



“Good Enough” Psychiatric Residency Training in Borderline Personality Disorder: Challenges, Choice Points, and a Model Generalist Curriculum

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Abstract: While the public health burden posed by borderline personality disorder (BPD) rivals that associated with other major mental illnesses, the prevailing disposition of psychiatrists toward the disorder remains characterized by misinformation, stigma, aversive attitudes, and insufficient familiarity with effective generalist treatments that can be delivered in nonspecialized health care settings. Residency training programs are well positioned to better equip the next generation of psychiatrists to address these issues, but no consensus or guidelines currently exist for what and how residents should be taught about managing BPD. Instead, disproportionately limited curricular time, teaching of non-evidence-based approaches, and modeling of conceptually confused combinations of techniques drawn from specialty BPD treatments are offered. In this article, we (1) explain why training in a generalist model is sensible and why alternative approaches are not appropriate for residents, (2) propose a plan for giving residents adequate training via a generalist model, highlighting minimal didactic and clinical-training objectives (dubbed “core competencies” and “milestones”) and a model curriculum developed at the Massachusetts General Hospital/McLean Hospital residency program, and (3) describe obstacles to implementation of effective generalist training posed by infrastructural, faculty-centered, and resident-centered variables.

Keywords: borderline personality disorder, core competencies, generalist treatment, Good Psychiatric Management, milestones, residency training

INTRODUCTION: THE PUBLIC HEALTH SIGNIFICANCE OF BPD AND NEED FOR MORE EFFECTIVE RESIDENCY TRAINING

The borderline personality disorder (BPD) diagnosis has historically been used to label psychiatric patients regarded as unlikable, untreatable, and not of primary importance within the wider treatment-seeking population.¹ It is now known to be a widespread, highly heritable disorder that is linked with a good prognosis. Its prevalence is estimated at around 2%, making it more prevalent than schizophrenia and roughly as prevalent as bipolar disorder.^{2–6} It is highly responsive to a variety of evidence-based treatments (EBTs), but contrary to earlier prevailing views, its course is not unremittingly chronic. A majority of BPD patients achieve sustained symptomatic remission without intensive, long-term, specialized treatments, and recurrence after remission is relatively rare.^{7,8} While most demonstrate enduring vocational and social

dysfunction, only a minority persist as high utilizers of intensive mental health services.

Despite this revolution in our understanding of BPD, old myths, misinformation, and problematic attitudes endure. In the popular media, BPD continues to be regarded as intractable.⁹ Mental health clinicians’ attitudes toward BPD as compared to other diagnostic groups reveal a higher predominance of negative feelings such as anger and hostility, diminished liking and empathy, increased blame and pejorative judgment, heightened difficulty with providing care, and intentional avoidance.^{10–15} Even among psychiatrists the BPD diagnosis tends to be underutilized, misused to disparage “difficult” patients, and associated with general dislike and aversion.^{16–23} Psychiatrists additionally report lacking confidence in the adequacy of nonspecialist training for managing the often truly daunting clinical and interpersonal challenges associated with BPD.

The myth that years of costly specialty training are required to effectively manage BPD was stoked by the advent of specialized EBTs. Randomized, controlled trials successively established the effectiveness of three major specialty EBTs: dialectical behavior therapy (DBT), mentalization-based treatment (MBT), and transference-focused psychotherapy (TFP), with DBT widely considered to be the gold standard treatment, with the highest number of confirmatory trials.^{24–28} Yet, more recent head-to-head comparisons to less intensive generalist treatments demonstrate roughly equal

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effectiveness for most patients.²⁹ Achieving relatively good outcomes with most cases therefore requires not specialty EBT training but more basic comfort with general principles and techniques common to all effective treatments.³⁰

Additionally promising is the finding that even short-term training workshops offered to mental health professionals with various degrees and levels of experience are effective in producing a sense of generalist proficiency and also in improving attitudes toward BPD.^{22,31–34} Although these workshops have been taught from a variety of theoretical perspectives, they all present an understandable phenomenology of symptoms, an updated etiology combining heritable and environmental factors, evidence supporting prognostic optimism, enthusiasm for working with this population, and core principles for managing common causes of aversion and burnout. The success of these generalist training workshops challenges the earlier presumption of clinicians, patients, and families that extensive time, effort, and money are required for effective and empathic BPD treatment.

These advances collectively pave a clearer path toward equipping the next generation of psychiatrists to meet the public health need with a broadly effective generalist BPD treatment approach that can be learned efficiently during the busy residency years and later implemented within a wider spectrum of practice settings. And yet, the current residency training system seems poorly aligned with this public health imperative. No clear path toward psychiatric competence with BPD has been established. No top-down, consensus training guidelines have been published within the academic psychiatry literature or by psychiatric residency accreditation bodies to stipulate what core knowledge and skills concerning BPD should be emphasized. Predictably, significant heterogeneity exists in what and how residents are actually taught. In the era of increasing competition among diagnoses and therapeutic modalities for residents' attention and enthusiasm, the quality and content of BPD training may be largely determined by the theoretical loyalties and curricular constraints of particular institutions, departments, and faculty members.

Very little material has been published on effective residency training concerning BPD. Available literature warns that current training approaches may even perpetuate among trainees and junior faculty the misinformation and nihilistic responses found in psychiatry more generally, or highlights specific supervisory challenges around resident countertransference reactions and misuse of the BPD diagnosis.^{20,35} These cautionary accounts do not establish what minimum knowledge base and clinical techniques are required for general psychiatric competence with managing BPD, or how such material might be most effectively organized and disseminated across diverse U.S. residency programs.

In this Perspectives article, we advance a generalist BPD training approach for psychiatric residencies by (1) explaining why a generalist model is more sensible than alternative approaches, (2) proposing a set of minimum BPD-specific

training objectives, grouped into didactic “core competencies” and skill-based “milestones,” and showing how these have been organized across a model four-year BPD curriculum at the Massachusetts General Hospital/McLean Hospital residency training program, and (3) describing infrastructural, faculty-centered, and resident-centered challenges to implementation. Along the way, we commend Gunderson and Links' manual for Good Psychiatric Management (GPM)³⁶ as an effective teaching device for the generalist model. We end by summarizing how a generalist training model can equip most future psychiatrists, no matter their ultimate direction or degree of specialization, with the knowledge, skills, and confidence needed to be “good enough” agents of change in the lives of most BPD patients.

PROBLEMS WITH PREVAILING RESIDENCY TRAINING APPROACHES

In this section we critically evaluate existing BPD residency training approaches (see Table 1). Scant data exist on the actual prevalence of each approach among U.S. residency programs. More than half of the responding programs in a recent survey of 83 psychiatric residencies incorporate BPD teaching into more general psychopathology or psychotherapy course work, where an average of less than three hours is dedicated to BPD. Of those programs offering a specific didactic course in BPD, the most commonly taught techniques are DBT (89% of responding programs), TFP (54%), MBT (38%), and other specialty EBTS at far less frequency.³⁷ The conclusion is that residency BPD teaching at present is typically either subsumed into more general psychotherapy or psychopathology curricula, or equated with teaching specialty EBT techniques. Although the prevailing approaches each pose some enduring appeal, they lack data supporting their efficacy and are misaligned with the public health landscape and the developmental trajectory of most residents.

Pedagogical errors about BPD within residency programs primarily involve the following: overvaluing the usefulness of broad psychotherapy training for BPD-specific challenges; overlooking the potential harms of offering intensive psychodynamic or specialty therapies as a first-line intervention; underestimating the difficulty of learning specialty EBTS; and neglecting or overvaluing the inescapable medical aspects of the contemporary psychiatrist's role.

The most basic error is to hold that general training in psychopathology and psychodynamic or cognitive-behavioral psychotherapies provides a sufficient platform for managing clinical scenarios unique to BPD, such as countertransference anger and aversion, splitting, and recurrent self-harming behavior. The reality is that BPD patients do better in treatments that anticipate and address the special problems central to their illness. Learning to conduct such treatment involves developing BPD-specific knowledge and skills that are typically not well taught in traditional psychotherapy or psychopharmacology curricula. These techniques include the following:

Table 1**Alternative Paths to Training Residents to Competency in Treating BPD**

Training approach	Benefits/appeal	Problems/risks
Subsuming/minimizing BPD within general psychotherapy training	Favors broad psychodynamic and cognitive-behavioral concepts and techniques applicable across varying types of psychopathology	Leaves residents ill prepared to recognize and manage clinical challenges unique to BPD Overlooks value added by newer EBTs
“Alphabet soup” of concepts/techniques drawn from multiple specialist EBTs	Appeals to resident wishes for concrete techniques for managing patients’ and their own anxieties Learning particular specialist EBT concepts and skills can promote empathy and attitudinal change toward BPD Some specialist EBT concepts and skills are broadly useful outside a BPD context (DBT skills for distress tolerance, MBT stance for exploring misunderstandings, TFP concepts for understanding the role of anger)	Fragmented overall understanding of BPD, with concepts linked to specialty EBTs that residents cannot easily implement Incoherent clinical approach reliant on a “grab-bag” of unintegrated techniques rather than clear conceptual understanding
Training toward adherence in a particular specialist EBT	Caters to resident wishes to learn “gold standard” treatment May galvanize interested/talented residents to pursue further BPD specialty training Achieving adherence in one EBT can improve skill in other forms of psychotherapy	Requires large investment of time, money, infrastructure, and supervision by program and faculty Difficult if not impossible to achieve adherence with any EBT during residency training Specialist EBTs are not translatable in adherent form to most practice settings Underserves public health need to equip all psychiatrists with generalist competency

BPD, borderline personality disorder; DBT, dialectical behavioral therapy; EBT, evidence-based treatment; MBT, mentalization-based treatment; TFP, transference-focused psychotherapy.

carefully delineating the role of each treatment team member; establishing clear-cut goals; safety/crisis planning; active clinician responsiveness; and access to peer or supervisory consultation around emergent problems.^{27,30,38,39}

Subsuming BPD within general psychodynamic teaching may appeal to the zeal of classically oriented faculty and residents for the psychoanalytic worldview, but may set up residents to repeat history’s mistakes. Specific BPD course work can, instead, transmit relevant conceptual contributions from the psychoanalytic era—such as BPD patients’ “stable instability,” attachment to others as transitional objects, identity diffusion, splitting, and abandonment fears—without minimizing BPD’s track record of frequent drop-outs and iatrogenic harm done by lengthy, intensive, uncontainable treatments.¹

A second error is for residents to be taught particular specialty EBTs such as DBT, MBT, or TFP as the means of treating BPD. One example is the use of a “potpourri” approach transmitting a mixture of components culled from different specialty EBTs. Residents might be taught DBT distress-tolerance skills to help lower acute emotional arousal, a basic MBT stance to work through interpersonal misunderstandings, and TFP formulation to interpret rapid oscillations in relatedness and identity as shifts in internal object relations.

Some evidence suggests that compact training sessions in particular components of specialty EBTs for generalist clinicians can actually lead to improved confidence and attitudes as well as to increased use of the parent EBT in future practice.^{40,41} One survey of residency graduates suggested that the “dose” of DBT training received during residency influenced the number of DBT interventions used in post-residency practice.⁴² The notion that effective BPD treatment is equivalent to selecting the correct technique from an “arsenal” is one that appeals to trainees seeking cookbook guidelines about what to do and when to do it, and to faculty hoping to disseminate their own favorite EBTs.⁴³ Nevertheless, learning a smorgasbord of techniques without an integrative sensibility or coherent generalist conceptualization of BPD and without a careful formulation of the case at hand typically yields a superficial understanding of why one would choose certain interventions over others.⁴⁴ An “alphabet soup” conceptual morass and a “grab-bag” technique can do real harm to BPD patients.⁴⁵ Furthermore, in our experience, learning to flexibly blend various EBT approaches requires many years of experience plus postgraduate training and supervision.

Training toward adherence in a single specialty EBT is also unrealistic for most, if not all, residents, though it holds appeal for those hoping to learn apparently “gold

standard” or “most popular” treatments. The few published implementations of specialty EBT training during residency (in DBT and TFP) highlight serious problems with this approach, including the following: difficulty achieving the levels of clinical efficacy reported in research trials; lack of any data linking effective didactic teaching to residents with improved clinical outcomes; unrealistic requirements regarding the availability of supplemental money and time outside of standard residency provisions to learn and deliver the specialty treatments; and lack of generalizability of findings to residents with varying levels of interest and talent who would not electively opt in to special training opportunities.^{46–48} Furthermore, our own experience of learning and teaching specialty EBTs within the MGH/McLean residency training program and our interactions with residency faculty and program directors elsewhere suggest that even the most interested and talented PGY-4 residents self-selecting to join DBT and MBT training clinics struggle to deploy these models adherently or confidently before graduation. Yet, even if specialty EBTs could be effectively taught during residency, this should not be the goal for all residents because these resource-intensive approaches are undeliverable in their adherent forms outside of academic or specialist centers, where few psychiatrists will continue to work beyond their training years.

An additional problem with teaching specialty EBTs to residents is that the EBTs present psychotherapeutic approaches that unnecessarily depart from the medicalized stance with which psychiatrists are often more accustomed. The generalist approach encourages residents to adopt their familiar stance as authorities to offer diagnoses and discuss prognosis, etiology, and treatment options that include medications. This approach also permits the usual doctorly interventions of advice and directives. The psychotherapist’s toolkit of listening, emphasizing, exploring, challenging, and interpreting is best superimposed upon this generalist stance.

THE CASE FOR A GENERALIST MODEL OF RESIDENCY BPD TRAINING

Our case for a generalist model for residency BPD training rests on three lines of reasoning. First, treatments requiring less time, cost, and training to deliver turn out to be nearly as effective as specialty EBTs in a majority of settings for most patients.^{29,49,50}

Second, as discussed above, more broadly deliverable treatments are easier and less resource-intensive to teach and learn. Achieving proficiency with a single generalist treatment model requires less money, faculty time and training, curricular hours, resident enthusiasm and talent, and supervision, while having the further benefit of producing greater coherence of understanding and applied skill than alternative models.

Third, generalist training reclaims BPD treatment from the grip of special psychotherapeutic guilds and re-situates it within more universal paradigms of general medical and psychiatric training. This medical orientation helps residents integrate the wide variety of roles that they may play

in overseeing medications, medical comorbidities, access to other medical and psychiatric treatments not targeting BPD, and medicolegal responsibility for treatment-team decisions they are not directly carrying out.

WHAT AND HOW RESIDENTS SHOULD LEARN: MINIMAL DIDACTIC AND CLINICAL TRAINING OBJECTIVES

In 1999, the Accreditation Council for Graduate Medical Education (ACGME) and American Board of Medical Specialties introduced six domains of general competency into medical education in order to better measure the outcomes of residency training. These “core competencies” provided an early framework for residency training objectives but were overly abstract. ACGME together with the American Board of Psychiatry and Neurology (ABPN) eventually mandated the development of more specific, meaningful, performance-based “milestones” describing core benchmarks of didactic knowledge and clinical skill that residents must demonstrate at progressive intervals throughout their training in a variety of scenarios and settings corresponding to typical clinical practice.^{51,52} The milestones provide a framework for assessing whether residents’ development has been “good enough” at the group level for residency program accreditation and on an individual resident basis for accountability to the wider medical establishment and future patients.

Notably, these core competencies and milestones are diagnostically nonspecific. They offer no “top-down” consensus about which didactic material, therapeutic modalities, and clinical skills should be taught for particular disorders such as BPD. The development of disorder-based curricula is left up to program directors, chairs, and educators working at the level of residency training, in a “bottom-up” approach. This absence of diagnosis-specific training guidelines may be especially problematic in the arena of BPD, where a greater heterogeneity of training approaches is more liable to bring harm to patients at the hands of ill-equipped residents.

In this section, we adapt the general terminology and approach of residency accreditation bodies in outlining a minimum set of BPD-specific residency training proficiencies that are the backbone of a generalist training curriculum. Text Boxes 1 and 2 summarize our proposal for the minimum amount of didactic knowledge (“core competencies”) and clinical roles and skill sets (“milestones”) that residents should be expected to demonstrate on this path. For the sake of clarity, we deviate slightly from the above ACGME and ABPN definitions by distinguishing “core competencies” as areas of didactic knowledge and “milestones” as clinical roles and skills that residents must learn.

Our proposed core competencies and milestones are informed by years of experience with didactic teaching and clinical supervision of residents with varying levels of talent and interest learning both generalist and specialist treatments for BPD. The competencies and milestones, like their ACGME/ABPN equivalents, are structured in a developmentally

Text Box 1
Minimum Didactic Knowledge (“Core Competencies”) Required for Residents to Achieve Generalist Proficiency with BPD

Core competencies (didactic knowledge)	Key targets for didactic learning
DSM-5 diagnostic criteria and their meaning	Symptoms can widely vary but are unified by a coherent phenomenology of interpersonal hypersensitivity (presentation fluctuates predictably according to levels of interpersonal connectedness/threat/aloneness)
Etiology	BPD arises as an interaction between heritable/genetic and environmental/developmental factors
Prognosis	Typical course is symptomatic remission with persistent social and vocational dysfunction, so treatment must emphasize “building a life” outside therapeutic settings Progress within treatment typically follows, and should be evaluated by, a standard timeline and sequence of change that should be actively discussed with patients
Comorbidity	Psychiatric comorbidities are common and most (e.g., MDD, panic disorder, bulimia) should be treated secondarily and can be expected to respond only if BPD improves; those that actively impair thinking or engagement (e.g., mania, substance use, anorexia, ASPD, complex PTSD) warrant primary focus or an alternate treatment approach Medical comorbidities are common, and those which interact with BPD symptoms (e.g., migraines, chronic pain, fibromyalgia, obesity) must be addressed integratively
Proper use and hazards of levels of care	Inpatient/residential/partial hospitalizations are helpful for initiating/restructuring outpatient treatment and containing true suicidality, but prolonged stays create iatrogenic dependency on unsustainable, overly responsive holding environments Recurrent hospitalizations should prompt consultation about viability of the outpatient treatment
Importance of generalist and case-management approach	Less-intensive case management is usually more helpful and efficient than individual psychotherapy, and should be “first-line” before consideration of specialty EBTs
Suicidality and nonsuicidal self-harm	Distinguishing dangerous from non-dangerous self-harm and suicidal from non-suicidal behavior is critical for properly managing risk and utilizing levels of care Acute-on-chronic elevations in suicide risk usually merit brief restabilizing and consultative “stepping up” to higher level of care
Role and liabilities of medications	Polypharmacy should be minimized through stepwise, symptom-targeted treatment (for emotional, impulsive, cognitive-perceptual symptoms)
Role of specialist evidence-based treatments and limitations of treatment	Treatment (and each of its component parts) should be continued only if proven useful Consultation, with possible reduction in treatment intensity or referral to specialty EBTs, is appropriate if expected timeline and benchmarks of change are not met (e.g., self-endangering behaviors persist, alliance remains poor, crises escalate, vocational endeavors are avoided)
ASPD, antisocial personality disorder; BPD, borderline personality disorder; DBT, dialectical behavioral therapy; EBT, evidence-based treatment; GPM, Good Psychiatric Management; MDD, major depressive disorder; MBT, mentalization-based treatment; PTSD, posttraumatic stress disorder; TFP, transference-focused psychotherapy.	

progressive hierarchy and targeted to the typical clinical settings encountered, challenges faced, and skills needed at each level of training.

A MODEL GENERALIST BPD TRAINING CURRICULUM FROM MGH/MCLEAN

In this section, we present a four-year curriculum used at our home program that employs evidence-based generalist treatment as an overarching training frame. The curriculum is progressively threaded through all four years and targets the

proposed core competencies and milestones described in Text Boxes 2 and 3. This model has been introduced and refined progressively over the past two decades with input from many residents and junior and senior faculty. The model follows expert pedagogical consensus about tailoring residency psychotherapy teaching to residents’ developmental progression, beginning with basics of engagement—such as assessment, formulation, alliance building, and goal setting—while reserving the teaching of specific psychotherapeutic techniques and more integrative approaches for senior residents.⁴⁴

Text Box 2
Minimum Clinical Roles and Skills (“Milestones”) Required for Residents to Achieve Generalist Proficiency with BPD

Milestones (clinical roles and skills)	Key targets for supervision
Level 1. Getting started: initial assessment, diagnosis, and engagement (beginning residents)	<ul style="list-style-type: none"> Make/disclose the diagnosis in understandable terms Provide psychoeducation (etiology, prognosis, available treatments) and hope Clarify the primary diagnostic/treatment focus from among psychiatric comorbidities Identify BPD-related medical comorbidities and their interactions with BPD Work toward initial alliance through empathic exploration of symptoms, assigning homework, and setting goals
Level 2. Case-management role in acute inpatient/residential/partial hospital settings (beginning/intermediate residents)	<ul style="list-style-type: none"> Use chain analysis to explore/identify precipitants for hospitalization Enlist patients in actively identifying and addressing outpatient challenges (including any problems with failing treatments) for themselves prior to discharge Monitor/evaluate hospital course and minimize harms of extended stays and polypharmacy Structure effective discharge/stepdown plans, including careful risk assessment to guide patient and outpatient team in future level-of-care decisions
Level 3. Supportive/secondary role within split outpatient treatments (intermediate residents)	<ul style="list-style-type: none"> Effectively manage medications and medical comorbidities interacting with BPD Set limits around use of medications, hospitalization, and somatic interventions (ECT/TMS) when unlikely to help Effectively coordinate with other members of treatment team to manage splits Effectively manage intersession contact Treat the relationship as real/dyadic by learning to share one’s own reaction, “lean into” intense affect, and apologize when indicated Appreciate the added value of group and family treatments
Level 4. Primary clinical responsibility for longitudinal outpatient treatment (intermediate/graduating residents)	<ul style="list-style-type: none"> Establish primary case-management role and working alliance around clearly and jointly defined goals Prioritize generalist case-management role rather than defaulting to begin intensive psychotherapy Deploy individual therapy, groups, family involvement, medications, and other adjuncts in a targeted way, when useful Coherently conceptualize and manage shifting symptoms and presentations over time Tolerate vicissitudes of the relationship to sustain long-term alliance, balancing support with confrontation Preserve consistent emphasis on the importance of “getting a life” outside of treatment Seek consultation, refer to specialty EBTs, and reduce treatment as indicated
Level 5. Advanced integration of specialty EBT approaches with generalist treatment (optional for prospective specialists)	<ul style="list-style-type: none"> Gain proficiency in managing patients who do not progress with generalist treatment and warrant trial of specialty EBTs Develop capacity to fluidly shift approaches in a pragmatic, non-dogmatic manner, as called for by the clinical situation

BPD, borderline personality disorder; DBT, dialectical behavioral therapy; EBT, evidence-based treatment; ECT, electroconvulsive therapy; TMS, transcranial magnetic stimulation.

In keeping with the predominant view that early-to-mid-level trainees learn more easily when a single model is presented, the MGH/McLean program employs Good Psychiatric Management for BPD as an overarching frame.^{36,43} We have had the advantage, and perhaps the bias, of having the developer of GPM (the second author) on our residency training faculty while this training curriculum was developed, in part through his involvement.

Figure 1 provides a year-by-year overview of the MGH/McLean BPD-specific curriculum offerings. Didactics are

structured as a thread of progressively deepening workshops that combine didactic presentations using content from the GPM manual, teaching slides, and videos with interactive discussion targeted to the practice settings and clinical issues that residents encounter during each of the four residency training years. The primary GPM supervisory modality is a weekly small group introduced during the third year conducted by a senior faculty member trained in generalist treatment. In addition, some residents during the second year and beyond receive additional GPM immersion by being paired, by

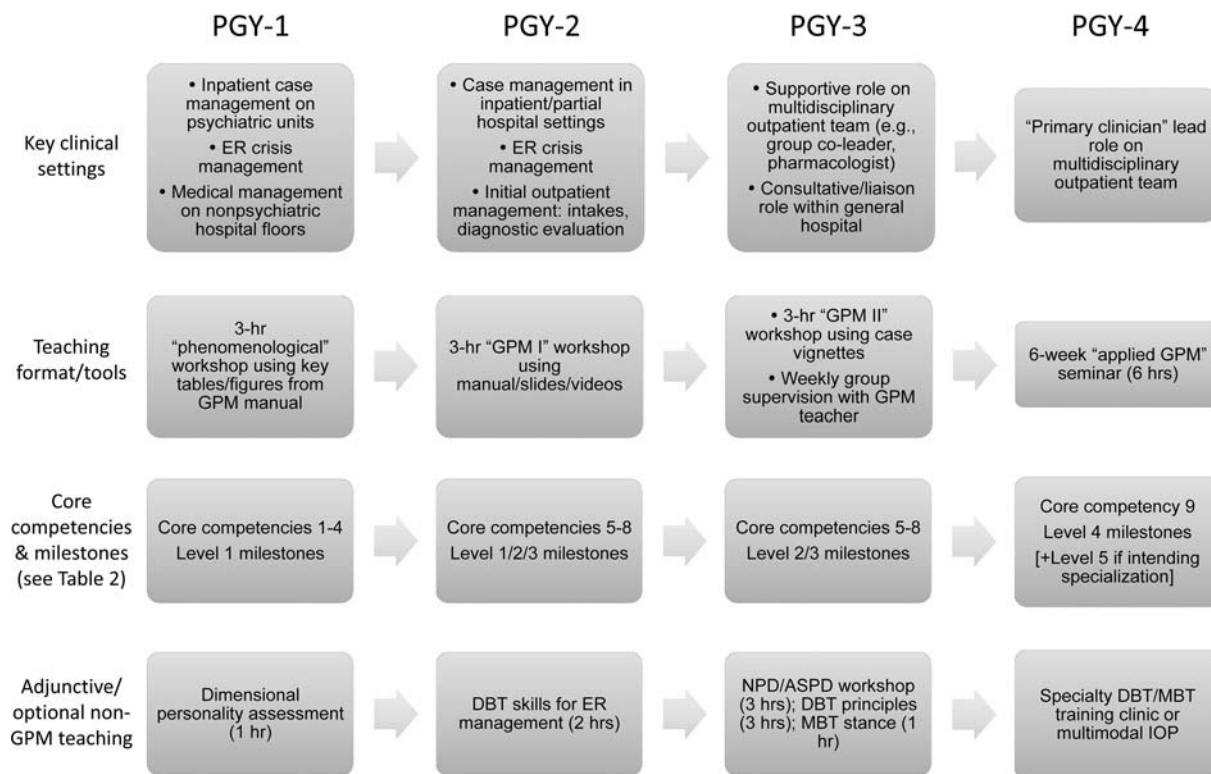


Figure 1. A model BPD generalist training curriculum from the Massachusetts General Hospital/McLean Hospital residency program. ASPD, antisocial personality disorder; BPD, borderline personality disorder; dialectical behavioral therapy; GPM, Good Psychiatric Management; IOP, intensive outpatient program, MBT, mentalization-based treatment; NPD, narcissistic personality disorder.

chance or by request, with individual supervisors employing this framework.

PGY-1

Mental disorders are increasingly understood and taught as primarily biological disorders. While such reductive explanations of psychopathology can increase public acceptance and reduce stigma, they can have the unintended effects—when they predominate over psychosocial explanations—of limiting clinicians' empathy and of strengthening unjustified endorsement of medication over psychotherapy.⁵³ In the case of BPD, ascendant explanations from epigenetic, hormonal, endogenous opioid, and neuropeptide viewpoints might advance its acknowledgment as a major mental illness with unexpected heritable and biological contributions to etiology that might become viable targets for intervention. Such an acknowledgment, however, should not eclipse awareness of the availability and efficacy of psychosocial treatments grounded on personal interactions aimed at helping patients and clinicians make shared sense of overwhelming experiences.

Hence, our BPD training curriculum begins in PGY-1 with an emphasis on learning the core interpersonal phenomenology of BPD as outlined by GPM. This framework helps residents view their very first BPD patients as understandable and even as relatable. Our three-hour "phenomenological workshop" begins by generating a list of questions, topics of interest, and clinical dilemmas from within residents' earliest experiences on inpatient psychiatric units, medical wards, and emergency rooms. This interactive process typically elicits questions related to specific clinical challenges around self-harm and suicidality, the emergency room "frequent flier," and the "non-dischargeable inpatient"—but most of all concerning how to understand BPD patients at a basic level. When myths and aversive attitudes (reflecting those found more generally within psychiatry) get elicited in the discussion, they are reworked through the lens of interpersonal phenomenology into experiences that residents can understand, empathize with, and sensibly explain as they begin to engage patients and families with a psychoeducational stance.

This phenomenological approach follows research indicating that, as compared to a didactic seminar merely teaching content, a workshop focused on eliciting trainees' personal emotional reactions to BPD patients—in order to gain a more nuanced comprehension of, and empathy for, patients' typical experiences—improved trainees' reflective functioning and empathic understanding toward BPD patients.⁵⁴ The key teaching that creates understanding and empathy concerns how symptoms such as idealization, nonsuicidal self-harm, angry devaluation, dissociation, and true suicidality arise as patients progressively move from feeling connected within a supportive relationship, to anxiously preoccupied by threatened or actual separation, to despairing and suicidal in the face of more final withdrawal of support—and aloneness.

Understanding how the diagnostic criteria make sense within this phenomenology is the primary “core competency” emphasized at this level, although etiology, prognosis, and comorbidities are briefly discussed. Making and explaining the diagnosis, providing psychoeducation, and actively exploring symptoms to facilitate shared reflection are the core “Level 1 milestones,” or clinical skills, needed most at this earliest level of training. Finally, basic principles of psychopharmacology and of planning for hospital discharge/stepdown treatment are briefly introduced to augment confidence around the clinical decisions for which PGY-1 residents are typically responsible.

Residents at the end of this seminar typically report increased confidence and interest in working with BPD, even at this early stage, and express eagerness for more BPD-specific teaching in future years.

PGY-2

Our three-hour PGY2 “GPM I” workshop begins by using the GPM teaching slides to expand residents' didactic knowledge base about the etiology, prognosis, and comorbidities of BPD. The highlight for most residents, however, is our use of teaching videos to illustrate techniques of clinical management derived from GPM's phenomenology of interpersonal hypersensitivity for initially engaging patients during the early stages of treatment. What residents most want to learn at this point is how to respond when a newly assigned patient invites or demands intervention, such as by discussing suicide, disclosing cutting, expressing anger, or pleading to be medicated or hospitalized. Specific algorithms are provided for thinking through whether to hospitalize, switch levels of care, or prescribe in these scenarios, and actors model how to effectively interact and share clinical decisions with the patient *in vivo*.

Residents come away with more confidence around how to respond to the issues that generate the most urgency at this level of training, such as how to respond while being angrily devalued and how to distinguish true suicidal intent from the more common issue of self-injurious behavior functioning

to communicate through “action rather than words.” Specific core competencies and milestones addressed at this stage are outlined in Figure 1 and are generally directed toward helping BPD patients settle into beginning outpatient treatment, move toward an initial therapeutic alliance, and access other levels of care when needed.

PGY-3

Core didactics in the third training year continue with another three-hour workshop (“GPM II”) aimed at tools for organizing effective longer-term outpatient treatment. The chief goal is to provide every resident with the minimum core knowledge and skills needed to be effective in deploying portions of multimodal treatments for which they begin to be responsible (see Figure 1). The primary teaching modality in this workshop is group discussion of the case vignettes in the GPM handbook and of why certain clinical decisions are preferred over others from a generalist perspective. The addition of a longitudinal weekly group supervision with a senior generalist instructor provides a forum in which residents get help integrating core didactic knowledge with approaches to case formulation and outpatient treatment planning from this perspective. Here, common difficulties with particular types of presentations (e.g., the angry patient, the somatically preoccupied patient) can be addressed through more individualized teaching.

PGY-4

The fourth year didactics are about performing a more involved, integrative function as the “primary clinician” on a multidisciplinary team delivering multimodal treatments, possibly including psychotherapy of various modalities. A six-session sequence operates as a forum to address the most complex issues of treatment planning for BPD patients—in particular, those involving complex comorbidities and other persistent challenges to effective generalist treatment. Core competencies and milestones at this level (see Figure 1) concern how to respond to these higher-level challenges within a generalist treatment frame, and what to do when that is not sufficient. Highlighted at this level are principles for when to obtain consultation, refer for specialty EBTs, and reduce or end treatments that have become harmful.

For graduating residents who have become interested in longer-term work with BPD, GPM training at this level is easily linked with optional experiences involving specialty EBT training. Our program happens to offer DBT and MBT clinical training tracks in which residents can begin learning specialty manualized treatments. However, programs should not expect all or even most residents to participate in these experiences. These training opportunities are best reserved for the final stage of training so as not to interfere with the consolidation of basic generalist understanding and technique at earlier stages.

CHALLENGES TO IMPLEMENTATION

The public health demand for more broadly accessible BPD treatment mandates the adoption of more clear-cut, top-down guidelines about what and how residents should be taught. We have argued that this need is best met by organizing BPD training around a generalist treatment model rather than the paradigms of classical psychotherapy or specialty EBTs. If the public health significance posed by BPD is to be addressed within psychiatry, it cannot be viewed as the sole domain of a small minority who go on beyond residency training to invest significant time, effort, and money to secure specialty training. Generalist competence with managing BPD in most of its forms must become an end-point of psychiatric residency training in this country.

However, challenges to more widespread dissemination of generalist training paradigms persist at the level of infrastructural, faculty-centered, and resident-centered variables. Text Box 3 summarizes factors that may obstruct effective generalist BPD training and that account for the significant heterogeneity and hobbling of current training approaches described above in Table 1.

Yet, overall, generalist models for BPD treatment and clinical training are on the rise. Currently, implementation of GPM curricula is under way at a variety of residency training sites by educators and program directors with whom we are

corresponding. Input from the growing number of colleagues implementing generalist treatments adds to our understanding of which formats may work best. For example, two residency programs currently implementing GPM have found that a four-session structure delivered during the PGY-2 or PGY-3 years works well, roughly organized around (1) diagnostic disclosure, psychoeducation, and theory of interpersonal hypersensitivity, (2) frame, alliance, and suicide-risk management, (3) comorbidities, pharmacology, and secondary modalities, and (4) interactive case discussion. These implementers are encountering many of the challenges outlined in Text Box 3—but primarily competition with CBT, DBT, and psychodynamic therapies for curricular space and also resistance from faculty wedded to specialty EBT dissemination or a psychoanalytic emphasis. They also describe anecdotally, however, that most residents learning GPM report reduced stress when encountering BPD patients and that residents find GPM easier to learn, whereas specialty EBTs are too much for most residents.

There is growing recognition that core aspects of GPM and other generalist treatments may transmit basic principles for effective psychotherapy and good general psychiatric practice. Some accounts of residents learning specialty EBTs find that residents commend them as tools for learning more general techniques of psychotherapy. In one report, residents

Text Box 3 Challenges to Implementation of Effective Generalist BPD Residency Training

Faculty centered:

- Faculty bias or misinformation about importance, prognosis, or treatability
- Faculty ignorance about effective generalist treatment approaches
- Lack of consensus within faculties and departments about what should be taught
- Confusion over complexity posed by multiplicity of incongruous theories and techniques
- Overvaluation of the role of traditional psychodynamic psychotherapy
- Faculty allegiance or “special interest” around teaching specialty EBTs
- Conflation of specialty EBT adherence with general competence

Resident centered:

- Lack of interest in, or aversion to, the unique challenges and rewards of treating BPD
- Failure to grasp the public health need for generalist treatments to be first-line
- Request to learn the “most popular” or “gold standard” treatments
- Allegiance/idealization toward charismatic faculty members advocating specialty EBTs
- Premature devotion to specialty EBTs before learning generalist theory and technique

Infrastructural:

- Absence of training guidelines (core competencies/milestones) from accreditation bodies
- Absence of informed faculty with time and motivation to oversee curricular integration across all four years
- Lack of ready-made curricular/teaching materials
- Underweighting of allotted curricular time relative to other serious mental illnesses
- Programmatic emphasis of biological explanation and intervention over psychosocial approaches
- Dearth of data comparing outcomes of various residency-training approaches

BPD, borderline personality disorder; EBT, evidence-based treatment.

learning TFP felt more permission than their non-TFP-trained peers to have expectations of their patients, such as getting a job.⁵⁵ Here, too, generalist training models may outperform specialist approaches by offering guidelines for a broader scope of non-psychotherapeutic interventions effective for BPD but potentially also applicable to non-BPD patients with multiple comorbid disorders or areas of symptomatology causing functional impairment. Core generalist treatment features—such as the importance of delivering psychoeducation, holding to an accessible theoretical viewpoint and basic techniques distilled within a compact training manual, emphasizing the need to set goals and benchmarks by which to evaluate progress, and insisting on functional improvement through building a life outside of treatment—may allow residents to more quickly gain competence and confidence in their broader identities as psychiatrists. Most important for the aims of this article, generalist training approaches (such as the model advanced here) best position residency programs to meet the BPD public health demand by equipping every future psychiatrist with the core knowledge and skills required to be a capable treater, planner, and adviser for BPD patients and their families.

On a personal note, the first author feels that immersion in a GPM orientation during his own residency training years provided an invaluable early platform for containing and tolerating his own challenging emotional reactions to working with BPD patients, and for becoming a “good enough” clinician during PGY-3 to begin carrying out the role of primary clinician on multimodal treatment teams. Even as he went on in the years beyond to extend his generalist skill set with training in specialty EBTs and to become a BPD specialist, it was his GPM training during residency that first shaped his enthusiasm for working with BPD patients and confidence that he could be “good enough” for most of them. These consequences can be the boons of adopting a generalist residency training model—for each young psychiatrist in need of a compass to this complex disorder and for each unreached BPD patient in need of competent treaters.

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