly sessions of couple DBT	WL	primary BPD severity individual BPD symptoms psychosocial func-tioniong	BPDSI-IV GHQ	14 weeks (post)	stat. sig. be-tween-group differences at post-treat-ment (Cohen’s d 0.76 to 0.91) reported for BPDSI-IV total and individual BPD symp-toms (except dissociation)	study meth-ods poorly de-scribed, high risk of bias

Full reference Country	Study Design/ Level of Evidence	N (n)	Participants Age Gender Diagnosis Other	Intervention	Com-parison	Outcomes	Meas-ure/s	Length of follow-up	Effect Size	Comments
									and psychoso-cial function-ing (Cohen's *d* 0.39, *p*=0.001)	
Kramer et al. 2016[64] **Switzerland**	Level II/RCT	N=41 (n=31)	adult outpatients with BPD (100%), mean age 34,4 years, 87.8% fe-male gender	DBT-informed skills training (20 sesisons) + TAU	TAU	primary: psychosocial func-tioning interpersonal problems	OQ-45	20 weeks	"significant omnibus ef-fect favouring overall symp-tom reduction for SKILLS (F(3, 34) = 2.92; p = 0.04), com-pared with TAU", also psy-chosocial functioning (F(3,34) = 12.13; p<.01) and interper-sonal prob-lems (F(3,34) = 7.09, p<.01; (Kramer et al. 2016, p. 195)	
Kredlow et al. 2017[65] **USA**	Level II/RCT	Study 1: N=27 par-tici-pants	Study 1: People aged 18 years or older, with PTSD and BPD, plus any se-vere mental ill-ness (MDD (67%),	Study 1: CBT (12 to 16 sessions includ-ing psychoeduca-tion about PTSD, breathing retraining for anxiety, safety planning, cognitive	Study 1: TAU (contin-ued com-munity mental	Both studies: PTSD severity PTSD knowledge Posttraumatic Cognitions	CAPS PTSD knowledge test PTCI	Post-treat-ment	Study 1: no sig. time x group interac-tions for any primary or secondary outcome	

Full reference Country	Study Design/ Level of Evidence	N (n)	Participants Age Gender Diagnosis Other	Intervention	Comparison	Outcomes	Measure/s	Length of follow-up	Effect Size	Comments
		Study 2: N=55 participants	bipolar disorder (33%)), Mean age 45.7 years, 96% females Study 2: People aged 18 years or older with PTSD and BPD + severe mental illness (MDD (27%), bipolar disorder (47%), schizoaffective disorder (26%)), mean age 40.4 years, 78% females	restructuring; N=15) Study 2: CBT (description s. study 1; N=29)	health service care; N=12) Study 2: Brief intervention (3 first sessions of CBT intervention, including psychoeducation, breathing retraining for anxiety, safety planning)	Depression Anxiety Study 1 only: General burden Physical and mental health Study 2 only: Rates of severe PTSD Schizophrenia severity Quality of life General functioning	BDI BAI BPRS CAPS 65 or over PANSS QOLI GAF		Study 2: no sig. time x group effects	
Laurenssen et al. 2018[66] **The Netherlands**	Level II/RCT	N=95 (n=95)	adults with BPD (100%),	day hospital mentalization-based treatment (MBT-DH; highly	specialist TAU (manualised;	primary: BPD severity and individual symptoms	BPDSI-IV, PAI-BOR EQ-5D	18 monhs	no stat. sig. differences between groups on any	robust, manualized control condition; large.

Full reference Country	Study Design/ Level of Evidence	N (n)	Participants Age Gender Diagnosis Other	Intervention	Comparison	Outcomes	Measure/s	Length of follow-up	Effect Size	Comments
				structured day hospitalization program with a maximum duration of 18 months, covering 5 days/ week, approximately 6 h/day; daily group psychotherapy, weekly individual psychotherapy, individual crisis planning, art therapy twice a week, mentalizing cognitive group therapy, and writing therapy; medication as needed)	offered by a well-established treatment service; extensive psychiatric examination, offering emotional and practical support and structure, Patients were subsequently referred	Quality of life			primary or secondary outcome (BPDSI-IV: MD 3.43, 95% CI -3.72 to 10.57;	reductions of BPD severity within both groups (MBT-DH: *d* = 1.33, S-TAU: d=1.28; stat. significance not specified)

Full reference Country	Study Design/ Level of Evidence	N (n)	Participants Age Gender Diagnosis Other	Intervention	Com-parison	Outcomes	Meas-ure/s	Length of follow-up	Effect Size	Comments
					to evi-dence-based treat-ments that have no ex-plicit focus on fos-tering mental-izing					
Leichsenring et al. 2016[67] **Germany**	RCT/Leve l II	N=12 2 (n=	adult inpatients with Cluster B PD (83% BPD), 69% female gender, mean age 28.6 years	Psychoanalytic-In-teractional Therapy (PIT): therapist in responsive mode (another feeling person in a dyadic interaction, selec-tive self-disclo-sure/use of coun-tertransference to make the patient's interpersonal world more transparent),	Waiting list (WL) or second active treat-ment: non-manu-alized psycho-dy-namic therapy by ex-perts in person-ality	primary BPD sever-ity/symptoms interpersonal problems	BPI IIP	mean 2.5-3.5 months (post as-sessments done at discharge from ward)	"PIT (n = 44) was signifi-cantly supe-rior to the [WL] con-trols (n = 46) in all outcome measures (BPI – Total Score: [Cohen's d=0.61] p = 0.0043…" (Leichsenring et al. 2016, p. 78)	risk of selec-tive reporting (IIP scores not reported for comparison controls vs. PIT)

Full reference Country	Study Design/ Level of Evidence	N (n)	Participants Age Gender Diagnosis Other	Intervention	Com-parison	Outcomes	Meas-ure/s	Length of follow-up	Effect Size	Comments
					disor-ders (E-PDT); usual special-ised treat-ment at the special-ised clinic					
Leppänen et al. 2016[68] **Finland**	RCT/Leve l II	N=71 (n=51)	adult outpatients (>20 years of age) with severe BPD (severe symptoms of BPD. Severe symptoms in-cluded parasui-cidal behaviour (such as cutting, other forms of self-harm, impul-sive overdosing of medicines), at-tempted sui-cide, considerable emotional insta-bility affecting so-cial and profes-sional life, and previous	manualized SFT- and DBT-informed treatment called "Community treat-ment by experts"; 40 weekly individ-ual therapy plus 40 weekly psychoedu-cational group; community thera-pists had been edu-cated one year on BPD, SFT, DBT and attachment therapy	TAU (usual treat-ment re-ceived in the com-munity)	primary: BPD symptoms quality of life	BPDSI-IV HRQoL	12 months	mean BPDSI-IV score was lower in the CTBE group, but not stat. sig. so (t(49)=-1.24, p=0.220) total quality of life was stat. sig. lower in CTBE than TAU group (t(49)=2.10, p=.041) stat. sig. within-group decreases of several BPD symptoms	substantially higher attri-tion rate in control group (experimental treatment: 16%, TAU: 32.0%), com-pleter anal-yses only

Full reference Country	Study Design/ Level of Evidence	N (n)	Participants Age Gender Diagnosis Other	Intervention	Comparison	Outcomes	Measure/s	Length of follow-up	Effect Size	Comments
			unsuccessful treatments (one or more), where the patient withdrew from treatment or was still suffering from severe symptoms despite treatment), 86.0% female gender, mean age 32.2 years						(both groups: BPDSI-IV total, interpersonal problems, identity disturbance, emptiness, anger; CTBE only: impulsivity, parasuicidality/suicidality, paranoid ideation/dissociation)	
Majdara et al. (2019) [69] **Iran**	RCT/Level II	N=30 (n=26)	60% female gender, mean age 27.3 years	Dynamic Deconstructive Psychotherapy	supportive treatment (medication management plus intermittent brief supportive psychotherapy	primary: BPD symptoms	BEST	12 months	stat. sig. less BPD severity in DDP group ($F(2,28)=13.55$, $p=.001$)	participants had to have a higher education degree to be eligible for study participation (IQ not specified)

Full reference Country	Study Design/ Level of Evidence	N (n)	Participants Age Gender Diagnosis Other	Intervention	Comparison	Outcomes	Measure/s	Length of follow-up	Effect Size	Comments
					ses-sions					
McMain et al. 2017[70] **USA**	Level II/RCT	N=84 (n=76)	adult outpatients with BPD and active self-harm, 78.6% female gender, mean age 29.7 years	DBT skills training	Waiting list	primary: BPD severity self-harm suicidal behaviour impulsivity psychosocial functioning	BSL DSHI DSHI BIS-11 SAS-SR	20 weeks	stat. sig. lower BPD severity in DBT group (p<.01), difficulties in emotion regulation (p<.001), and better psychosocial functioning (p<.02)	at 3 months follow up: greater reductions in DBT than WL participants on suicidal and NSSI behaviours between baseline and 32 weeks (P < 0.0001). DBT participants showed greater improvement than controls on measures of anger, distress tolerance and emotion regulation at 32 weeks
McMurran et al. 2016 **UK**	RCT/Level II	N=306 (full sample), n=	adult individuals with PDs, 75.2% female gender (full sample), mean age (full	Psychoeducation and Problem Solving + TAU	TAU	primary: psychosocial functioning	SFQ	72 weeks	psychosocial functioning at 72 wekks: no stat. sig. difference	authors conclude: PEPS therapy is not an effective treatment for

Full reference Country	Study Design/ Level of Evidence	N (n)	Participants Age Gender Diagnosis Other	Intervention	Com-parison	Outcomes	Meas-ure/s	Length of follow-up	Effect Size	Comments
BPD subsample data cited from Storebø et al. 2020 [30]		183 (BPD sub-sam-ple)	sample) 38.6 years						between groups, better scores in TAU group (SMD 0.22 [-0.14, 0.58]	improving so-cial function-ing of adults with personal-ity disorder living in the community
Mehlum et al. 2014[71] **NORWAY**	Level II/RCT	N=77	adolescents (12-18 years) with re-cent and repeti-tive self-harm and at least 2 criteria of DSM-IV BPD (plus the self-de-structive crite-rion), or, alterna-tively, at least 1 criterion of DSM-IV BPD plus at least 2 subthreshold-level criteria, 87% female sex, 21% full BPD	Dialectical Behav-iour Therapy adapted for adoles-cents (DBT-A)	en-hanced usual care	self-harm epi-sodes suicidal ideation depression hopelessness BPD symptoms	self-report SIQ-JR SMFQ MADRS BHS BSL	19 weeks	between-group differ-ence in self-harm fre-quency was statistically significant (Δ slope=-0.92, 95% CI -1.69 to -0.15, *p*=0.21), also suicidal idea-tion (Δ slope=-0.62 per week, *p*=.010)	full diagnosis of BPD and high baseline depression predict higher depression at trial comple-tion; DBT-A predictive of lowever de-pression at completion of the trial[36]
Mohamadizadeh et al. 2017[72] **Iran**	RCT/Lev-elII	N=36 (n=36)	adult inpatient women with BPD, mean age not specified	DBT-informed group (12 sessions) SFT-informed group (12 sessions)	no treat-ment	primary: suicide ideation	SSI	16 weeks	No between-group effects reported for individual ac-tive treat-ments against control.	effect size cal-culation on basis of re-ported data result in ex-traordinary large effect sizes, s.

Full reference Country	Study Design/ Level of Evidence	N (n)	Participants Age Gender Diagnosis Other	Intervention	Com-parison	Outcomes	Meas-ure/s	Length of follow-up	Effect Size	Comments
									SSI scores post-treat-ment:DBT: mean=15.25, SD=1.65; SFT: mean=14.33, SD=1.55; con-trol group: mean: 31.0, SD=0.96	Storebø et al. 2020[30]: DBT-control SMD -11.27, SFT-cntrol SMD -16.67
Morton et al. 2012[73] **Australia**	RCT/Leve l II	N=41 (n=24)	adult outpatients with four or more BPD criteria (87.8% full BPD), 92.7% female gen-der, mean age 34.8 years	ACT+TAU	TAU	BPD severity affective instabil-ity	BEST DERS	13 weeks	"The BEST Composite in-teraction be-tween treat-ment condi-tion and time was signifi-cant [esti-mate=9.71, SE=4.21, t(32.5)=2.30, p=.028, 95% CI: 1.13, 18.28, d=.81], with a signifi-cant and large improve [esti-mate= ment in the ACT+TAU mean 11.52, SE=2.75, 30.8)=- t(4.18,	risk of bias due to non-blinding of outcome as-sessors

Full reference Country	Study Design/ Level of Evidence	N (n)	Participants Age Gender Diagnosis Other	Intervention	Com-parison	Outcomes	Meas-ure/s	Length of follow-up	Effect Size	Comments
									p=.000, 95% CI: -17.14, -5.90, d=.99] and [esti-mate=no sig-nificant change in the TAU mean 1.80, 33.8)=-.E=3.19, t(57, p=.575, 95% CI: -8.28, -4.67,d=.15]" (Morton et al., 2012, p. 537) "The DERS to-tal score con-dition interac-tion with timewas sig-nificant [esti-mate=23.94, SE=8.48, t(33.0)=2.82,p =.008, 95% CI: 6.69, 41.20, d=.98] with significantim-provement and moderate effect size for	

Full reference Country	Study Design/ Level of Evidence	N (n)	Participants Age Gender Diagnosis Other	Intervention	Com-parison	Outcomes	Meas-ure/s	Length of follow-up	Effect Size	Comments
									the ACT+TAU=-31.8)=condi-tion [esti-mate19.17, SE= 5.68, t(3.38,p=.002, 95% CI: -30.74, -7.60, d=.78] and no significant-change for the TAU condition [estimate =4.77, SE=6.30,t(34.1)=.76, p=.454, 95% CI: -8.03, 17.57, d=.19].” (Mor-ton et al. 2012, p. 539)	
Philips et al. 2018[74] **Sweden**	RCT/Level II	N=46 (n=24)	adult outpatients with BPD (100%) and substance de-pendence (45.7% alcohol, 39.1% opioids, 21.7% sedatives/hypnot-ics/anxiolytics), currently	MBT	TAU	primary: BPD symptoms self-harm suicide attempts interpersonal problems secondary: adverse effects	BPDSI-IV DSHI IIP	18 months	stat. sig. time effects on BPDSI-IV total and interper-sonal prob-lems; “no sig-nificant differ-ences be-tween the	“majority of the therapists did not show suffi-cient MBT ad-herence and quality” (Philips et al., p. 1)

Full reference Country	Study Design/ Level of Evidence	N (n)	Participants Age Gender Diagnosis Other	Intervention	Com-parison	Outcomes	Meas-ure/s	Length of follow-up	Effect Size	Comments
			undergoing sub-stance depend-ence treatment, 80.4% female gen-der, mean age 36.7 years						groups on any outcome vari-able." (Philips et al. 2018, p. 1) 0 suicide at-tempts in MBT group, 4 (com-mitted by 3 participants) in control group	
Priebe et al. 2012[75] **United Kingdom**	RCT/Leve l II	N=80 (n=74)	adult outpatients with a PD (98.8% with full BPD ac-cording to Sto-rebø et al. 2012[30])	DBT	TAU	primary self-harm BPD symptoms quality of life secondary costs of care	 days with self-harm Zan-BPD MANS	12 months	"Patients al-located to DBT showed a greater re-duction of days with self-harm over time. There was a statistically significant interaction between treatment condition and time (in-cidence rate ratio 0.91;	Pragmatic RCT including an unselected sample

Full reference Country	Study Design/ Level of Evidence	N (n)	Participants Age Gender Diagnosis Other	Intervention	Com-parison	Outcomes	Meas-ure/s	Length of follow-up	Effect Size	Comments
									p<! 0.001).” (Priebe et al. 201, p. 360 “no signifi-cant effect of DBT on BPD symptoms obser-rated and self-re-ported psy-chiatric symptom se-verity, or subjective quality of life at month 12” (Priebe et al. 2012, p. 361) “Total ser-vice costs were higher for the DBT group (mean 5,685 8 6,431 GBP in DBT com-pared to	

Full reference Country	Study Design/ Level of Evidence	N (n)	Participants Age Gender Diagnosis Other	Intervention	Com-parison	Outcomes	Meas-ure/s	Length of follow-up	Effect Size	Comments
									3,754 8 6,045 GBP in TAU), but the difference was not statistically significant (95% CI –603 to 4,599 GBP. (Priebe et al. 2012, p. 361)	
Reneses et al. 2013[76] **Spain**	RCT/Level II	N=53 (n=44)	adult outpatients with BPD (100% full diagnosis), 70.5% female gender, mean age 33.8 years	Psychic Representation focused Psychotherapy (PRFP)	TAU	primary: psychosocial functioning BPD symptoms impulsivity	SASS, CGI Zan-BPD BIS	20 weeks	"Clinical improvement was observed in both groups […] of variables regarding disease symptoms (MADRS suicide scores *d*=0.88, *p*=.006; BIS *d*=0.61, *p*=0.009; Zanarini interpersonal cluster *d*=0.83,	large between-group effects, small sample size indicative of bias

Full reference Country	Study Design/ Level of Evidence	N (n)	Participants Age Gender Diagnosis Other	Intervention	Com-parison	Outcomes	Meas-ure/s	Length of follow-up	Effect Size	Comments
									p=.029, Zan-BPD feeling of emptiness *d*=0.84, *p*=0.046) except for social adaptation measured with the SASS scale. The latter increased in the control group and very significantly decreased in the experimental group [favouring the experimental treatment] (*d*=0.80, *p*=0.001).	
Robinson et al. 2016[77] **UK**	Level II/RCT	N=68 (n=43)	Adult patients with any eating disorder and BPD or BPD symptoms; Final sample: 76% had full BPD, 5.9% anorexia nervosa, 63.2% bulimia nervosa, 2.9%	Outpatient MBT adapted for eating disorders; weekly individual and group sessions	Specialist supportive clinical management for eating	Eating Disorder psychopathology Global functioning BPD symptoms Quality of life	Eating Disorder Examination (EDE) GAF Zan-BPD EuroQol-5D	12 months	EDE, Zan-BPD did not differ sig. between groups at the end of treatment, nor for any other outcome	No indication for effects of MBT-ED as compared to Very high drop-out rates in both groups (78% overall)

Full reference Country	Study Design/ Level of Evidence	N (n)	Participants Age Gender Diagnosis Other	Intervention	Comparison	Outcomes	Measure/s	Length of follow-up	Effect Size	Comments
			binge eating, 27.9% eating disorder NOS; 92.7% females		disorders (SSCM-ED); control treatment designed for studies in anorexia nervosa patients; 20 individual sessions over the one year period	General psychopathology(depression/anxiety) Service use Personality dimensions	DASS-21 Adult Service Use Schedule Big Five Inventory			
Rossouw et al. 2012[78] **United Kingdom**	Level II/RCT	N=80	Adolescents presenting after self-harm, 12 to 17 years of age, 73% with BPD, 97% with MDD, 85%	MBT-A: MBT for adolescents, weekly individual and monthly family sessions with focus on impulsivity and affect regulation	TAU: routine care by community-based	Self-harm, Depression, Risk taking, BPD severity	RTSHI (Risk Taking and Self-harm Inventory) Mood and Feelings	12 months	Sig. group differences at post-treatment for self-harm (OR 0.24, p<.01) and	MBT-A may be helpful in reducing both depression and BPD symptoms in adolescents

Full reference Country	Study Design/ Level of Evidence	N (n)	Participants Age Gender Diagnosis Other	Intervention	Com-parison	Outcomes	Meas-ure/s	Length of follow-up	Effect Size	Comments
			females, mean age 15.1 years		aservic es		Question-naire RTSHI CI-BPD, BPFS-C		depression (OR 0.21, p<.05), BPD features (OR 0.07, p<.05 and OR -0.29, p<.05)	with both dis-orders
Salzer et al. 2014[79] **Germany**	RCT/Leve l II	N=66, N=39 with full BPD	adolescents aged 14-19 years (mean 16.5 years), with mixed disorder of conduct and emo-tions (F92 accord-ing to ICD-10)	Psychodynamic Therapy based on the psychoanalytic-interactional method (PiM)	Waiting List/TA U	Remission (not meeting F92 crite-ria anymore) General psycho-pathology Mental health	SCID DISYPS-KJ SCL-90R/GSI SDQ (Strenghts an Difficul-ties Ques-tionnaire	Post-treat-ment: mean 34.15 weeks (PiM)	Remission: OR=26.41 (95% CI 6.42-108.55) SDQ: Be-tween-group effect *d*=0.38 (no CI re-ported) SCL-90-R/GSI: between-group effect *d*=0.18 (no CI reported)	
Santisteban et al. 2015[80] **USA**	RCT/Leve l II	N=40 (n=24)	Adolescents ages 14 to 17 years (mean 15.8 years) with BPD, 37,5% females, all ful-filled criteria for substance abuse; recent use (30	I-BAFT: individual intervention, skills training modules from DBT and family interventions from structural family therapy	IDC Individ-ual drug coun-seling accod-ing to 12-step	BPD diagnosis Therapeutic alli-ance BPD behavior	DIB-R WAI MACI (Mil-lon adoles-cent clini-cal inven-tory)	12 months	No sig differ-ences be-tween condi-tions in work-ing alliance, total number of sessions, BPD behavior, substance use	

Full reference Country	Study Design/ Level of Evidence	N (n)	Participants Age Gender Diagnosis Other	Intervention	Com-parison	Outcomes	Meas-ure/s	Length of follow-up	Effect Size	Comments
			days): 85% marijuana, 56% alcohol	Weekly family session and skills training or individual session with the adolescent	philosophy; 2 session/week	Depression Substance use	DPS (Diagnostic Interview Schedule for Children- Predictive Scales) Timeline Follow-back (TLFB) Urine samples			
Schilling et al. 2018[81] **Germany**	RCT/Level II	N=48 (n=48)	adult inpatients with BPD, mean age 30.3 years, 91.7% female gender,	meta-cognitive training plus standard treatment (a dialectical behavior therapy-oriented skills group (a total of eight one-hour sessions, twice a week), occupational therapy, physical activity, medical visits, a weekly psychotherapeutic individual session,	progressive muscle relaxation (PMR) plus standard treatment (a dialectical behavior therapy-	primary BPD symptoms	BSL-23, Zan-BPD	4 weeks	"patients in the metacognitive training for BPD group benefited significantly more from the training than the patients in the progressive muscle relaxation group as measured by the reduction in	

Full reference Country	Study Design/ Level of Evidence	N (n)	Participants Age Gender Diagnosis Other	Intervention	Com-parison	Outcomes	Meas-ure/s	Length of follow-up	Effect Size	Comments
				and medication as needed)	ori-ented skills group (a total of eight one-hour ses sions, twice a week), occu-pa-tional ther-apy, physi-cal ac-tivity, medical visits, a weekly psycho-thera-peutic individ-ual ses-sion, and medi-cation				symptom se-verity in the primary out-come Borderline Symptom List-23 (t(43) = 2.163, p = 0.031) and Za-narini Rating Scale (t(36) = 2.078, p = 0.038).” (Schiling et al. 2018, p. 462)	

Full reference Country	Study Design/ Level of Evidence	N (n)	Participants Age Gender Diagnosis Other	Intervention	Com-parison	Outcomes	Meas-ure/s	Length of follow-up	Effect Size	Comments
					as needed)					
Sinnaeve et al. 2018[82] **The Netherlands**	RCT/Level II	N=84 ran-dom-ised, n=55 ana-lysed	BPD (DSM-IV), 18-45 years, 95% women, ≥1 self-harm episode within prior month	3 months of resi-dential DBT+6 months outpatient DBT	12 months of stand-ard out-patient DBT	self-harm/suicidal behaviour BPD severity quality of life Costs of treatment	LPC BPDSI-IV EQ-5D-3L TIC-P	12 months	no sig. change in suicidal be-haviour over 12 months (both groups); sig. decrease of the proba-bility of NSSI over 12 months in step-down group only: OR=.90, 95% CI (.82 -.98), p=.02; BPD severity decreased sig. in both treat-ment groups: F(1, 109)=33.63, p<.0001; quality of life: step-down mean 0.65 (SD=.33), out-patient meant 0.62 (SD=.28);	extremely high drop-out rate in stand-ard DBT group: 55% of those allo-cated to this group did not start treat-ment decrease of NSSI small in size in both groups

Full reference Country	Study Design/ Level of Evidence	N (n)	Participants Age Gender Diagnosis Other	Intervention	Com-parison	Outcomes	Meas-ure/s	Length of follow-up	Effect Size	Comments
									healthcare costs higher in step-down DBT (€19899, SD=14210) than outpa-tient DBT (€12472, SD=14300)	
Stanley et al. 2017[83] **USA**	RCT/Leve l II	N=86 (n=55)	aeligibility crite-ria: dults 18-55 years with BPD, mean age: 30.2 years, 77.3% fe-male gender	DBT + fluoxetine, DBT + placebo	sup-portive therapy + fluox-etine, sup-portive therapy + pla-cebo	primary suicide attempts	counted in bimonthly assess-ments	12 months	less suicide at-temts iin DBT-treated groups, non-significant be-tween-group effect (RR 0.51 [0.14, 1.90]; quoted from Storebø et al. 2020[30])	results are only available from the study registry entry but have not been pub-lished in full
Zanarini et al. 2018[84] **USA**	RCT/Leve l II	N=80 (n=74)	outpatient women with BPD, mean age 21.4 years	internet-based psy-choeducation treat-ment group	inter-net-based control group with-out psy-choedu cation	primary BPD symptoms psychosocial func-tioning	Zan-BPD SDS	12 weeks	"In the acute phase of the study (see Ta-ble 2), those in the treat-ment group were found to have a signifi-cant decline in their scores on all ten	

Full reference Country	Study Design/ Level of Evidence	N (n)	Participants Age Gender Diagnosis Other	Intervention	Com-parison	Outcomes	Meas-ure/s	Length of follow-up	Effect Size	Comments
									outcomes studied. Those in the control group were found to have a signifi-cant decline in their scores on seven of these out-comes—all but the cogni-tion and im-pulsivity sec-tor scores on the Zanarini Rating Scale for Borderline Personality Disorder and the Social Ad-justment Scale total score. Two between-group differ-ences were found to be significant. More specifi-cally, those in the treatment	

Full reference Country	Study Design/ Level of Evidence	N (n)	Participants Age Gender Diagnosis Other	Intervention	Com-parison	Outcomes	Meas-ure/s	Length of follow-up	Effect Size	Comments
									group re-ported a sig-nificantly greater de-cline in their impulsivity as measured by the Zanarini Rating Scale for Borderline Personality Disorder and a significantly greater in-crease in their psychosocial functioning as measured by the Social Ad-justment Scale than those in the control group.“ (Za-narini et al. 2018, p. 55)	

9.4.5 Evidenztabellen Fragestellung 9

Level I

Reference	Inclusion criteria	Antidepressants	Mood stabilisers	Antipsychotics	Others
Gartlehner 2021[85]	SR and MA of RCTs, non-randomised controlled trials or observational controlled studies			adverse events as compared to placebo: *d*=1.10 (95% CI 1.00 to 1.21)	
Hancock-Johnson 2017[86][8]	SR and MA of RCTs and observational studies of long-term pharmacotherapy published since the Cochrane Review (Stoffers et al. 2010); search date: September 2016	Fluoxetine 1 RCT (Bellino et al. 2010a [87]): 32 weeks of fluoxetine 20-40mg/d +IPT vs. fluoxetine 20-40mg/d +CM in 55 participants; significant effects favouring fluoxetine + IPT for SAT-P subscales "psychological functioning" (p=.001) and "social functioning" (p=.03), BPDSI-subscales "interpersonal relationships" (p=.0001)," impulsivity" (p<.001) and "affective instability" (p=.0007)	Valproic Acid (VA) vs. Omega-3 fatty acids (Bellino et al. 2014) [88]: 12-week non-blinded RCT of VA compared to VA+omega-3 fatty acids in 43 participants. Improvement in both groups, more improvement; significantly better treatment outcomes by combined treatment for outbursts of anger (p=.001) and impulsivity (p=.031) Divalproex vs. placebo (Moen et al. 2012) [89]: double-blind RCT 12-weeks RCT in 15 participants who also took part in a DBT programme: improvements in both groups over time, no significant between-group differences	Olanzapine: vs. placebo 1 open-label extension study (Zanarini et al. 2012) [90] [91,92] additional 24 weeks of olanzapine treatment (after initial 12 weeks of either olanzapine or placebo) in N=451 patients with BPD: In those who had originally received olanzapine, mean scores continued to improve; those who originally had received placebo reported similar improved scores to those originally randomized to olanzapine by the second week of the open-label extension vs. haloperidol (Shafti et al. 2010) [93]: 8 week double-blind RCT in N=28 female inpatients; large effect	Naltrexone (opiod antagonist): 2 randomised cross-over trials (Schmahl et al. 2012) [94] 1st cross-over trial: 3 weeks of 50mg/d naltrexone, afterwards 3 weeks of placebo vs. vice versa in N=11 female patients; marginally more intense and longer dissociation under placebo (d=.13, d=.09), no significant between-group difference 2nd cross-over trial: two treatment phases of 3 weeks duration each, namely: 50mg of naltrexone followed by placebo OR up to 200 mg/d naltrexone followed by placebo OR reverse in N=14 female participants; no significant differences between

[8] Review schließt RCTs und kontrollierte, nicht-randomisierte Beobachtungsstudien ein; hier nur RCTs (=Level-II-Evidenz) berücksichtigt.

				sizes d>.8 in both treatment arms, no significant between-group differences vs. aripiprazole (Shafti et al. 2015): 8-week open-label RCT in N=24 female inpatients; no significant differences between groups, large effect sizes for both (d>.8), reduced BPRS scores in both conditions (olanzapine p<.01, aripiprazole p<.04) ; reduction of CGI-S in olanzapine group (p<.04) vs. sertraline (Jariani et al. 2010: un-blinded, 12-week RCT in female patients with BPD on methadone maintenance therapy. Significant post-treatment difference between groups: less self-injurious behavior in olanzapine group (p<.001); reduction of anxiety and depression in both groups, greater reduction of anxiety (p=.00) and aggression (p=.025) by olanzapine, greater reduction of depression by sertraline (p=.017) Quetiapine	placebo and active treatment, numerically lower intensity and duration of dissociation by naltrexone (d=.41 and d=.24, n.s.)

				vs. placebo 1 RCT (Black et al., 2014): 8-week double-blind RCT in 95 subjects of moderate clinical severity comparing low (150 mg/d) and higher (300 mg/d) doses of quetiapine to placebo; symptom improvement in all groups; only significant between-group difference: weekly change in total ZAN-BPD-score higher in low-dosage group as compared to placebo (p=.031), large effect indicating the difference between lower dosage group and placebo (d=-.79)	
Ingenhoven 2011 [95]	Meta-analysis of placebo-controlled RCTs on the effectiveness of antipsychotics regarding cognitive, impulsive and affective symptom domains 16 RCTs identified, 11 RCTs [91,96–104] included in meta-analyses (search date: January 2011)			Cognitive-perceptual symptoms: 9 RCTs; pooled *SMD .23*, (95% CI .11 to .35, p=.0002, I^2=44%) Impulsive behavioural dyscontrol: 10 RCTs; pooled *SMD .19* (95% CI -.01 to .38, p=.05, I^2=52%) Affective dysregulation: Depression 9 RCTS; pooled SMD .25 (95% CI -.03 to .53, p=.09, I^2=76%)	

				Anxiety 6 RCTs; pooled SMD .23 (95% CI -.06 to .52; p=.13, I^2=52%) Anger 9 RCTs; pooled *SMD .39* (95% CI .18 to .60, p=.0003, I^2=56%) Mood lability 5 RCTs; pooled *SMD .20*, 95% CI .07 to .33, p=.003, I^2=0%) Global functioning 8 RCTs; pooled *SMD .25*, 95% CI .03 to .47, p=.03, I^2=61)	
Stoffers & Lieb (2015)[105]	Review of RCTs and observational studies covering the period between publication of the Cochrane review in 2010 and August 2014. New findings are put in context of the Cochrane 2010 review and the need for changing of conclusions is discussed.	Sertraline vs. olanzapine: 1 RCT (Jariani et al. 2010) Significant effects favouring sertraline for depression (SMD -.90), favouring olanzapine in terms of interpersonal problems (SMD .95), anger/aggression (SMD .77) and anxiety (SMD 1.12) Summary/Conclusion "Conclusions drawn from RCTs included within the CC review still apply: Since no statistically or clinically significant effects of any	Valproate semisodium vs. placebo (Moen et al. 2012): very small sample of N=15, no significant post-group differences after 12 weeks Summary/conclusion "[…] pooling these study findings to the remaining study estimates already included in the Cochrane Collaboration review does not result in any substantial changes. […] Previous findings of the Cochrane Collaboration review still apply." (p. 6)	Olanzapine vs. haloperidol (Shafti et al. 2010): no significant differences in terms of pre-post group differences vs. sertraline (Jariani et al. 2010): less depression post-treatment in sertraline group (-.90, p<.0001), but Olanzapine significantly superior in terms of interpersonal problems (SMD .95, p<.0001), anger/aggression (SMD .77, p<.0001), anxiety (SMD 1.12,	Omega-3 fatty Acids vs. placebo (Amminger 2013): 12-week trial in 15 adolescent participants at high risk for psychosis; significant post-treatment group difference in terms of overall functioning (SMD 1.51) Omega-3 fatty acids+valproic acid vs. valproic acid alone (Bellino 2014): significant effects favouring augmented treatment (BPD severity SMD-1.08, p=.001; impulsivity SMD-1.64, p<.0001;

		SSRI were observed, SSRIs still lack evidence undermining their dominant role within BPD treatment. [...] As for other-class antidepressants, placebo-controlled RCTs of phenelzine and mianserin included in the CC review yielded no significant effects. The only antidepressant agent demonstrating superiority over placebo was the tricyclic antidepressant (TCA) amitriptyline, with a statistically significant, moderate effect in terms of depression (SMD −0.59, 95 % CI −1.12 to −0.06). However, TCAs may not be a treatment option due to severe toxic effects in case of overdose." (p. 2, right column)		p<.0001) and paranoid ideation (SMD 1.01, p<.0001) <u>open-label extension of 2 placebo-controlled RCTs</u> of olanzapine (Zanarini 2011): Modest improvements for BPD core symptoms, no substantial difference at end of the observation period between those who had received a total of 24 weeks of olanzapine and those who had only 12 weeks. Quetiapine <u>Different dosages vs. placebo</u>: Black et al. (2014) Significant pre-post effects for both low and moderately dosed quetiapine for all kinds of BPD symptom domains (BPD severity, interpersonal cluster symptoms, affective cluster symptoms, cognitive cluster symptoms) except for impulsivity. Significant pre-post effects also for anger and general psychopathology (moderate dose only). No significant pre-post effects on depression or functioning, Summary/Conclusion	affective instability SMD -1.10, p=0.008; outbursts of anger SMD -1.79, p<.0001) Summary/conclusion "CC review […] data indicated beneficial effects in terms of reducing elevated suicidality (RR.52) […] and depression (RR.48) […] omega-3 fatty acids have gained high amounts of attention, with positive results both as a stand-alone medical intervention and as augmentation." (p.6 et seq.) Opiod Antagonists <u>2 randomised crossover trials of naltrexone and placebo</u> (Schmahl et al. 2012): no significant effects of naltrexone over placebo, but a decline of dissociative and flashback symptoms was observed.

				In sum, the available RCT evidence has not changed substantially, and the main conclusions of the CC review still apply. […] Only the evidence base for quetiapine has accumulated recently with a first placebo-controlled RCT indicating beneficial effects. However, data are scarce regarding the outcome of self-harming behaviour, and a paradoxical effect on this domain (similar to that seen for olanzapine) cannot be ruled out. In fact, this study found least positive effects for impulsive cluster symptoms (including self-harming and suicidality) as compared to the remaining three BPD symptom clusters (affective, cognitive and interpersonal). Since at least two RCTs of quetiapine have been initiated but never been published in full, a possible publication bias cannot be excluded. Only open studies are available for the SGAs risperidone, paliperidone and especially clozapine, which is obviously highly used in special contexts	

				with severely affected patients." (p. 5 et seq.)	
Vita et al. (2011)[106]	Meta-analysis of RCTs and open-label trials testing antidepressants, mood stabilisers and antipsychotics in BPD; search date June 2010; Included here: Between-group effect sizes of RCTs, 27 RCTs included	Affective dysregulation: RCTs: Hedges g=-.62, p=.001 Open-label: Hedges g= Impulsive-behavioural dyscontrol: RCTs: n.s.; Open-label: Hedges g=-1.08, p<.001 Cognitive-perceptual: RCTs: n.s. Early discontinuation: RCTs: n.s.	Affective dysregulation: RCTs: Hedges g=-1.72, p<.001; Open-label: Hedges g=-1.71, p<.001 Impulsive-behavioural dyscontrol: Hedges g=-.84, p.011; open-label: Hedges g=-1.20, p<.001 Early discontinuation: n.s.	Affective dysregulation RCTs: Hedges g= -.27, p=.004 (SGAs only); open-label: Hedges g=-.88, p<.001 Impulsive-behavioural dyscontrol RCTs: Hedges g=-.43, p=.001; open-label: Hedges g=-1.07, p<.001 cognitive-perceptual RCTs: symptoms Hedges g=-.53, p=.020; open-label: Hedges g=-.93, p<.001 Early discontinuation: n.s.	Placebo Significant global placebo effect on all BPD symptom domains pooled together: Hedges g=.40, p<.001 Affective dysregulation: Hedges g=-.59, p<.001 Impulsive-behavioural dyscontrol: Hedges g=-.34, p<.001 Cognitive-perceptual symptoms: Hedges g=-.33, p=.001

BIS-11 – Barrett Impulsivity Scale; BPDSI-IV – Borderline Personality Disorder Severity Index-IV; BPRS – Brief Psychiatric Rating Scale; BSL-23 – Borderline Symptom List 23; CGI-BPD – Clinical Global Impression Scale for Borderline Personality Disorder; CGI-S – Clinical Global Impression Scale-Severity; CM – Clinical Management; FGAs – first-generation antipsychotics; IPT – interpersonal Psychotherapy; HDRS – Hamilton Rating Scale for Depression; SAT-P – Satisfaction Profile; SGAs – second-generation antipsychotics; SOFAS – Social and Occupational Functioning Assessment Scale; ZAN-BPD – Zanarini Rating Scale for Borderline Personality disorder;

Level II

Full reference Country	Study Design/ Level of Evidence	N (n)	Participants Age Gender Diagnosis Other	Intervention	Comparison	Outcomes	Measure/s	Length of follow-up (weeks)	Effect Size	Comments
Amminger et al. (2013) [107] Austria	RCT	N=15	mean age 16.2 years, 93% females, diagnosis of BPD and ultra-high risk of psychosis	Eicosapentaenoic Acid (EPA; 700 mg/d) + Docosahexaenoic acid (DHA; 480 mg/d) + Vitamin E (7.6 mg/d)	placebo (capsules with coconut oil)	BPD severity, psychosocial functioning, psychotic symptoms, depression	PANSS-BPD symptoms; GAF, PANSS-total, MADRS	12	significant better social functioning in active group (SMD 1.51, 95% CI 0.32 to 2.71)	Very small study, insufficient power. Sole RCT of drug therapy in adolescents.
Bellino et al. (2014) [88] Italy	RCT	N=34	men age 25.2 years, 76% females, co-occuring major depression or substance use disorder excluded	Eicosapentaenoic Acid (EPA; 1.2 g/d) + Docosahexaenoic acid (DHA; 0.8 g/d)+valproic acid (plasma level 50–100 µg/ml, mean final doses 800 mg/d to 1300 mg/d)	valproic acid (plasma level 50–100 µg/ml, mean final doses 800 mg/d to 1300 mg/d)	BPD severity, self-harm, suicidality, psychosocial functioning, anger, affective instability, emptiness, impulsivity, interpersonal problems, abandonment, identity disturbance, dissociation/psychotic-like symptoms, adverse events	BPDSI-IV, SHI, CGI-S, MOAS, BIS, DOTES	12	significantly less BPD severity in combined treatment group (SMD -1.08, p=.001), significantly less impulsivity (SMD -1.64, p<.0001), affective instability (SMD -1.10, p=.008), anger (SMD -1.79, p<.0001)	completer analyses only (34 out of 43 particiapants initially enrolled)

Full reference Country	Study Design/ Level of Evidence	N (n)	Participants Age Gender Diagnosis Other	Intervention	Comparison	Outcomes	Measure/s	Length of follow-up (weeks)	Effect Size	Comments
Black et al. (2014) [108] USA	RCT	N=95	mean age 29.5 years, 71% females, current substance dependence or recent substance abuse (alcohol, nicotine abuse were not excluded)	1. Quetiapine 150 mg/d 2. Quetiapine 300 mg/d	placebo	BPD severity, BPD symptoms, impulsivity, aggression psychosocial functioning, impulsivity, adverse events	Zan-BPD (clinician-rated and self-rated) BEST, BIS, MOAS, GAF, SDS,	8	significant post-treatment group effects of 150 mg/d quetiapine compared to placebo: Zan-BPD (clinicianrated): total score (d=-.79, p<.05), cognitive cluster (d=-0.63, p<.05); Zan-BPD (self-rated) total score (d=-0.88, p<.01), cognitive cluster (d=-0.71, p<.05), interpersonal cluster (d=-0.86, p<.05), BEST: total score (d=-0.85, p<.01); aggresson (d=-0.82, p<.05); SDS:	Neither dose was effective in the reduction of impulsivity; high response rates in all groups (quetiapine 150 mg/d: 82%; quetiapine 300 mg/d: 67%; placebo: 62%); no clear dose response relation, trend of better outcomes in lower dose quetiapine compared to higher dose, more adverse events in higher dose group compared to lower dose

Full reference Country	Study De-sign/ Level of Evidence	N (n)	Participants Age Gender Diagnosis Other	Intervention	Comparison	Outcomes	Measure/s	Length of follow-up (weeks)	Effect Size	Comments
									days lost (d-0.49, p<.05); higher risk of weight gain (mean 1 lb/10 weeks, p<.05), mouth dry-ness (HR=9.32, p<.05) significant post-treat-ment group effects of 300 mg/d queti-apine com-pared to pla-cebo: Zan-BPD self-rated: total (D=-0.87, p<.05), affec-tive cluster (d=-0.87, p<.05), cogni-tive cluster (d=-0.73, p<.05); BEST: total score (d=-0.75,	

Full reference Country	Study Design/ Level of Evidence	N (n)	Participants Age Gender Diagnosis Other	Intervention	Comparison	Outcomes	Measure/s	Length of follow-up (weeks)	Effect Size	Comments
									p<.05); MOAS: total aggression (d-0.75, p<.05); SDS: days lost (d=-0.54, p<.05); higher risk of sedation (HR=2.16, p<.05), change in appetite (HR=3.89, p<.05), weight gain (mean 3lbs/10 weeks, p=.001), mouth dryness (HR=16.77, p<.05)	
Bozzatello et al. (2017)[109] Italy	RCT	N=51	Mean age 24.7 years, 63% females, co-occuring MDD or SUD excluded	Asenapine (5-10 mg/d)	Olanzapine (5-10 mg/d)	Overall severity of illness, depression, anxiety, functioning, BPD severity and symptoms,	CGI-S, HAM-D, HAM-A, SOFAS, BPDSI, BIS-11, MOAS, SHI, DOTES	12	Only two significant between-group effects: less affective instability by asenapine	Neither drug led to sig decreases of depression or aggression

Full reference Country	Study Design/ Level of Evidence	N (n)	Participants Age Gender Diagnosis Other	Intervention	Comparison	Outcomes	Measure/s	Length of follow-up (weeks)	Effect Size	Comments
						impulsivity, aggression, self-harm, adverse effects			(η^2=.53; p=.001), less dissociation/paranoid ideation by olanzapine (η^2=.25; p=.021)	
Crawford et al. (2018)[110] UK	RCT	N=276	mean age 36.1 years, 76% females, diagnosis of BPD, bipolar I and II excluded	up to 200 mg/d of generic lamotrigine, 400mg/d in women taking the combined oral contraceptive pill	Placebo	Symptoms of BPD, depression, deliberate self-harm, social functioning, alcohol and drug use, quality of life, side effects	ZAN-BPD, BDI, Acts of Deliberate Self-harm Inventory, SFQ, ASSIST, EQ-5D-3L	52	No evidence of any difference in terms of significant effects for any outcome	High-quality, study, sufficient power to detect effects. Robust finding of no effect by lamotrigine treatment.
Jariani et al. (2010) [111] Iran	RCT	N=120	mean age 28 years, 83% females, BPD + opoid depence, currently on methadone maintenance treatment	olanzapine (5-10 mg/d)	sertraline (50-100 mg/d)	self-harm, psychosocial functioning, anger, interpersonal problems, dissociation/psychotic-like symptoms	self-harm reports, SCL-90-R	12	sertraline: significantly less depression (SMD -.90, p<.0001): olanzapine: less interpersonal problems (SMD -0.95, p<.0001), aggression (SMD -0.77, p<.0001), paranoid	high risk of bias (allocation concealment, blinding, sponsoring unclear), study protocol unavailable

Full reference Country	Study Design/ Level of Evidence	N (n)	Participants Age Gender Diagnosis Other	Intervention	Comparison	Outcomes	Measure/s	Length of follow-up (weeks)	Effect Size	Comments
									ideation (SMD -1.01, p<.0001)	
Kulkarni et al. (2018)[112] Australia	RCT	N=33	Mean age 34.4 years, 88% females, all participants "stabilized on medication and psychotherapy", study drug as adjunct	Memantine 20 mg	placebo	BPD severity, adverse effects	ZAN-BPD, AE questionnaire	8	Significant change of ZAN-BPD-total across time, compared with placebo (p=.02); no significant difference for any AE	First RCT of antidementia drug in BPD
Moen et al. (2012) [89] USA	RCT	N=15	mean age 35 years, 80% females, current or previous axis I disorders excluded	divalproex ER (1500-2000 mg/d, mean final dose 1583 mg/d)	placebo	BPD symptoms, psychosocial functioning	BEST, PANSS, GAF, BPDSI-IV	12	no significant between-group differences at post treatment	very small study without sufficient statistical power
Schmahl et al. (2012) [94]: study 1 Germany	cross—over RCT	N=11	mean age 28.3 years, 100% females, current MDD excluded	naltrexone (50 mg)	placebo	dissociation	DES, DSS,	two 3-weekperiods	marginally more intense and longer dissociation under placebo (d=.13, d=.09), no significant between-group difference	small experiential study with insufficient statistical power to detect effects

Full reference Country	Study Design/ Level of Evidence	N (n)	Participants Age Gender Diagnosis Other	Intervention	Comparison	Outcomes	Measure/s	Length of follow-up (weeks)	Effect Size	Comments
Schmahl et al. (2012) [94]: study 2 Germany	cross-over RCT	N=14	mean age 29.2 years, 100% females, current MDD excluded	either period of naltrexone (50 mg/d) or of naltrexone (200 mg/d)	period of placebo sequence (all particiapnts)	BPD severity, dissociation, anger	BSL, DES, DSS, STAXI	two 3-week periods	no significant differences between placebo and active treatments, numerically lower intensity and duration of dissociation by naltrexone (d=.41 and d=.24, n.s.)	small experiential study with insufficient statistical power to detect effects; numerical trend of less intense and shorter duration of dissociation (s. also Schmahl et al. 2012[94], study 1)
Shafti et al. (2015) [113] Iran	RCT	N=24	mean age 27.4 years, 100% female inpatients	Olanzapin (10 mg/d)	Aripiprazol (10 mg/d)	clinical severity, hostility, psychotic symptoms	CGI-S, BDHI, BPRS	8	no significant differences between groups at post treatments, pre-post reductions of psychotic symptoms in both groups, olanzapine also hostility and clinical severity	open lable study

AE – Adverse effects; ASSIST – Alcohol, Smoking, and Substance Involvement Screening Test; BDI – Beck Depression Inventory; BDHI – Buss-Durkee Hostility Inventory; BIS-11 – Barrett Impulsiveness Scale; BPDSI – Borderline Personality Disorder Severity Index; BEST – Borderline Evaluation of Severity over Time; BPRS – Brief Psychiatric Rating Scale; BSL – Borderline Symptom List; CGI-S – Clinical Global Impression Scale-Severity; DES – Dissociative Experiences Scale; DSS – Dissociative States Scale; DOTES – Dosage Record and Treatment-Emergent Symptom Scale; EQ-5D-3L –EuroQol Quality of Live questionnaire (5 dimensions, 3 levels); GAF – Global Assessment of Functioning; HAM-A – Hamilton Anxiety Rating Scale; HAM-D – Hamilton Depression Rating Scale; MOAS – Modified Overt Aggression Scale; PANSS – Positive and Negative Symptoms Scale; SDS – Sheehan Disability Scale; SFQ – Social Functioning Questionnaire; SHI – Self-Harm Inventory; SOFAS – Social Occupational Functioning Assessment Scale; STAXI – Stait-Trait Anger Inventory; ZAN-BPD – Zanarini Rating Scale for Borderline Personality Disorder

9.4.6 Evidenztabellen Fragestellung 10

Level I

Keine relevanten Studien (Meta-Analyse auf Basis mindestens zweier Level-II-Studien) identifiziert.

Level II

Full reference Country	Study Design/ Level of Evidence	N (n)	Participants Age Gender Diagnosis Other	Intervention	Comparison	Outcomes	Measure/s	Length of follow-up	Effect Size	Comments
Antonsen BT, Kvarstein EH, Urnes O, Hummelen B, Karterud S et al. (2017). Favourable outcome of long-term combined psychotherapy for patients with borderline personality disorder: Six-year follow-up	Level II / RCT	N=52	women and men with BPD (85% women), mean age 29.0 years (SD 6.7)	Long-term combination program (18 weeks) day-hospital treatment (combination of psychodynamic and cognitive-behavioural group therapies) followed by outpatient combined group (weekly) and individual psychotherapy (weekly))	Outpatient individual therapy (therapists in private practice; treatment according to their own	Symptom distress Psychosocial functioning Interpersonal problems Quality of life Personal functioning Self-harm, suicidal thoughts, suicide attempts Diagnoses	SCL-90-R GAF CIP 10-point scale SIPP-118 Self-report/re-record SCID-I/SCID-II	Average duration: combined: 28 months, maximum 4 years Average duration outpatient: 24 months	No stat. sig. group x time interactions at 36 months for any relevant outcome	6 year-follow-up: stat. sig. interaction group x time

Full reference Country	Study Design/ Level of Evidence	N (n)	Participants Age Gender Diagnosis Other	Intervention	Com-parison	Outcomes	Measure/s	Length of follow-up	Effect Size	Comments
of a random-ized study. Psychother-apy Research, 27(1); 51-63[114]					pre-ferred metho d and prac-tice					
Linehan MM, Korslund KE, Harned MS, Gal-lop RJ, Lungu A, Neacsiu AD, McDavid J, Comtois KA, Mur-ray-Gregory A. „Dialectical Be-havior Therapy for High Suicide Risk in Individu-als with Border-line Personality Disorder: A Ran-domized Clinical Trial and Compo-nent Analysis". *JAMA Psychiatry* 72, Nr. 5 (Mai 2015): 475–82.[115] USA	RCT/Leve l II	N=99 ran-dom-ised n=99 ana-lysed	99 women with DSM-IV-BPD and at least 2 suicide attempts within past 5 years, at least 1 suicide at-tempt in the last year, mean age 30.3 (8.9) years	33 women received standard DBT (indi-vidual DBT + DBT Skillsgroup)	33 women re-ceived DBT skill-strain-ing +in-di-viudal case man-age-ment (DBT-S) 33 women re-ceived individ-ual DBT therapy + activ-ity-	suicidality depression anxiety	SASI, SBQ, RLI Ham-D Ham-A	12 months	suicidality: no sig. between-group differ-ences NSSI: fre-quency among those engaging in NSSI sig. higher in DBT-I (F1,85=59.1, p<.001) and DBT-S (F1, 85; p<.001) depression: less improve-ment in DBT-I than in stand-ard DBT (*t*399 = 1.8[*P* = .03]) and DBT-S DBT-S (*t*399 = 2.9	

Full reference Country	Study Design/ Level of Evidence	N (n)	Participants Age Gender Diagnosis Other	Intervention	Com-parison	Outcomes	Measure/s	Length of follow-up	Effect Size	Comments
					based sup-port group				[*P* = .004]) anxiety: no sig. between-group differ-ences	
Moen R, Freitag M, miller M, Lee S, Romine A, Song S, Adityan-jee A, Schulz SC. „Efficacy of Ex-tended-Release Divalproex Com-bined with ‚Con-densed' Dialecti-cal Behavior Therapy for Indi-viduals with Bor-derline Personal-ity Disorder". *An-nals of Clinical Psychiatry: Offi-cial Journal of the American Acad-emy of Clinical Psychiatrists* 24, Nr. 4 (November 2012): 255–60. **USA**	RCT/Leve l II	N=15 ran-dom-ised	participants (80% women) with DSM-IV BPD and SCL-90-R total score of ≥150 af-ter 4 weeks of condensed DBT	12 weeks of con-densed DBT+di-valproex semiso-dium (mean highest dose 1,600, range 1,000 to 2,000)	12 weeks of con-densed DBT+pl acebo	Borderline sever-ity impulsivity depression	BEST BIS Ham-D	12 weeks	no sig. be-tween-group differences at post-treat-ment	small sample size

Full reference Country	Study Design/ Level of Evidence	N (n)	Participants Age Gender Diagnosis Other	Intervention	Com-parison	Outcomes	Measure/s	Length of follow-up	Effect Size	Comments
Sinnaeve R, van den Bosch LMC, Hakkaart-van Roijen L, Vansteelandt K. „Effectiveness of Step-down versus Outpatient Dialectical Behaviour Therapy for Patients with Severe Levels of Borderline Personality Disorder: A Pragmatic Randomized Controlled Trial". Borderline Personality Disorder and Emotion Dysregulation 5 (2018): 12. https://doi.org/10.1186/s40479-018-0089-5.	RCT/Level II	N=84 randomised, n=55 analysed	BPD (DSM-IV), 18-45 years, 95% women, ≥1 self-harm episode within prior month	3 months of residential DBT+6 months outpatient DBT	12 months of standard outpatient DBT	self-harm/suicidal behaviour BPD severity quality of life Costs of treatment	LPC BPDSI-IV EQ-5D-3L TIC-P	12 months	no sig. change in suicidal behaviour over 12 months (both groups); sig. decrease of the probability of NSSI over 12 months in step-down group only: OR=.90, 95% CI (.82 -.98), p=.02; BPD severity decreased sig. in both treatment groups: F(1, 109)=33.63, p<.0001; quality of life: step-down mean 0.65 (SD=.33), outpatient meant 0.62 (SD=.28); healthcare costs higher in step-down DBT (€19899,	extremely high drop-out rate in standard DBT group: 55% of those allocated to this group did not start treatment decrease of NSSI small in size in both groups

Full reference Country	Study Design/ Level of Evidence	N (n)	Participants Age Gender Diagnosis Other	Intervention	Com-parison	Outcomes	Measure/s	Length of follow-up	Effect Size	Comments
									SD=14210) than outpa-tient DBT (€12472, SD=14300)	
Smits ML, Feenstra DJ, Eeren HV, Bales DL, Laurenssen EMP, Blankers M, Soons MBJ, Dek-ker JJM, Lukas Z, Verheul R, Luyten P. „Day Hospi-tal versus In-tensive Out-Patient Men-talisation-Based Treat-ment for Bor-derline Per-sonality Disor-der: Multicen-tre Random-ised Clinical Trial". The British Journal of Psychiatry: The Journal of	RCT/Leve l II	N=11 4 ran-dom-ised, n=11 4 an-a-lysed	BPD (DSM-IV), ≥18 years (mean age 30.8 years, 82.5% women	MBT day hospital treatment (MBT-DH)	MBT-in-tensive outpa-tient treat-ment (MBT-IOP)	BPD severity personality func-tioning symptom severity interpersonal problems quality of life self-harm/suicid-ality	PAI-BOR SIPP BSI-GSI IIP EQ-5D SSHI	18 months	no evidence of a differen-tial rate of change be-tween the two groups for the pri-mary out-come (BPD severity) and most remain-ing outcomes. Exception: larger differ-ential rate of change for MBT-DH (β=0.12, 95% CI 0.02 to 0.22, *z*=2.26, p=.024); on secondary outcomes, be-tween-group effect sizes constantly	high risk of at-tention bias in terms of amounts of group ses-sions: MBT-DH includes 5-days per week treat-ment at the day hospital, with 9 group therapy ses-sions per week. MBT-IOP involves 2 group therapy sessions per week only

Full reference Country	Study Design/ Level of Evidence	N (n)	Participants Age Gender Diagnosis Other	Intervention	Com-parison	Outcomes	Measure/s	Length of follow-up	Effect Size	Comments
Mental Science, 22. Februar 2019, 1–6. https://doi.org/10.1192/bjp.2019.9. NL									favoured MBT-DH	

9.4.7 Evidenztabellen Fragestellungen 11 and 13

Level I

Keine relevanten Studien (Meta-Analyse auf Basis mindestens zweier Level-II-Studien) identifiziert.

Level II

Komorbidität	Stichprobe	Intervention	Vergleich	Zwischengruppenunterschiede zu Behandlungsende: BPS-bezogene Ergebnismaße	Zwischengruppenunterschiede zu Behandlungsende: Komorbidiätsbezogene Ergebnismaße
Substanzbezogene Störungen					
+Substanzbezogene Störungen 46% Alkohol, 39% Opioide, 22% Sedativa/Hypnotika/Anxiolytika, 13% Amphetamine, 7% Cannabis) (Philips et al. 2018)[74]	46 Männer und Frauen (80%) mit BPS	18 Monate MBT + Standard-Suchtbehandlung	18 Monate Standard-Suchtbehandlung	Keine	Keine
+Substanzmissbrauch (85% Cannabis, 57% Alkohol) (Santisteban et al. 2015)[80]	40 Jugendliche (14-17 Jahre)	12 Monate Integrative BPD-/DBT-orientierte Familientherapie (Einzeltherapie, Skillsgruppe, Familientherapaie)	12 Monate Drogenberatung (Einzel)	Keine	Keine
Depressive Erkrankungen					
+MDD (Andreoli et al. 2016)[47]	170 Erwachsene mit BPS (84% Frauen, 18-60 Jahre) nach schwerem SVV	3 Monate „Abandonment-Psychotherapie“ (kognitiv-psychodynamische Intervention mit Fokus auf dem Erleben des Verlassenseins)	3 Monate ambulante Anbindung an Kriseninterventionszentrum	Ggü. Kontrolle weniger erneute Suizidversuche in AP-P (Pearson χ^2=8.09, df=1, p=.004) und AP-A (Pearson χ^2=9.33, df=1, p=.002)	Ggü. Kontrolle weniger Depressivität in beiden AP-Gruppen (AP-P: F(1,98)=10.13, p=.002; AP-N: F(1, 98)=9.78, p=.002

		Gruppe AP-N: durchgeführt von Pflegepersonal, Gruppe AP-P: durchgeführt von Psychotherapeuten		Besseres psychosoziales Funktionsniveau in aktiven Gruppen (AP-P: F(1, 98)=6.09, p=.015; AP-N: F(1, 98)=6.65, p=.011	
+depressive Erkrankungen n.n.b. (Jahangard et al. 2012)[60]	30 stationär behandelte Erwachsene mit BPS (53% Frauen, 18-35 Jahre)	12 Wochen Training der Emotionalen Intelligenz (EI)	12 Wochen Stationäre Standardbehandlung	Nicht erhoben	Sig. weniger Depressivität in EI-Gruppe *F*(1, 28)=20.21, p<.001
+MDD (Rossouw 2012)[78]	Jugendliche	12 Monate MBT-A	12 Monate TAU	BPS-Schweregrad über cut-off OR 0.07, p<.05) Selbstverletzungen ja/nein OR 0.24, p<.01)	Depressivität über cut-off (OR 0.21, p<.05)
Post-Traumatische Belastungsstörungen					
+PTBS (Bohus et al. 2013)[51]	33 Frauen mit BPS und PTBS nach sexuellem Missbrauch im Kindesalter	12 Wochen stationäre DBT erweitert für PTBS	Warteliste	Psychosoziales Funktionsniveau sig. größere Besserung in DBT-PTSD-Gruppe	PTBS-Schwere (CAPS) größere wöchentliche Besserung (CAPS=-1.510, SD=0.249, p<.001; PDS=-0.026, SD=0.009, p=.007)
+PTBS (Bohus et al. 2020)[116]	193 Frauen mit BPS (mind. 3 DSM-Kriterien) und PTSD nach sexuellem Missbrauch im Kindesalter	15 Monate ambulante DBT-PTSD (DBT adaptiert für komorbide PTSD nach Missbrauch im Kindesalter)	ambulante Cognitive Processing Therapy (CPT)[117]	BPS-Symptomatik: Cohen's *d*=-0.55, p<.001 Dissoziationen: Cohen's *d*=-0.50, p<.001	PTSD-Symptomatik: Cohen's *d*=-0.57, p<.001
+PTBS (Harned et al. 2014)[59]	26 Frauen mit BPD, im Mittel 32.6 Jahre alt	12 Monate Standard-DBT+DBT-PE (*Prolonged Exposure*-Therapie nach Foa)	12 Monate Standard-DBT	Weniger Suizidversuche in DBT+DBT-PE-Gruppe (38% vs. 50%), weniger SVV (69% vs. 88%), mehr Patienten mit normalem psychosozialen Funktionsniveau (58% vs. 50%)	Remissionsrate in DBT+DBT-PE-Bedingung höher (58% vs. 33%)
+PTBS (Kredlow 2017)[65]	27 Männer und Frauen (96%; alle Arten von Traumata)	16 Wochen Traumabezogene kognitive Verhaltenstherapie	16 Wochen TAU	Keine sig. Zwischengruppenunterschiede zu Behandlungsende	PTBS-Sympomatik-Reduktion um mind. 30%: 29% in aktiver vs. 0% in Kontrollgruppe, PTBS-Schwere (CAPS) *d*=1.07, p=.02; Intrusionen

					(*d*=1.17, *p*=0.02), Depressivität (*d*=1.22, *p*=.006
Essstörungen					
+Essstörungen (63% Bulimie, 28% Essstörung n.n.b., 6% Anorexie, 3% Binge Eating) (Robinson et al. 2016)[77]	86 Erwachsene mit BPS (93% Frauen)	18 Monate MBT-ED: MBT-Adaption für Essstörungen	18 Monate Kontrollbehandlung durch Spezialisten für Essstörungen	Keine	Sig. weniger Sorgen um Figur (adjusted mean difference = -0.7, p = 0.029) und Gewicht (adjusted mean difference = -0.7, p = 0.037, 95 % CI = -1.29 to -0.04)
Psychotische Störungen					
+erstmalige psychotische Episode	16 Jugendliche/junge Erwachsene (15-25 Jahre) mit BPS	CAT-Einzeltherapie und Frühinterventionen für BPS bei Jugendlichen + Anbindung an spezialisiertes Behandlungszentrum für Erstmanifestationen von Psychosen	Anbindung an spezialisiertes Behandlungszentrum für Erstmanifestationen von Psychosen	Keine Signifikanzberechnung aufgrund kleiner Stichprobe; Tendenz: besseres psychosoziales Funktionsniveau	Keine Signifikanzberechnung aufgrund kleiner Stichprobe; Tendenz: weniger Positiv- und Negativsymptomatik, bessere Medikationsadhärenz
Spezifische Persönlichkeitsstörungen					
+antisoziale PS (Bateman 2016)[118]	40 Erwachsene (31% Frauen)	18 Monate MBT	18 Monate Standard-Kontrollbehandlung	Weniger Ärger (MD -0.75, p<.05), Feindseligkeit (MD -0.60, p<.01), paranoides Erleben (MD-0.75, p<.05), SVV Episoden (MD-0.66, p<.001), Anteil mit SVV (OR 0.03, p<.05), besseres psychosoziales Funktionsniveau (MD 11.51, p<.001), weniger interpersonelle Probleme (MD -0.44, p<.001) in aktiver (MBT-)Gruppe	Soziale Anpassung (MD-0.60, p<.001)

CAPS – DBT – Dialektisch-Behaviorale Therapie, MBT – Mentalisierungsbasierte Therapie, MD – Mittelwertsdifferenz, MDD, PS – Persönlichkeitsstörung, PTBS – Posttraumatische Belastungsstörung, SVV – selbstverletzendes Verhalten, TAU – „Treatment as usual"/übliche Behandlung

9.4.8 Evidenztabellen Fragestellungen 15 und 16

Level I

No such evidence retrieved.

Level II

Full reference Country	Study Design/ Level of Evidence	N (n)	Participants Age Gender Diagnosis Other	Intervention	Comparison	Outcomes	Measure/s	Length of follow-up	Effect Size	Comments
Antonsen BT, Kvarstein EH, Urnes O, Hummelen B, Karterud S et al. (2017). Favourable outcome of long-term combined psychotherapy for patients with borderline personality disorder: Six-year follow-up of a	Level II / RCT	N=52	women and men with BPD (85% women), mean age 29.0 years (SD 6.7)	Long-term combination program (18 weeks) day-hospital treatment (combination of psychodynamic and cognitive-behavioural group therapies) followed by outpatient combined group (weekly) and individual psychotherapy (weekly))	Outpatient individual therapy (therapists in private practice; treatment according to their own	Symptom distress Psychosocial functioning Interpersonal problems Quality of life Personal functioning Self-harm, suicidal thoughts, suicide attempts Diagnoses	SCL-90-R GAF CIP 10-point scale SIPP-118 Self-report/record SCID-I/SCID-II	Average duration: combined: 28 months, maximum 4 years Average duration outpatient: 24 months	No stat. sig. group x time interactions at 36 months for any relevant outcome	6 year-follow-up: stat. sig. interaction group x time

Full reference Country	Study Design/ Level of Evidence	N (n)	Participants Age Gender Diagnosis Other	Intervention	Comparison	Outcomes	Measure/s	Length of follow-up	Effect Size	Comments
randomized study. Psychotherapy Research, 27(1); 51-63[114]					preferred method and practice					
Pearce, Steve, Lisle Scott, Gillian Attwood, Kate Saunders, Madeleine Dean, Ritz De Ridder, David Galea, Haroula Konstantinidou, und Mike Crawford. „Democratic therapeutic community treatment for personality disorder: randomised	Level II / RCT	N=70 rand.	adults with personality disorders (93% BPD), 21.4% women, mean age 32.9 years	Democratic therapeutic community (DTC) treatment (3-12 months DTC preparatory meetings, joining DTC if elected democratically by current members and staff, up to 18 months DTC	TAU: local primary care services	psychosocial functioning health care utilization	SFQ proportion with inpatient treatment, inpatient days, proportion with emergency department (ED) attendence, ED visits	12 months, 24 months	sig. between-group differences: 12 months: 48% fewer participants with ED attendance in DTC group (18.2% vs. 66.7%, p=0.019) 24 months: no stat. sig. difference on relevant outcomes	sig. higher client satisfaction in DTC group at 24 months

Full reference Country	Study Design/ Level of Evidence	N (n)	Participants Age Gender Diagnosis Other	Intervention	Comparison	Outcomes	Measure/s	Length of follow-up	Effect Size	Comments
controlled trial.“ *The British journal of psychiatry : the journal of mental science* 210, Nr. 2 (2017): 149–56. https://doi.org/10.1192/bjp.bp.116.184366.										
Sinnaeve R, van den Bosch LMC, Hakkaart-van Roijen L, Vansteelandt K. „Effectiveness of Step-down versus Outpatient Dialectical Behaviour Therapy for Patients with Severe Levels of Borderline Personality	RCT/Level II	N=84 randomised, n=55 analysed	BPD (DSM-IV), 18-45 years, 95% women, ≥1 self-harm episode within prior month	3 months of residential DBT+6 months outpatient DBT	12 months of standard outpatient DBT	self-harm/suicidal behaviour BPD severity quality of life Costs of treatment	LPC BPDSI-IV EQ-5D-3L TIC-P	12 months	no sig. change in suicidal behaviour over 12 months (both groups); sig. decrease of the probability of NSSI over 12 months in step-down group only:	extremely high drop-out rate in standard DBT group: 55% of those allocated to this group did not start treatment decrease of NSSI small in

Full reference Country	Study Design/ Level of Evidence	N (n)	Participants Age Gender Diagnosis Other	Intervention	Comparison	Outcomes	Measure/s	Length of follow-up	Effect Size	Comments
Disorder: A Pragmatic Randomized Controlled Trial". Borderline Personality Disorder and Emotion Dysregulation 5 (2018): 12. https://doi.org/10.1186/s40479-018-0089-5.									OR=.90, 95% CI (.82 -.98), p=.02; BPD severity decreased sig. in both treatment groups: F(1, 109)=33.63, p<.0001; quality of life: step-down mean 0.65 (SD=.33), outpatient meant 0.62 (SD=.28); healthcare costs higher in step-down DBT (€19899, SD=14210) than outpatient DBT (€12472, SD=14300)	size in both groups
Smits ML, Feenstra DJ, Eeren HV, Bales DL, Laurenssen EMP,	RCT/Level II	N=114 randomised,	BPD (DSM-IV), ≥18 years (mean age 30.8 years, 82.5% women	MBT day hospital treatment (MBT-DH)	MBT-intensive outpatient	BPD severity personality functioning symptom severity	PAI-BOR SIPP BSI-GSI IIP	18 months	no evidence of a differential rate of change between the	high risk of attention bias in terms of amounts of group

Full reference Country	Study Design/ Level of Evidence	N (n)	Participants Age Gender Diagnosis Other	Intervention	Comparison	Outcomes	Measure/s	Length of follow-up	Effect Size	Comments
Blankers M, Soons MBJ, Dekker JJM, Lukas Z, Verheul R, Luyten P. „Day Hospital versus Intensive Out-Patient Mentalisation-Based Treatment for Borderline Personality Disorder: Multicentre Randomised Clinical Trial". The British Journal of Psychiatry: The Journal of Mental Science, 22. Februar 2019, 1–6. https://doi.or		n=114 analysed			treatment (MBT-IOP)	interpersonal problems quality of life self-harm/suicidality	EQ-5D SSHI		two groups for the primary outcome (BPD severity) and most remaining outcomes. Exception: larger differential rate of change for MBT-DH (β=0.12, 95% CI 0.02 to 0.22, *z*=2.26, p=.024); on secondary outcomes, between-group effect sizes constantly favoured MBT-DH	sessions: MBT-DH includes 5-days per week treatment at the day hospital, with 9 group therapy sessions per week. MBT-IOP involves 2 group therapy sessions per week only

Full reference Country	Study Design/ Level of Evi- dence	N (n)	Participants Age Gender Diagnosis Other	Intervention	Com- pari- son	Outcomes	Meas- ure/s	Length of fol- low-up	Effect Size	Comments
g/10.1192/bjp .2019.9.[119] NL										

9.4.9 Evidenztabellen zu Fragestellung 20

Level I

Keine entsprechende Evidenz identifiziert (September 2021).

Level II

Keine entsprechende Evidenz identifiziert (September 2021).

9.4.10 Evidenztabellen zu Fragestellungen 21 und ADD.3

Level I

Keine entsprechende Evidenz identifiziert (September 2021).

Level II

Keine entsprechende Evidenz identifiziert (September 2021).

9.4.11 Evidenztabellen zu Fragestellung 22

Level I

Keine entsprechende Evidenz identifiziert (September 2021).

Level II

Keine entsprechende Evidenz identifiziert (September 2021).

9.4.12 Evidenztabellen zu Fragestellungen 23 and 24

Level I

Full reference Country	Study Design/ Level of Evidence	N (n)	Participants Age Gender Diagnosis Other	Intervention	Com-parison	Outcomes	Measure/s	Length of follow-up	Effect Size	Comments
Fitzpatrick, Skye, Anne C. Wagner, und Candice M. Monson. „Optimizing Borderline Personality Disorder Treatment by Incorporating Significant Others: A Review and Synthesis". *Personality Disorders*, 4. Februar 2019. https://doi.org/10.1037/per0000328.	Level I/ systematic review/synthesis including different kinds of studies, partly level II studies	N=4 Level II studies	Blum et al. 2008 [120], N=165 persons with BPD Bos et al. 2010 [121] N=85 persons with BPD Grenyer et al. 2019 N=68 carers	STEPPS+TAU STEPPS+individual therapy Staying Connected (SC; relationship-oriented program for carers)	TAU TAU WL	no carer-related outcomes assessed no carer-related outcomes assessed carer's relationship satisfaction family empowerment		20 weeks 6 months 12 months	 carer's relationship satisfaction: SC > WL from pre- to posttreatment, maintained at follow-up carer's reported family empowerment: SC>WL (pre-to post-treatment, maintained at follow-up)	positive effects observed for carer-related outcomes (Staying Connected Programe, Couple DBT). Not in the review: Bateman & Fonagy 2018 (find at Level II evidence below). Study on Couple DBT [63] poorly described, high risk of bias

			Kamalabadi et al. 2012 [63] N=30 couples including minimum one person with BPD each	Couple DBT (CDBT)	WL	partner's perceived relationship quality		14 weeks	CDBT>WL satisfaction (*d*=.59), commitment (*d*=.57), intimacy (*d*=.71), passion (*d*=.90), love (*d*=.72), trust (*d*=.59)	

Level II

Full reference Country	Study Design/ Level of Evidence	N (n)	Participants Age Gender Diagnosis Other	Intervention	Comparison	Outcomes	Measure/s	Length of follow-up	Effect Size	Comments
Bateman, A & Fonagy P (2018) UK	RCT/Level II	N=56	Family members or significant others living with/supporting people with BPD	MBT-FACTS (supportive and skills-based program delivered by trained family members);5 evening meetings	Waiting List	Family-reported adverse incidents with person with BPD family well-being family empowerment burden anxiety depression	incident diary WEMWBS FES BAS STAI BDI	5 weeks of treatment + 4 weeks follow-up	Less **adverse incidents** in MBT-FACTS group (post: MD=-1.70; 95% CI -2.38, -1.01; z=-4.85; p<.000; follow-up: MD=-2.75; 95%CI -3.57, -1.94; z=-6.62; p<.000) **family empowerment** : sig. between group difference (one-tail) at follow-up (FES MD =9.41; 95% CI -0.41 19.24; z=4.98, p<.06) Sig. higher **well-being** in MBT-FACTS group at the	MBT-FACTS delivered by families to families may be helpful, for family-related outcome (adverse events, family problems, family empowerment, well-being No effects found on individual carers' well-being

									end of treatment and follow-up (post: MD=5.74; 95% CI 0.10, 11.39; z=1.99, p=.046; follow-up: MD=6.66; 95% CI 0.45, 12.78, z=2.11, p=.035) Sig. less **family problems**, difference increasing from week 2 on, highest difference at follow up (MD=-10.65; 95% CI -16.31, -4.99; z=-3.69, p=.0003). **Anxiety, depression, burden**: no sig. group differences at any time point; improvements in both groups	

Grenyer et al. (2018) **Australia**	Level II/RCT	N=68	Carers (aged 16 or older, mean age 54.2 years, 66.2% female, 73.5% parents) for a person (aged 14 or older, mean age 30.4 years, 75% female) with a diagnosis of personality disorder or symptoms consistent with personality disorder, including problems in managing strong emotions, self-harming behaviour, self-destructive behavior, problems with identity and sense of self	Group psychoeducation ("Staying Connected"), groups of 6 to 8 carers, 16 hours of face-to-face contact over 10 weeks (1-day psychoeducation group + 4 2-hour group sessions every 2 weeks), Treatment aims: Empower carers with skills to change themselves in relationships, provide knowledge about BPD and challenging behaviours, facilitate options for support, facilitate sharing experiences with other carers Based on Family systems theory (Bowen 1993), including experiential exercises (role play, communication practice exercises)	Waiting List (3 months)	objective and subjective burden, relationship quality, family empowerment, mental health, expressed emotion/criticism in the family	BAS, DAS-4, FES, MHI-5, TFQ	Post: 10 weeks, follow-up 12 months	Sig interaction (time X condition) for **BAS** (d=.78, p=.008); **TFQ-emotional overinvolvement** (d=-.35, p=.026); **TFQ-Criticism** (d=-.66, p=.026); **FES** (d=1.40, p=.003) No sig. interactions for MHI-5, BAS Sig. improvement after treatment up to 12-months follow-up only for BAS (d=.45, p=.042) and MHI-5 (d=.52, p=.0.47)	Effects on relationship quality and relationship behaviour Again, no immediate effects on carers' burden or mental health (but after 12-month follow-up)
Kamalabadi et al. 2012 **Iran**	Level II/RCT	N=30 couples	Males 18-50 years with their partners, at least one partner with BPD	14 weekly sessions of couple DBT	WL	Relevant for Q24: Perceived relationship quality (partner-rated)	PRFQ	14 weeks (post)	couple DBT > waitlist for satisfaction (*d* = .59), commitment (*d*	study methods poorly described, high risk of bias

									=.57), intimacy (*d* = .71), passion (*d* = .90), love (*d* = .72), and trust (*d* = .59)	

9.4.13 Evidenztabellen Fragestellungen 25 and 26

Level I

Keine entsprechende Evidenz identifiziert (September 2021)

Level II

Full reference Country	Study Design/ Level of Evidence	N (n)	Participants Age Gender Diagnosis Other	Intervention	Comparison	Outcomes	Measure/s	Length of follow-up	Effect Size	Comments
Bateman, Anthony, und Peter Fonagy. „A Randomized Controlled Trial of a Mentalization-Based Intervention (MBT-FACTS) for Families of People with Borderline Personality Disorder“. Personality Disorders 10, Nr. 1 (2019): 70–79. UK	II (RCT)	N=56 adult carers	Family members or significant others living with/supporting people with BPD	MBT-FACTS (supportive and skills-based program delivered by trained family members);5 evening meetings	waiting list	Family-reported adverse incidents with person with BPD family well-being family empowermentfamily burden anxiety depression	incident diary WEMWBS FES BAS STAI BDI	5 weeks of treatment + 4 weeks follow-up	Less **adverse incidents** in MBT-FACTS group (post: MD=-1.70; 95% CI -2.38, -1.01; z=-4.85; p<.000; follow-up: MD=-2.75; 95%CI -3.57, -1.94; z=-6.62; p<.000) **family empowerment** : sig. between group difference (one-tail) at follow-up (FES	MBT-FACTS delivered by families to families may be helpful, for family-related outcome (adverse events, family problems, family empowerment, well-being No effects found on

									MD =9.41; 95% CI -0.41 19.24; z=4.98, p<.06) Sig. higher **well-being** in MBT-FACTS group at the end of treatment and follow-up (post: MD=5.74; 95% CI 0.10, 11.39; z=1.99, p=.046; follow-up: MD=6.66; 95% CI 0.45, 12.78, z=2.11, p=.035) Sig. less **family problems**, difference increasing from week 2 on, highest difference at follow up (MD=-10.65; 95% CI -	individual carers' well-being

									16.31, -4.99; z=-3.69, p=.0003). **Anxiety, depression, burden**: no sig. group differences at any time point; improvements in both groups	
Grenyer, Brin F. S., Rachel C. Bailey, Kate L. Lewis, Michael Matthias, Toni Garretty, und Annemaree Bickerton. „A Randomized Controlled Trial of Group Psychoeducation for Carers of Persons With Borderline Personality Disorder.“ *Journal of Personality Disorders* 33, Nr. 2 (April 2019): 214–28. Australia	II (RCT)	N=68 adult carers of a person with PD (74% BPD)	carers: mean age 54.2 years, 66% women, 72% primary carers: persons cared for: mean age 30.4 years, 75% women	group program: “Staying Connected”; psychoeducation based on relationship model and family systems therapy; 16 hours within 10 weeks (one-day psychoeducation group followed by four 2-hour group sessions every other week)	waiting list	Burden (subjective/objective) Dyadic Adjustment Family empowerment mental health of the caring person expressed emotion/criticism	BAS DAS-4 FES MHI-5 TFQ	10 weeks (post-treatment), 12 months follow-up	post-treatment (sig. interactions between time and conditions): DAS $F(1, 40,184)=7.738$, p=0.008; TFQ-Emotional Overinvolvement $F(1, 55.050)=5.247$, p=0.26; FES $F=(1, 55.279)=9.898$, $p=.003$ 12-month follow-up: sig. improvement of	PE group led to improvements on outcome probably relevant for the well-being of the person cared for (dyadic djustment, family empowerment, reduced expressed emotion) In addition,

									MHI-5 (*d*=0.52, *p*=0.47) and BAS (*d*=0.45, *p*=0.42) between post- and follow-up	positive long-term effects on carers burden and mental health

9.4.14 Evidenztabellen zur Fragestellung ADD5

Level I

Keine entsprechende Evidenz identifiziert (September 2021).

Level II

Keine entsprechende Evidenz identifiziert (September 2021).

9.4.15 Evidenztabellen zur Fragestellung ADD6

Level I

Keine entsprechende Evidenz identifiziert (September 2021).

Level II

Keine entsprechende Evidenz identifiziert (September 2021).

9.4.16 Evidenztabellen zur Fragestellung ADD7

Level I

Keine entsprechende Evidenz identifiziert (September 2021).

Level II

Keine entsprechende Evidenz identifiziert (September 2021).

9.4.17 Evidenztabellen zur Fragestellung ADD8

Level I

Keine entsprechende Evidenz identifiziert (September 2021).

Level II

Keine entsprechende Evidenz identifiziert (September 2021).

9.4.18 Evidenztabellen zur Fragestellung ADD9

Level I

Keine entsprechende Evidenz identifiziert (September 2021).

Level II

Keine entsprechende Evidenz identifiziert (September 2021).

9.5 Anhang 5: Kritische Bewertung der Evidenz (Evidence Statement Form)

Key question:		
Evidence base		
I) NICE 2009 findings		
II) NHMRC findings		
III) NICE 2018 findings		
III) Updated search		
Consistency		(if only one study was available, rank this component as 'not applicable')
	A	All studies consistent
	B	Most studies consistent and inconsistency can be explained
	C	Some inconsistency, reflecting genuine uncertainty around question
	D	Evidence is inconsistent
	N/A	Not applicable (no or one study only)
Clinical impact		(indicate in the space below if the study results varied according to some unknown factor (not simply study quality or sample size) and thus the clinical impact of the intervention could not be determined)
	A	Very large
	B	Substantial
	C	Moderate
	D	Slight/restricted
Generalisability		(How well does the body of evidence match the population and clinical settings being targeted by the Guide-line?)
	A	Evidence directly generalisable to target population
	B	Evidence directly generalisable to target population with some caveats
	C	Evidence not directly generalisable to the target population but could be sensibly applied
	D	Evidence not directly generalisable to target population and hard to judge wheter it is sensible to apply
Applicability		(Is the body of evidence to the German healthcare context in terms of health services/delivery of care and cultural factors?)

	A	Evidence directly applicable to German healthcare context
	B	Evidence applicable to German healthcare context with few caveats
	C	Evidence probably applicable to German healthcare context with some caveats
	D	Evidence not applicable to German healthcare context
Other factors		(indicate here any other factors that you took into account when assessing the evidence base (for example, issues that might cause the group to downgrade or upgrade the recommendation)

9.6 Anhang 6: Strukturierter Kommentierungsbogen

Kommentierung der Konsultationsfassung der S3-Leitlinie Borderline-Persönlichkeitsstörung

Name:	
E-Mail-Adresse:	
Adresse:	
Institution:	

Kapitel/Seite	**Entwurfstext der Leitlinie**	**Vorgeschlagene Änderung**	**Begründung (mit Literaturangaben)**

9.7 Anhang 7: Kommentare aus der externen Konsultationsphase und Umgang mit diesen Kommentaren

Einreichende	Fachgesellschaft/Verband/Institut	Kapitel/Seite (externe Konsultationsfassung)	Entwurfstext	Vorgeschlagene Änderung	Begründung (mit Literaturangabe)	Antwort Steuergruppe
Prof. Dr. Falk Leichsenring	DGPT e. V. (Deutsche Gesellschaft für Psychoanalyse, Psychotherapie, Psychosomatik und Tiefenpsychologe)	Kapitel 4.1.2.1, S. 52, Empfehlung 10	„Wenn der primäre Fokus in der Reduktion schwerwiegenden selbstverletzenden Verhaltens (isuizidales Verhalten inkludiert) besteht, soll DBT oder MBT angeboten werden.“	Streichung	s. nächste Zeile	Empfehlung 10 wird beibehalten (Begründung s. übernächste Zeile)
	Begründung der vorgeschlagenen Änderung (Prof. Leichsenring): **1.** die Metaanalyse von Storebø, Stoffers-Winterling et al. (1) fand keine Unterschiede zwischen den verschiedenen Therapien im Vergleich zu TAU. Dies gilt für Schwere der Borderline-Symptomatik und psychosoziales Funktionieren. Für Selbstverletzungen und suizidales Verhalten haben Storebø et al diese Analysen leider nicht durchgeführt. **2.** Die Effekte von DBT und MBT bei Selbstverletzungen und suizidalem Verhalten sind klein ((1), S. 329, 330, 338): SMD=0.28, 0.23 für DBT, 0.10 und RR=0.62 für MBT und liegen unterhalb der von Storebø’ et al. definierten minimalen klinisch relevanten Differenz. ((1), S. 2, 4-5) Es ist daher nicht zu rechtfertigen, zwei Verfahren spezifisch hervorzuheben und zu empfehlen, die kleine und klinisch nicht relevante Effekte bei Selbstverletzung und suizidalem Verhalten zeigen. Und bei denen es darüber hinaus nicht klar ist, ob sie hier anderen Verfahren überlegen sind (s. Punkt 1: wurde nicht geprüft). **3.** Es trifft nicht zu, dass keine RCTs vorliegen die verschiedenen Therapieverfahren direkt gegeneinander getestet haben, wie auf Seite 47 der LL behauptet ((2), S. 926): Auf Seite 926 beschreiben Clarkin et al dass sie Kontraste, also Direktvergleiche,			

	gerechnet haben für die verschiedenen Outcome-Bereiche, die aber keine signifikanten Unterschiede zwischen den Therapieformen gefunden haben. Das bedeutet, dass DBT nicht wirksamer als TFP gewesen ist, auch nicht bei SSV und suizidalem Verhalten Dieser Satz zu den Kontrasten wird gerne übersehen. **4.** Doering, Hörz et al. (3) berichten im supplement für number of suicides attempts one year before and after beginning of psychotherapy einen F- Wert von 3,522, dies entspricht d=0.36. Für die observed cases berichten die Autoren im Artikel ein t=2.99, was d=0.72 entspricht. Diese Effekte sind tendenziell sogar größer als die für DBT, siehe Storebø' et al ((1), S. 329, 330): 0.28 und 0-23. Die Empfehlung 10 ist nicht evidenz-basiert. Sie weckt den Verdacht von bias und researcher allegiance. Referenzen: (1) Storebo OJ, Stoffers-Winterling JM, Vollm BA, Kongerslev MT, Mattivi JT, et al. Psychological therapies for people with borderline personality disorder. *Cochrane Database Syst Rev.* May 4 2020;5:CD012955. (2) Clarkin JF, Levy KN, Lenzenweger MF, Kernberg OF. Evaluating three treatments for borderline personality disorder: a multiwave study. *Am J Psychiatry.* Jun 2007;164(6):922-928. (3) Doering S, Horz S, Rentrop M, Fischer-Kern M, Schuster P, et al. Transference-focused psychotherapy v. treatment by community psychotherapists for borderline personality disorder: randomised controlled trial. *British Journal of Psychiatry* 2010(196):389-395.
	Antwort: **Ad 1.:** Es ist zutreffend, dass bezüglich der Ergebnisvariablen „self-harm" und „suicidality" aus der Meta-Analyse von Storebo et al. (2020) keine Subgruppenanalyse vorliegt, die auf die relative Wirksamkeit unterschiedlicher Therapien hinsichtlich dieser Ergebnisvariablen schließen ließe.

	Gleichzeitig geht die dieser Empfehlung zugrundeliegende Fragestellung 7 auch nicht dem relativen Wirksamkeitsvergleich nach (vgl. Übersicht der Fragestellungen im Anhang 1: „Welche Psychotherapien sind wirksam?“. Vielmehr wird die grundsätzliche Wirksamkeit fokussiert. Insofern ist aus allen als relevant identifzierten Level-I und Level-II-Studien (nicht nur Storebo et al. 2020, vgl. u.a. Tab. 10 sowie Evidenztabellen zu Fragestellung 6-8 im Anhang 4 des Leitlinienreports) die jeweiligen Vergleichseffekte der einzelnen Therapien mit unspezifischen Kontrollgruppen („TAU“) zur Bewertung der absoluten Wirksamkeit relevant (vgl. auch folgender Punkt 2.). **Ad 2.:** Es ist zutreffend, dass sich die Effekte von DBT und MBT im Vergleich zu TAU im kleinen bis moderaten Bereich bewegen. Entscheidend für die Formulierung von Empfehlung 10, die sich sehr eng an der australischen Quell-LL orientiert (vgl. Recommendation 18: „When reduction in self-harm is a treatment goal for women with BPD, offer a comprehensive* dialectical behaviour therapy program.” [26]), waren neben der Evidenz der Meta-Analyse von Storebo et al. [30] und der übrigen Meta-Analysen [27,28,32,122–126] (vgl. Tab. 10-12) das Gewicht des Endpunkts „selbstgefährdendes Verhalten“, welcher für so wichtig erachtet wurde, dass auch kleinen bis mittleren Effekten Relevanz zugedacht wurde. Weiterhin waren die Konsistenz der Befunde über mehrere Meta-Analysen und randomisiert-kontrollierte Studien hinweg sowie die Tatsache, dass DBT und MBT mit Abstand am häufigsten Gegenstand von RCTs waren und damit die belastbarste Evidenz aufweisen, ausschlaggebend (vgl. Storebo et al. [30]: 26 von 75 eingeschlossenen RCTs untersuchten DBT, 7 MBT, alle übrigen Therapieformen wurden seltener, i.d.R. in einzelnen RCTs, getestet). **Ad 3.:** Die Textstelle „Direkte randomisierte Vergleiche der wesentlichen Therapieverfahren liegen derzeit nicht vor, so dass jeweils nur Rückschlüsse auf die Wirksamkeit der jeweiligen Therapien gegenüber einer unspezifischen Kontrollbehandlung, jedoch nicht im relativen Vergleich untereinander gezogen werden können.“ (s. 47 der Konsultationsfassung) ist ungenau formuliert, wir bedanken uns für den Hinweis. Tatsächlich liegen mehrere randomisiert-kontrollierte Studien zu direkten Therapievergleichen vor, neben Clarkin et al. [127] bspw. auch die Studie von Giesen-Bloo et al. , in welcher TFP und SFT verglichen wurden, sowie diverse weitere (u.a. [59,116,128–134]). Die Textstelle wurde entsprechend umformuliert (Kapitel 4.1., S. 49f.): „Direkte randomisierte Vergleiche der wesentlichen Therapieverfahren liegen derzeit nur jeweils aus Einzelstudien[59,116,128–135] vor, so dass keine belastbaren Rückschlüsse auf die relative Wirksamkeit der Therapien untereinander möglich sind. Einzelne,

	nicht replizierte Studienbefunde sind aufgrund bekannter methodischer Problem nicht hinreichend verlässlich: nicht-replizierte Befunde aus Einzelstudien stellen unpräzise Schätzer dar, wobei die Behandlungseffekte meist überschätzt werden [136]; gleichzeitig handelt es sich meist um frühe Pilotstudien, die nicht unabhängig durchgeführt werden, sondern in denen Entwicklerinnen und Entwickler ihre eigenen Therapien evaluieren, so dass ein hohes Verzerrungsrisiko aufgrund von „Allegiance bias“ nicht ausgeschlossen werden kann [137,138]).“ **Ad 4.:** Das ist zutreffend, vielen Dank für den Hinweis. Da es sich hier jedoch wie auch bei der o.g. Studie von Clarkin um nicht replizierte Befunde aus einer einzelnen Studie handelt, kann die Präzision der Befund nicht hinreichend gut eingeschätzt werden, während tendenziell von einer Überschätzung auszugehen ist [136]. Vgl. hierzu auch die Ausführungen zu 3. **Zusammenfassend ist festzuhalten, dass es sich bei Empfehlung 10 um eine evidenzbasierte Empfehlung handelt und „bias und researcher allegiance“ nicht zutreffen.** Zu beachten ist u.a., dass nicht ausschließlich die Evidenz aus der Meta-Analyse von Storebo et al. (2020), an der die Arbeitsgruppe von Prof. Lieb beteiligt war, für diese Empfehlung ausschlaggebend ist, vgl. Tab. 10-12 sowie Evidenztabellen zu Fragestellungen 6 – 8 (Kapitel 9.4.4 im Leitlinienreport), sondern ebenso acht weitere Meta-Analysen [27,28,32,122–126] und mehr als 70 randomisiert-kontrollierte Studien (s. Tab. 10). Zudem wird auf die hohen Standards des IK-Managements hingewiesen, die in dieser LL angewandt wurden, vgl. hierzu auch Kapitel 5 im Leitlinienreport. Hierzu gehörten u.a. die Einsetzung einer externen IK-Management Gruppe, die pluralistische Zusammensetzung der LL-Gruppe, u.a. hinsichtlich der Zugehörigkeit zu Richtlinienverfahren und Psychotherapiemethoden, der formale Prozess der Konsensfindung sowie die neutrale Moderation. Insbesondere die Doppelabstimmung der Empfehlung 10 unter Ein- und Ausschluss aller Mandatstragenden mit Affiliation zu den betroffenen Methoden (d.h. DBT und MBT), die jeweils im Konsens resultierte, schließt den Verdacht auf „bias und researcher allegiance“ aus (Konsens unter Berücksichtigung aller 20 anwesenden Mandatstragenden: 95% Konsens unter Berücksichtigung lediglich der Mandatstragenden ohne Affiliation zu DBT oder MBT (11 von 20 Anwesenden): 91% Konsens. **Empfehlung 10 wird unverändert beibehalten.**

Weitere externe Kommentierungen sind nicht eingegangen.

9.8 Anhang 8: Formular zur Erfassung von Interessenkonflikten der Mandatstragenden

Erfassung von Interessen der Mitglieder der Leitlinienkommission (Version 4.9.2017)

Eine wichtige Voraussetzung für die Arbeit der S3-Leitlinienkommission Borderline-Persönlichkeitsstörung ist die Unabhängigkeit bei Bewertungen der Wirksamkeit von Psychotherapieverfahren und –methoden einschließlich der vergleichenden Wirksamkeit gegenüber anderen therapeutischen Strategien. Die Mitglieder der Leitlinienkommission legen daher ihre Interessen an einzelnen Psychotherapieverfahren und –methoden sowie deren Erforschung und Anwendung, aber auch andere Beziehungen, insbesondere zu pharmazeutischen Unternehmen, Herstellern von Medizinprodukten oder industriellen Interessenverbänden, offen.

Im Folgenden werden sechs Fragen zu unterschiedlichen Interessen gestellt. Die Fragen beziehen sich auf die letzten drei Jahre (2014-2016) und schließen das aktuelle Jahr bis zum Zeitpunkt des Ausfüllens des Formulars (Jan – Sep. 2017) ein. Alle Angaben zu Beziehungen/Interessen sind obligat zu beantworten, unabhängig davon, ob ein Einfluss auf die Unabhängigkeit gesehen wird oder nicht. Angaben zur Höhe erhaltener Zuwendungen sind fakultativ.

Die Angaben zu Beziehungen/Interessen werden im Rahmen der Leitlinienerstellung öffentlich gemacht. Die Höhe von Zuwendungen wird nicht veröffentlicht.

Die Leitlinienkommission gibt sich vor Aufnahme ihrer Arbeit Regeln zum Umgang mit Interessen und Interessenkonflikten ihrer Mitglieder, um ein möglichst hohes Maß an Unabhängigkeit in der Bewertung von Therapien zu erreichen.

Name, Vorname, Titel	
Entsendende Fachgesellschaft	

Frage 1: Beschäftigungsverhältnis

Zeitraum, auf den sich die Angaben beziehen: 2014-2017

Geben Sie hier bitte an, wer Ihr Arbeitgeber ist, ob Sie freiberuflich arbeiten und in welcher Position.

Tätigkeit	**von (Monat/Jahr)**	**bis (Monat/Jahr)**	**Position/Funktion**

Frage 2: Psychotherapeutische Verfahrens-/Methodenschwerpunkte

Zeitraum, auf den sich die Angaben beziehen: 2014-2017

Machen Sie hier bitte Angaben zu Psychotherapeutischen Verfahrens-/Methodenschwerpunkten, die Sie in der eigenen Psychotherapieaus- oder -weiterbildung erlernt haben, die Sie in der eigenen psychotherapeutischen Tätigkeit anwenden bzw. die Sie als Inhaber/in einer Leitungsposition verantworten (z.B. in einer Klinik).

a) Verfahren/Methoden, die in der eigenen Psychotherapieaus-oder -weiterbildung erlernt wurden
b) Verfahren/Methoden, die in der eigenen psychotherapeutischen Tätigkeit angewandt werden
c) Verfahren/Methoden, die in einer Leitungsposition verantwortet werden (z.B. in einer Klink)

Frage 3: Tätigkeit/Geschäftsanteile an einem Aus-/Weiterbildungs-Institut für Psychotherapie

Zeitraum, auf den sich die Angaben beziehen: 2014-2017

Machen Sie hier bitte Angaben zur Position/Art der Tätigkeit/Geschäftsanteile (z.B. Leitung des Instituts, Vortragstätigkeit für ein Institut, Supervision für ein Institut, Beratervertrag mit einem Institut; Geschäftsanteile an einem Institut). Hier wird nicht die hauptberufliche Tätigkeit an der eigenen Wirkungsstätte erfasst; diese wurde bereits mit Frage 1 und 2 erhoben.

Tätigkeit	von (Monat/Jahr)	bis (Monat/Jahr)	Honorar/Anteile (fakultativ)

Frage 4: Zusammenarbeit/persönliche Beziehungen mit/zu der pharmazeutischen Industrie oder Medizinprodukte-Herstellern

Zeitraum, auf den sich die Angaben beziehen: 2014-2017

Machen Sie hier bitte Angaben zu:

- Honoraren für Vortragstätigkeit, finanzielle Unterstützung von Kongressbesuchen, Fortbildungen o.ä. (Name der Firma)
- Beratertätigkeit (Name der Firma)
- Besitz von Aktien eines pharmazeutischen Unternehmens/Medizinprodukteherstellers oder Aktienbesitz von Erstgradangehörigen (Name der Firma)
- Beschäftigung eines Erstgradangehörigen bei einem pharmazeutischen Unternehmen/Medizinprodukthersteller (Name der Firma)

Unternehmen	Art der Tätigkeit/Beziehung	Ggf. Zeitraum/Jahr	Honorar/Wert (fakultativ)

Frage 5: Forschung

Zeitraum, auf den sich die Angaben beziehen: 2014-2017

Machen Sie hier bitte folgende Angaben:

1) Thematik der Forschungstätigkeit (psychotherapeutische Verfahren/Methoden; hier auch Forschung zu anderen nicht-medikamentösen Verfahren zur Behandlung psychischer Erkrankungen und pharmakologische Forschung angeben)

Thematik	

2) Öffentliche und nicht-öffentliche Förderer der eigenen Forschungsaktivitäten (hier neben DFG, BMBF, Stiftungen etc. auch Forschungsförderung durch die pharmazeutische Industrie oder Medizinproduktehersteller angeben)

Förderer	Art der Zuwendung	Thema	Zeitraum	Summe (fakultativ)	Empfänger

Frage 6: Weitere Tätigkeiten

Zeitraum, auf den sich die Angaben beziehen: 2014-2017

Machen Sie hier bitte Angaben zu aktiven Tätigkeiten in Fachgesellschaften, Berufsverbänden, Institutionen der Selbstverwaltung, Fachgremien, Vereinen, Patientenselbsthilfegruppen o. ä. (nicht zu nennen sind passive Mitgliedschaften, die Mitgliedschaft im WBP und Mitgliedschaften in thematisch nicht relevanten Vereinen)

Berufsverband etc.	Position	Zeitraum von … bis	Honorar (ja/nein)	Höhe des Honorars (fakultativ)

Ich bestätige mit meiner Unterschrift, dass meine Angaben wahrheitsgemäß und vollständig sind. Änderungen, die sich auf diese Erklärung auswirken, werde ich umgehend schriftlich bekanntgeben.

Datum Unterschrift

- Bitte speichern Sie das handschriftlich oder elektronisch ausgefüllte Formular und senden es an klaus.lieb@unimedizin-mainz.de
- Bitte drucken Sie das Formular aus, nachdem Sie es ausgefüllt haben.
- Senden Sie bitte eine unterschriebene Kopie per Post an: Leiliniensekretariat S3-Leitlinie, Borderline-Persönlichkeitsstörung c/o Prof. Dr. Klaus Lieb, Klinik für Psychiatrie und Psychotherapie, Universitätsmedizin Mainz, Untere Zahlbacher Str. 8, 55131 Mainz

9.9 Anhang 9: Interessenkonflikte der Mandatstragenden

Fachsellschaft/Orghanisation	Mandatastragende	Hauptmandatstragende® (M)/stellvertretend Mandatstragende® (Stv)	Richtlinienverfahren	Verfahren/Methoden, die in der eigenen Psychotherapie- aus- oder -weiterbildung erlernt wurden	Verfahren/Methoden, die als Inhaber/in einer Leitungsposition verantwortet werden (z.B. in einer Klinik)	Zusammenarbeit/persönliche Beziehungen mit/zu pharmazeutischer Industrie oder Medizinprodukteherstellern
BDP Berufsverband deutscher Psychologinnen und Psychologen e. V.	Dipl.-Psych. Ralph Schliewenz	M.	VT	GT, Hypno, klientenzentrierte Spieltherapie, System. Th.	VT	keine
BDP Berufsverband deutscher Psychologinnen und Psychologen e. V.	Dipl.-Psych. Inge Neiser	Stv.	TP	keines	keine	keine
BKJ e. V. Berufsverband der Kinder- und Jugendlichenpsychotherapeutinnen und Kinder- und Jugendlichenpsychotherapeuten	Dipl.-Soz.Päd. Beate Leinberger	M.	VT	Schematherapie, EMDR, Traumatherapie (Krest)	keine	keine
BKJ e. V. Berufsverband der Kinder- und Jugendlichenpsychotherapeutinnen und Kinder- und Jugendlichenpsychotherapeuten	Dipl.-Soz.Päd. Kerstin Kubesch	Stv.	TP	TP, positive Psychotherapie, strukturelle Therapie nach Rudolf, konfliktfokussierte Psychotherapie, traumatherapeutische Methoden nach Reddemann, MBT, Selbst- Objekt-Regulierung nach Kernberg und Mentzos, Kohut	keine	keine
Borderline-Trialog	Dipl.-Soz.Päd. (FH) Anja Link	M.	keine	keine	keine	keine
Borderline-Trialog	Dipl.-Psych. Katrin Zeddies	Stv.	keines	innere Kindarbeit, Psychodrama, STEPPS, system. Familienth. system. integrative Th.	keine	keine
Bundestherapeutenkammer	Dr. Andrea Benecke	M.	VT	Hypno	VT	keine
Bundestherapeutenkammer	Dr. Alessa Jansen	Stv.	VT	keines	keine	keine
BVVP Bundesverband der Vertragspsychotherapeuten	Dipl.-Psych. Rainer Cebulla	M.	VT	Gestalt	keine	keine

BVVP Bundesverband der Vertragspsychotherapeuten	Dipl.-Päd. Ariadne Sartorius	Stv.	VT	System. Th.	keine	keine
DÄVT Deutsche Ärztliche Gesellschaft für Verhaltenstherapie e. V.	Dr. Michael Armbrust	M.	VT	DBT, KVT	DBT, KVT, ST, VT	keine
DÄVT Deutsche Ärztliche Gesellschaft für Verhaltenstherapie e. V.	Dr. Markus Reicherzer	Stv.	PA, TP, VT	DBT	VT, DBT, DBT-PTSD, TREEP	keine
DDBT Dachverband Dialektisch-Behaviorale Therapie e. V.	Prof. Dr. Martin Bohus	M.	TP, VT	Bioenergetik, KVT, DBT, Hypno	DBT, KVT	keine
DDBT Dachverband Dialektisch-Behaviorale Therapie e. V.	Prof. Dr. Christian Schmahl	Stv.	VT	DBT	KVT, DBT	Böhringer Ingelheim - Beratertätigkeit
DeGPT Deutschsprachige Gesellschaft für Psychotraumatologie	Prof. Dr. Ingo Schäfer	M.	VT	Hypno, EMDR	KVT	keine
DeGPT Deutschsprachige Gesellschaft für Psychotraumatologie	Prof. Dr. Astrid Lampe	Stv.	PA	EMDR, GT, PITT, spez. Psychotraumatherapie	EMDR, GT, PA	keine
DFPP Deutsche Fachgesellschaft Psychiatrische Pflege e. V.	Dr. rer. medic. Susanne Schoppmann	M.	keine	keine	keine	keine
DFPP Deutsche Fachgesellschaft Psychiatrische Pflege e. V.	Dorothea Sauter	Stv.	keine	keine	keine	keine
DGGÖ Deutsche Gesellschaft für Gesundheitsökonomie e. V.	Prof. Dr. Hans-Helmut König	M.	keine	keine	keine	keine
DGGÖ Deutsche Gesellschaft für Gesundheitsökonomie e. V.	Dr. Christian Brettschneider	Stv.	keine	keine	keine	keine
DGKJP Deutsche Gesellschaft für Kinder- und Jugendpsychiatrie, Psychosomatik und Psychotherapie	Prof. Dr. Michael Kaess	M.	VT	CAT, DBT-A, VT	DBT-A, system. Therapie, TFP, VT	keine
DGKJP Deutsche Gesellschaft für Kinder- und Jugendpsychiatrie, Psychosomatik und Psychotherapie	Prof. Dr. Paul Plener	Stv.	VT	DBT-A, EMDR	"schulenübergreifend"	Shire - Vortragstätigkeit (3000€)
DGPs Deutsche Gesellschaft für Psychologie	Prof. Dr. Babette Renneberg	M.	VT	DBT	KVT	keine
DGPs Deutsche Gesellschaft für Psychologie	Prof. Dr. Christoph Kröger	Stv.	VT	DBT, GT, IPT	VT, DBT	keine
DGPM Deutsche Gesellschaft für Psychosomatische Medizin und ärztliche Psychotherapie e. V.	Univ.-Prof. Dr. Stephan Doering	M.	PA	TFP	PA, TFP	keine
DGPM Deutsche Gesellschaft für Psychosomatische Medizin und ärztliche Psychotherapie e. V.	Univ.-Prof. Dr. Anna Buchheim	Stv.	TP, PA	TFP	DBT, humanist. Verfahren, KVT, MBT, PA, PD, ST, system. Verfahren	keine

DGPPN Deutsche Gesellschaft für Psychiatrie und Psychotherapie, Psychosomatik und Nervenheil-kunde	Prof. Dr. Sabine Herpertz	M.	PA	TP, KVT	DBT, KVT,MBT, ST, TP	keine
DGPPN Deutsche Gesellschaft für Psychiatrie und Psychotherapie, Psychosomatik und Nervenheil-kunde	Prof. Dr. Martin Driessen	Stv.	PD, VT	Familientherapie	CRA, DBT, Familie, IPT, NET, PD, VT	keine
DGPPN Deutsche Gesellschaft für Psychiatrie und Psychotherapie, Psychosomatik und Nervenheil-kunde	Prof. Dr. Christian Schmahl	Stv.	VT	DBT	KVT, DBT	Böhringer Ingelheim - Berater-tätigkeit
DGPT Deutsche Gesellschaft für Psychoanalyse, Psychotherapie, Psychosomatik und Tiefenpsycho-logie e. V.	Prof. Dr. Silke Wiegand-Grefe	M.	PA. TP	Familientherapie, Paartherapie	Familientherapie, PA, Paartherapie, TP	keine
DGPT Deutsche Gesellschaft für Psychoanalyse, Psychotherapie, Psychosomatik und Tiefenpsycho-logie e. V.	PD Dr. Dipl.-Psych. Clau-dia Subic-Wrana	Stv.	PA, TP	keine	PA, TP	keine
DGSF Deutsche Gesellschaft für Systemische Therapie, Beratung und Familientherapie e. V.	Martina Lochmann, Dipl.-Sozialarbeiterin, Sys-tem.Therapeutin	M.	System. Th.	keines	keine	keine
DGVT Deutsche Gesellschaft für Verhaltenstherapie e. V.	Dr. Rudi Merod	M.	VT	DBT	VT, DBT	keine
DGVT Deutsche Gesellschaft für Verhaltenstherapie e. V.	Dr. Prisca Weiser	Stv.	VT	DBT, Psychoonkolo-gie	VT, DBT	keine
DGVT Deutsche Gesellschaft für Verhaltenstherapie e. V.	Prof. Dr. Miachael Withöft	Stv.	VT	VT	VT	keine
DKPM Deutsches Kollegium für Psychosomatische Medizin	Univ.-Prof. Dr. Anna Buch-heim	M.	PA, TP	TFP	DBT, humanist. Ver-fahren, KVT, MBT, PA, PD, ST, system. Verfahren	keine
DKPM Deutsches Kollegium für Psychosomatische Medizin	Univ.-Prof. Dr. Stephan Doering	Stv.	PA	TFP	PA, TFP	keine

DPV Deutsche Psychoanalytische Vereinigung	Prof. Dr. Joachim Küchenhoff	M.	PA, TP	konzentrative Bewegungsth., Psychodrama	analyt. Kunst- u. Musikth., Gruppentherapie nach Yalom, Gruppentherapie nach Foulkes, konzentrative Beweungsth., KVT, PA, system. Th, TFP	keine
DPV Deutsche Psychoanalytische Vereinigung	Dipl.-Psych. Christa Leiendecker	Stv.	PA, TP	GT	keine	keine
DVT Deutscher Fachverband für Verhaltenstherapie	Prof. Dr. Ulrich Schweiger	M.	VT	VT	ACT, BA, CBASP, DBT, KVT, MCT, ST	Servier, Janssen, Neuraxpharm - finanzielle Unterstützung von Tagungen
DVT Deutscher Fachverband für Verhaltenstherapie	Dr. Claudia Stromberg	Stv.	VT	VT, ST	VT, ST	
GePs, Gesellschaft zur Erforschung und Therapie von Persönlichkeitsstörungen e. V.	Dr. Birger Dulz	M.	TP	TFP	DBT, MBT, TFP, TP, VT	keine
GePs, Gesellschaft zur Erforschung und Therapie von Persönlichkeitsstörungen e. V.	Prof. Dr. Carsten Spitzer	Stv.	TP	psychoanalyt. interaktionelle Methode	PD, CBASP, DBT, MBT, MCT	Jannssen-Cilag: AMDP-Seminare (2017), Honorar 1500 €
Mentalisierungsbasierte Therapie (MBT)	Prof. Dr. phil. Svenja Taubner	M.	PA, TP	MBT	MBT, PA, TP	keine
Mentalisierungsbasierte Therapie (MBT)	Dr Jana Volkert	Stv.	TP	TFP, MBT	keine	keine
VAKJP - Vereingiung Analytischer Kinder- und Jugendlichenpsychotherapeuten	Prof. Dr. Annette Streeck-Fischer	M.	PA, TP	TP	analyt. Therapie, PiM, VT	keine
VAKJP - Vereingiung Analytischer Kinder- und Jugendlichenpsychotherapeuten	Prof. Dr. Simone Salzer	Stv.	PA, TP	PA, TP	keine	keine

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