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# Teaching Personality Disorders: An Essential Component of Psychiatry Residency Training

Verónica Steiner [1], Anuja Mehta [2], Aurora Döll Gallardo [3, 4], Mark L. Ruffalo [2, 5, 6]

1. Clinical Psychology, Instituto Transference-Focused Psychotherapy (TFP) Hispanoamérica, Santiago, CHL 2. Medicine, University of Central Florida, Orlando, USA 3. Personality Disorders, Hospital Universitario Dr. Rodríguez Lafora, Madrid, ESP 4. Medicine, Universidad Francisco de Vitoria, Madrid, ESP 5. Psychiatry, Tufts University, Boston, USA 6. Psychoanalysis, The New Jersey Institute for Training in Psychoanalysis, Teaneck, USA

**Corresponding author:** Mark L. Ruffalo, mlruffalo@gmail.com

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## Abstract

Personality disorders are common across psychiatric settings yet may receive insufficient attention in residency training. This may contribute to diagnostic error, inappropriate polypharmacy, and failure to recognize clinically meaningful interpersonal patterns and countertransference reactions. We argue that competence in personality pathology should be considered a fundamental component of psychiatric training rather than a subspecialty interest. We propose a tiered educational model in which all residents learn to assess personality organization, understand major evidence-based treatments, and develop generalist competence in the management of personality disorders, while more specialized psychotherapy training remains elective. Psychotherapy education provides an especially valuable setting for learning to recognize defenses, disturbances of identity, recurrent interpersonal patterns, and enduring personality pathology over time. Even as fewer psychiatrists provide formal psychotherapy, training in personality disorders remains important for accurate diagnosis, comprehensive formulation, appropriate treatment selection, and effective referral across psychiatric practice.

**Categories:** Psychiatry, Psychology
**Keywords:** borderline personality disorder, personality disorders, psychiatric diagnosis, psychiatry residency training, psychotherapy education

## Editorial

Consider the following hypothetical case, illustrating a familiar scenario in psychiatry residency training: A resident presents a patient with treatment-resistant depression. Over several years, the patient has received multiple trials of antidepressants, mood stabilizers, and antipsychotics. A course of transcranial magnetic stimulation provided minimal relief. The reported episodes last hours rather than days or weeks, reliably follow perceived rejection, and improve rapidly when attachment is restored. A detailed history reveals chronic dysphoria, an unstable and rapidly shifting self-image, and polarized relationships. The case had already generated diagnostic data of another kind. During a recent inpatient admission, nursing staff had described the patient as “difficult,” and the team disagreed sharply over whether he was “truly depressed” or “attention-seeking.” Privately, the resident dreaded the appointments. These reactions were not incidental but provided important sources of clinical information. The revised formulation situates the patient’s depression in the context of borderline personality disorder (BPD), not a primary mood illness. The medication list is reconsidered, and the patient is referred for intensive psychotherapy. The teaching point is simple: when personality is omitted, diagnosis may be wrong.

We believe that psychiatry training programs should place greater emphasis on the recognition, formulation, and treatment of personality disorders. A survey of U.S. psychiatry residency programs found that fewer than half of responding programs offered a dedicated didactic course on BPD, suggesting that training in this common and clinically consequential condition has been inconsistent [1]. More broadly, personality disorders have been identified as an underemphasized component of psychiatric training, despite their frequent presentation in clinical practice [2]. These disorders are not confined to specialized psychotherapy settings; they are encountered throughout psychiatric practice and frequently mimic other psychiatric syndromes. In a recent study of 526 psychiatric inpatients, 37% were diagnosed with at least one personality disorder [3]. Despite the limited evidence supporting pharmacotherapy for personality pathology, patients with these conditions are frequently exposed to extensive psychotropic polypharmacy [4,5]. Without a working knowledge of personality functioning, residents may mistake chronic dysphoria, affective instability, interpersonal hypersensitivity, impulsivity, aggression, and other manifestations of personality disorder for separate mood, anxiety, or other psychiatric conditions. The consequences may include false comorbidity, unnecessary polypharmacy, repeated attempts to medicate symptoms that are primarily interpersonal or characterological, and failure to recognize countertransference reactions and enactments. Competence in personality disorders is therefore not a subspecialty interest but a fundamental component of sound psychiatric practice.

Personality disorders have long occupied an uneasy position within psychiatry. The Diagnostic and

Statistical Manual of Mental Disorders, Third Edition (DSM-III) multiaxial system placed them on a separate axis in 1980, intending to ensure that personality was not overlooked amid florid Axis I symptomatology; the unintended effect was to segregate it [6]. The fifth edition of DSM [7] abandoned the multiaxial structure in 2013, and the International Classification of Diseases, Eleventh Revision (ICD-11) [8] has since replaced discrete personality categories with a severity-based dimensional model. Although our nosology is evolving, the basic problems represented by personality disorders remain a common and persistent clinical challenge. Even as fewer psychiatrists provide psychotherapy themselves [9], a decline attributable in part to reimbursement structures and in part to shifting training priorities, the case for teaching personality assessment does not weaken; it becomes more urgent. A psychiatrist who never conducts a weekly session still decides what to prescribe, how to diagnose the problem, and where to refer.

We therefore propose a tiered model of training in personality disorders. Although our discussion focuses primarily on psychiatric residency training in the U. S., the competencies outlined here may be adapted to training programs in other countries. First, every resident should be able to assess personality organization as a routine component of psychiatric formulation. One useful approach is Kernberg's model of structural diagnosis, which emphasizes three domains: the coherence and stability of identity, the predominant level of defensive functioning, and the integrity of reality testing [10]. These features can be assessed within an ordinary diagnostic interview and may provide information about severity and treatment needs beyond that captured by diagnostic criteria alone. Although these domains overlap with ICD-11's severity model, they are not identical: identity and reality testing have counterparts in ICD-11 assessment, whereas defensive functioning represents an additional psychodynamic dimension [11]. Second, every resident should understand the major evidence-based treatments for personality disorders, including transference-focused psychotherapy (TFP), dialectical behavior therapy (DBT), and mentalization-based treatment (MBT), well enough to recognize their indications and refer appropriately, even if they do not ultimately practice these treatments themselves [4]. These approaches should be taught with attention to their respective theoretical foundations, clinical methods, and empirical support, without privileging any particular school of psychotherapy. Third, all residents should graduate with generalist competence along the lines of good psychiatric management (GPM), developed by Gunderson specifically for clinicians who are not psychotherapy specialists [12]. More specialized training in a particular modality can then be offered to interested residents as an elective rather than a prerequisite for basic competence.

This necessarily places psychotherapy education within the broader project of teaching personality pathology and is consistent with existing Accreditation Council for Graduate Medical Education (ACGME) requirements for competence in supportive, psychodynamic, and cognitive-behavioral psychotherapies [13]. Residents learn to recognize defenses, patterns of relating, disturbances of identity, and recurrent interpersonal dynamics not only through lectures on diagnosis but also through the close observation of patients over time. Psychotherapy training provides one of the principal settings in which these dimensions of psychopathology become visible. Its value therefore extends beyond preparing residents to conduct formal psychotherapy: it strengthens diagnostic formulation, helps clinicians make sense of countertransference reactions and therapeutic enactments, and improves their ability to distinguish enduring personality pathology from episodic psychiatric syndromes.

The practical challenge is how to provide such training in programs with limited psychotherapy resources, particularly newer, community-based, or rural residencies. Programs need not reproduce the resources of large academic centers to teach these competencies effectively. Partnerships with local universities, psychoanalytic institutes, and experienced therapists in the community, as well as resources available through the American Association of Directors of Psychiatric Residency Training (AADPRT) Psychotherapy Committee, can supplement existing faculty expertise. Where resources permit, specialized psychotherapy tracks can provide additional depth for residents who wish to pursue more advanced study.

At our community-based, university-affiliated program in the southern United States, two of us (A.M. and M.R.) have developed a two-tiered approach to psychotherapy education. All residents receive a core curriculum beginning in postgraduate year (PGY)-1, with two hours of weekly psychotherapy didactics throughout residency. Early instruction includes four sessions each in motivational interviewing and cognitive-behavioral therapy (CBT), followed by teaching in supportive and psychodynamic psychotherapy, family and group therapies, and other approaches. More advanced training includes longitudinal case seminars, clinical supervision, and discussion of psychotherapy process. Residents with a particular interest in psychotherapy may elect a specialized Psychotherapy Track, which provides additional psychotherapy cases, enhanced supervision, monthly meetings devoted to clinical and theoretical topics, and opportunities to study seminal papers and books and attend lectures by invited experts. Track participants also complete a scholarly project, such as a conference presentation or publication. The curriculum allocates approximately four to seven hours weekly to psychotherapy training in PGY-2, 10 hours in PGY-3, and eight to 10 hours in PGY-4, including clinical work and supervision.

Since its inception several years ago, the Psychotherapy Track has become a popular offering among residents, with four receiving certificates in the most recent academic year. Although systematic data on educational outcomes have not yet been collected, the program illustrates how generalist psychotherapy education can be supplemented by more intensive elective training. We are also developing a pathway with a local psychoanalytic institute to provide interested residents with additional training.

The purpose of such efforts is not to suggest that every psychiatrist must become a psychotherapist or train within a particular theoretical tradition. Rather, psychotherapy education offers an especially rich context for learning how personality is expressed across time and relationships. Concepts such as defense, transference, countertransference, identity, interpersonal patterns, and the meanings attached to symptoms remain clinically relevant whether a psychiatrist ultimately conducts weekly psychotherapy, manages medications, works on an inpatient service, or practices consultation-liaison psychiatry. Specialized psychotherapy training should remain optional; competence in recognizing and formulating personality pathology should not.

Teaching personality disorders is therefore not merely one component of psychotherapy education. It is essential to training psychiatrists who can diagnose accurately, formulate comprehensively, avoid unnecessary treatment, and understand psychiatric symptoms within the broader context of the patient's personality and relationships. Psychotherapy education, in turn, provides a valuable means of developing that capacity.

# Additional Information

## Author Contributions

All authors have reviewed the final version to be published and agreed to be accountable for all aspects of the work.

**Concept and design:** Mark L. Ruffalo, Anuja Mehta, Aurora Döll Gallardo, Verónica Steiner

**Acquisition, analysis, or interpretation of data:** Mark L. Ruffalo, Anuja Mehta, Aurora Döll Gallardo, Verónica Steiner

**Drafting of the manuscript:** Mark L. Ruffalo, Anuja Mehta, Aurora Döll Gallardo, Verónica Steiner

**Critical review of the manuscript for important intellectual content:** Mark L. Ruffalo, Anuja Mehta, Aurora Döll Gallardo, Verónica Steiner

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