Evidence-Based Treatments for Borderline Personality Disorder: Implementation, Integration, and Stepped Care

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Learning Objective: After participating in this activity, learners should be better able to:

- Evaluate evidence-based therapies for borderline personality disorder

Abstract: Several manualized psychotherapies for treating borderline personality disorder (BPD) have been validated in randomized, controlled trials. Most of these approaches are highly specialized, offering different formulation of BPD and different mechanisms by which recovery is made possible. Mental health clinicians are challenged by the degree of specialization and clinical resources that these approaches require in their empirically validated adherent forms. While these effective treatments have renewed optimism for the treatment of BPD, clinicians may feel limited in their ability to offer any of them or may integrate an eclectic assortment of features from the different treatments. This article will evaluate four major evidence-based treatments for BPD—dialectical behavioral therapy, mentalization-based treatment, transference-focused psychotherapy, and General Psychiatric Management—and possible modes of implementation in adherent and integrative forms. Models of implementing these diverse treatment approaches will be evaluated, and the potential advantages of combining evidence-based treatments will be discussed, along with some cautionary notes. A proposal for providing stepwise care through assessment of clinical severity will be presented as a means of achieving system-wide changes and greater access to care.

Keywords: borderline personality disorder, dialectical behavioral therapy, General Psychiatric Management, mentalization-based treatment, transference-focused psychotherapy

When the term *borderline* first emerged in the psychiatric literature, it was used to refer to a distinctive group of patients who were neither chronically psychotic nor stably neurotic.[1] The patients on the borderline of these two well-defined groups were notably prone to "negative therapeutic reactions." For much of our field's history, we characterized them as "treatment resistant"—when in truth, our existing treatments were inadequate at best and harmful at worst. The stigmatization of these patients in our field began with this distinction of treatment resistance, causing most clinicians to give up hope for these individuals, rather than scrutinize the treatments that we offered them.

The good news is that researchers over the last two decades have elucidated the diagnosis afflicting these patients at the borderline, now known as borderline personality disorder (BPD). Research has shown that BPD is a prevalent,[2,3] disabling,[4,5] sometimes fatal[6] disorder; it therefore carries significant public health relevance. Longitudinal studies initiated before the proliferation of evidence-based treatments (EBTs) for BPD show that even without intensive or specific treatment, these patients experience high rates of remission in ten years[4,7] (Figure 1). While psychopharmacologic interventions have dominated as the gold standard of treatment for most major mental illnesses, research on the efficacy of medications in managing BPD has yielded mixed and inconsistent results. Related to this lack of robust and definitive data favoring medication, few trials on psychopharmacologic strategies in BPD have been undertaken. To date, there are more articles published out of the CATIE trial[8] (for schizophrenia) and three times as many reports from STAR-D[9] (for depression) than on medications for the treatment of BPD (with ClinicalTrials.gov listing 91 trials as of January 2016).[10,11] While no psychopharmacologic intervention has been shown to have more than moderate efficacy for BPD,[12] over half a

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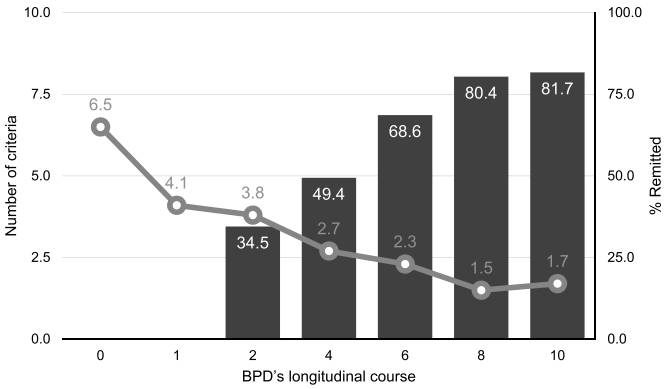

Figure 1. BPD's longitudinal course (in years).

dozen well-organized, manualized psychotherapies have been empirically validated for its treatment,[13] disproving strongly held assumptions that BPD patients are resistant to treatment.

Despite this favorable evidence for considering BPD as a good-prognosis diagnosis, patients with BPD continue to face stigmatization and aversion from generalist clinicians. Under- and misdiagnosis remains common[14,15] because of entrenched clinical practice to "defer" personality disorder diagnoses and also because of pressure to utilize diagnoses believed to be more biologically based and responsive to medications.[16] A separate but equally destructive problem is the limited access to care. The majority of the EBTs for BPD are highly specialized, requiring intensive training and clinical resources. The original trials for many of the EBTs for BPD used treatment-as-usual comparisons, which were neither organized nor coherent modes of treatment. As the methodological standards for comparison conditions in treatment studies became more rigorous, the EBTs went head to head with better-informed, structured clinical-management approaches, including supportive therapy and general clinical management of BPD informed by up-to-date knowledge about the disorder.[17–21] These trials demonstrated that less intensive but well-organized, informed models of BPD care are also effective.[18,20] See Table 1.

Now that many treatment options for BPD are available, both patients and clinicians are left with expanded choices—but with no road map for guiding clinical decisions in managing BPD. Although the EBTs for BPD have multiplied, the demand for BPD services continues to exceed supply. Clinicians specialized in treating BPD have invested in lengthy, time-consuming, and expensive trainings, and encounter more

Table 1

Resource Intensiveness of Evidence-Based Treatments for BPD

	Dialectical behavioral therapy	Mentalization-based treatment	Transference-focused psychotherapy	General Psychiatric Management
Description	Cognitive-behavioral therapy modified with concept of dialectics and technique of validation Skills training on emotion regulation, distress tolerance, interpersonal effectiveness, and mindfulness	Therapist assumes a curious stance of "not knowing," and promotes the capacity to think about oneself and others in terms of meaningful mental states	Psychoanalytically based, promoting integration of split-object representations to stabilize tendencies for unstable relationships and aggression toward self and others	Case-management approach that mixes dynamic and behavioral models, and focuses on interpersonal and situational stressors
Basic or foundational training requirements	Two five-day workshops separated by 6 months of implementation and self-study	Three-day basic workshop	Two three-day workshops One year of supervision	One-day workshop
Cost	$$$$	$$	$$$	$
Clinical face-to-face time	1 hr/week individual 2 hr/week group 24/7 skills coaching	1 hr/week individual 2 hr/week group	2 hr/week individual	1 hr/week individual, but only if patient is responding with symptomatic and functional change
Therapist supervision	2 hr/week group consultation	1 hr/week group consultation	1/week supervision	1.5 hr/week group consultation[a]
Total clinical-resource hours	5+	4	3	2.5

[a] 1.5 hours of group consultation was a formal methodological requirement in McMain (2009)[20] and in Gunderson (2014).[22]

demand than they can meet[23] (Table 1). Insurance companies rarely recognize BPD as a parity diagnosis despite evidence of its good prognosis and response to a variety of psychotherapeutic treatments.[24] This combination of economic factors underpins a clinical milieu in which BPD services are often available only for private pay in the United States. The system of care is most certainly broken if care for BPD—a potentially fatal and yet highly treatable disorder—remains so unevenly distributed and unavailable.

This article will review four major EBTs for BPD, including dialectical behavioral therapy (DBT),[25,26] mentalization-based treatment (MBT),[27,28] transference-focused psychotherapy (TFP),[29] and General (or "Good") Psychiatric Management (GPM).[20] The first three of these treatments are highlighted because they are studied most intensively in the research literature.[13] GPM is a manualized, empirically validated approach that represents a second wave of EBTs for BPD requiring less specialization and clinical resources, and that serves as a new paradigm for less intensive, more available approaches. We will compare their distinctive features and overlaps, and will propose different modes of implementation, ranging from adherent single-model approaches to integrated models of care. A proposal for organizing system-wide stepped-care algorithms[16,30] will be presented as a way to organize our field's approach to BPD to optimize appropriation of clinical resources.

PREVAILING EVIDENCE-BASED TREATMENTS FOR BPD

Dialectical Behavioral Therapy

The most well-known and widely available of the EBTs for BPD is DBT. Marsha Linehan[25] developed DBT based on her clinical experience with highly suicidal patients who did not respond as expected to standard cognitive-behavioral therapy (CBT) interventions. To enhance the efficacy of standard CBT in that group of patients, many of whom had BPD, Linehan integrated the concept of dialectics and the strategy of validation. Dialectics, a philosophical concept spanning back to ancient Greek thinkers and re-popularized by Hegel,[31] refers to historical processes as defined by opposing truths—a thesis and antithesis—that are resolved through synthesis. Linehan's conceptualization of dialectical dilemmas in the phenomenology of BPD captures its pathognomonic black-and-white thinking, relationship problems, and polarities of presentation. In addition, Linehan emphasized the need for validation—in other words, accepting the patient as she is (i.e., affirming the patient's experience and reason for being symptomatic)—as a motivational lever against the imperative to change. CBT's unilateral focus on change can trigger characteristic self-doubt and inadequacy fears in patients with BPD, so the balancing emphasis on validation and acceptance serves as a stabilizing addition in technique.

Similar to all the other EBTs presented here, DBT formulates the problems of the disorder in a transactional model. According to Linehan, individuals born with high emotional sensitivity encounter systems of people (i.e., families, schools, treatment settings, workplaces) who do not perceive, understand, or respond effectively to their vulnerabilities. DBT calls these systems "invalidating environments." The symptoms of BPD emerge from the transactional process between the emotionally sensitive individual and the invalidating environment. Specifically, sensitive individuals are prone to feeling mistreated and misunderstood, and to blame their environment for their distress. The environment responds in a way that leaves the individual feeling unseen and sometimes punished, which for a person with emotional sensitivities easily becomes overwhelming. This emotionally destabilizing process leads to problems of behavioral, cognitive, and interpersonal dysregulation. In addition, these sensitive individuals lack skills to manage their sensitivities and their ineffective responses to their environment. DBT aims to provide structured frameworks for considering what an individual's problems are and how the individual can be more effective in reaching her goals.

The recipe for DBT's success includes a robust empirical body of support and a widely exportable package of treatment materials. To date, over 14 rigorously conducted studies of DBT have been published, demonstrating DBT's efficacy versus treatment as usual,[20,32–37] treatment by community experts,[38,39] and other specialized BPD treatments.[17,40] The DBT manuals,[25,41] which include a voluminous explanatory textbook and a guide to a vast supply of worksheets, are user-friendly, comprehensive, prepackaged systems of treatment immediately employable in any setting by a team of professionals of any discipline or level of experience with the time and energy to read, learn, and apply it. DBT may be especially attractive to less experienced clinicians, who may welcome the structure. DBT's modules—distress tolerance, mindfulness, emotion regulation, and interpersonal effectiveness—widely target the pervasive difficulties faced by individuals with BPD. Linehan postulates that DBT provides the skills that an emotionally sensitive person with BPD needs, but would not otherwise possess, to manage "invalidating" environments (i.e., environments not tailored to understand or accommodate the sensitive individual's special needs).

Behavioral Tech, an independent, nonprofit organization that oversees official trainings of DBT, offers courses internationally that are led by a large cadre of officially sanctioned trainers. Any nonspecialist clinician working in a team environment can learn DBT and use its package of resources to comprehensively and reliably manage the clinical challenges of working with patients with BPD. Of all of the EBTs for BPD, training in DBT appears most widely available.

The major downside of DBT is that it is resource intensive (Table 1). In its standard, empirically validated form, DBT involves (1) weekly hour-long individual therapy, (2) weekly two-hour-long skills-training group therapy, (3) 24/7 paging for skills coaching, and (4) weekly hour-long team consultation for DBT therapists. Altogether, this amounts to a minimum 3–4 hours of treatment per patient per week.

Moreover, for the intensive training in DBT, clinicians attend two five-day trainings six months apart, during which time over 90 items of self-study homework are assigned. Before intensive training starts, participants are asked to read three DBT textbooks amounting to over 1000 pages of reading. Once fully trained, these DBT therapists have completed a comprehensive course of study that has typically rendered them quite specialized in treating BPD.

On face evaluation of the requirements described in the guidelines for the various EBTs for BPD, the investment of time for DBT in training, self-study, team consultation, face-to-face treatment, and intersession availability far exceed any other modality (Table 1). Since DBT predicts the reality of clinician burnout, it uses consultation teams to provide a forum where clinicians support each other in maintaining effectiveness, reducing therapy-interfering behavior, and maintaining core principles of DBT.[42] In a study of the effects of DBT training on burnout, Carmel, Fruzzetti, and Rose[43] found that formal intensive training reduced clinician burnout in a community-based agency in which demand was high and resources low. Of interest, in that study only 9 of the 34 people attending the first week of the two-week intensive-training protocol completed assessments in follow-up, suggesting that many clinicians in such settings change jobs and may not be able to easily complete requirements for the training.

In recognition of the need to understand which portions of the extensive DBT package lend most significantly to its benefits, Linehan[44] has recently published a dismantling study that compares three treatment conditions: (1) standard DBT, complete with the full package of individual skills coaching, skills-training group, consultation team for the therapist, and paging; (2) DBT individual therapy (DBT-I), defined as DBT individual therapy without DBT skills training but with an activity-based support group, and (3) DBT skills training (DBT-S), defined as DBT skills training without individual therapy but with manualized case management ranging from weekly to monthly. The groundbreaking finding is that all variants of DBT yielded significant improvements in suicidality and in reduced use of crisis services. The DBT-S condition showed greater improvement in frequency of self-harm, anxiety, and depression than the DBT-I condition. However, standard DBT did not show significant gains distinguishing it from DBT-S despite the substantial difference in total hours of treatment (average 55.3 hours in standard DBT versus 31.7 hours in DBT-S). These findings challenge previous claims that DBT has to be employed in an extensive, standard format in order to be effective.

DBT's effectiveness is not disputed. What is controversial is whether that much treatment is needed to help patients with BPD recover. Considering the shortage of care for BPD, offering DBT in its standard, empirically validated form is now under scrutiny. Whereas Linehan's component analysis of DBT shows the robust effect with group skills-training alone, Behavioral Tech and its DBT enterprise continue to develop a complex, resource-intensive process of certification for individual therapists. This paradox—evidence that DBT should be pared down even as requirements for individual DBT therapist are being elaborated—represents a tension within the DBT community that potentially limits DBT's feasibility as a standard of care for BPD.

Mentalization-Based Treatment

Around the time that Linehan was first piloting DBT, Peter Fonagy's first report describing BPD in terms of instability in mentalization[45] was published. Drawing from philosophical, neuroscientific, and psychoanalytic concepts, Fonagy redefined the term *mentalization* to stand for the complex capacity that human beings develop to understand the mental activity that underpins social interactions.[46] Robust mentalization enables an individual to conceptualize and manage the array of evolving thoughts, feelings, desires, and intentions that she and another person may have in an interpersonal interaction. Theoretically and empirically anchored in developmental psychology and attachment research, MBT centers on the reciprocal relationship between attachment security and mentalizing capacity.[47,48] Chronically limited or unstable mentalization results in the severe social-cognitive vulnerabilities seen in disorders such as autism and BPD.

Anthony Fonagy and Peter Bateman proposed that individuals with BPD have an unstable capacity to mentalize that is related to their attachment insecurity and disorganization.[49,50] The attachment styles associated with BPD in the research literature include preoccupied, fearful, and disorganized types. When activated, the BPD patient's attachment tendencies are conflicted between need and fear, and burdened by negative attributions to self and other as well as by attachment behaviors that are alternatingly hostile and helpless.[49–51] Subsequently, the mind of the BPD patient goes offline under the pressure of high-intensity affects and confusing interpersonal interactions.[52,53] BPD symptoms occur when a patient stops mentalizing, with the consequence that negative assumptions about oneself and others prevail, unfettered by influences of reality. Impulsivity, paranoia, anger, suicidality, tendencies to idealize or devalue, and efforts to avoid abandonment channel increased intensity and stress onto the attachment system, hyperactivating the attachment and, in turn, the stress-response system. This dynamic effectively perpetuates the instability of a BPD patient's capacity to mentalize.

Bateman and Fonagy designed MBT as a remedy to the instability of attachment and mentalizing in BPD. In particular, MBT centers on techniques aimed to stabilize an individual's capacity to mentalize under stress when attachment is activated.[28] MBT therapists take a curious, rather than knowing, stance to encourage patients to look more closely at the stressful realities at hand, and at what they are thinking and feeling about themselves and others in the midst of interpersonal interactions. The goal is to generate alternative perspectives that are less frightening and more benevolent, and that pave the way for less aggressive, more conciliatory

actions. Similar to DBT, MBT acknowledges the propensity to extreme unbalanced states of mind in BPD. Instead of using dialectics, however, MBT instructs its practitioners to aim for balance between mentalizing polarities: cognitions versus affects, self- versus other-orientation, certainty versus doubt, and automatic assumptions versus more controlled, thoughtful reflection.

Distinctive to MBT is its continuous assessment of both attachment activation and mentalization capacity. MBT practitioners are taught that as therapists, they may potentially hyperactivate the conflicted attachment system of BPD patients with too much warmth and concern. MBT teaches clinicians the need for balance in treating BPD patients: attachment needs to be activated enough to enable mentalization in session but not so much that mentalizing becomes impossible. A second typical iatrogenic problem that MBT warns against is the use of complex interventions (e.g., complicated safety planning or psychodynamic interpretation) when patients are not mentalizing. Such interventions tend to breed a "pretend mode" in which patients may participate in "talking the talk" but in a meaningless way that has no connection to the reality of the patient's experience. In pretend mode, BPD patients are unlikely to make use of complex interventions, whereas the clinician may feel gratified despite the lack of traction or change. MBT clinicians are instructed to reinstate mentalizing as the priority so that the patient can think through symptomatic states and problems for herself, instead of being given prepackaged, canned, intellectualized explanations by her therapist. Insights of particular types are not the goal in MBT; instead, the goal is to enable the patient to have a greater capacity for meaningful, self-generated, and realistic perspectives regarding her own life.

MBT's empirical basis is growing. When Bateman and Fonagy[54] published the outcomes for the randomized, controlled trial of MBT in a partial day hospital program, MBT became the second manualized EBT for BPD. The MBT studies demonstrated that a psychoanalytically oriented, structured therapy for BPD could be effective, thereby redeeming the value of psychodynamic approaches to BPD; in its open-ended, unstructured formats, psychoanalytic treatments had proved to be not only ineffective but often harmful to BPD patients.[55–57] MBT's simple, common-sense approach has been found effective in a public health setting with clinical teams of limited formal therapy training,[58] and has obvious practical advantages over DBT, which, as outlined, requires far more intensive clinical training and resources. MBT requires no homework for either patient or therapists, but rather focuses on stabilizing the capacity to mentalize both in session and out of session. The basic training for MBT is done over one three-day training and is enhanced through ongoing supervision and also an optional practitioner-level course. In the latter, participants bring video of MBT work for review by Bateman, Fonagy, and other course participants to consider areas of MBT implementation and areas of possible enhancement in MBT technique (Table 1).

Like DBT, MBT has been adapted to a variety of different patient populations, including adolescents, families, and mother-infant dyads, and also to the treatment of diagnoses often comorbid with BPD, such as antisocial personality disorder, depression, substance abuse, and eating disorders.[53] Mentalizing is now considered a broad common factor emphasized in all therapeutic approaches[46,53] and is readily integrated into other approaches.[59] Given its wide-ranging applicability and simple common-sense attitude, MBT is a potentially basic psychotherapeutic approach, like CBT, that can be taught to mental health trainees of all disciplines to prepare them for the wide range of clinical profiles encountered in general practice. Additionally, the outpatient trials of MBT, when compared to a structured clinical-management approach, demonstrated faster rates of change for patients with more complex personality pathology.[18]

As mentioned, MBT does not involve a complex package of skills, coaching, homework, or training—which confers both advantages and disadvantages. While it is easier to implement due to its less intensive demands on both patients and therapists, MBT's less intensive structure and less specific content may leave novices floundering with the interpersonal and emotional intensities of patients with complex personality disorders. The empirically tested version of MBT includes a combination of individual and group therapy, as well as a *mentalizing team* that, like the *consultation team* in DBT, helps therapists continue to robustly mentalize the way that they are reacting to patients. MBT's lack of structure and specific content suggests that it may not be ideal for therapists who are inexperienced or anxious, or who have difficulty relating to patients with BPD. It appears better suited for therapists with self-assurance, flexibility, and either experience or robust common sense.

Another major limitation of MBT is its lack of availability. A few MBT training centers exist in connection with the Anna Freud Centre in London. All basic training courses are taught mainly by Anthony Bateman and Peter Fonagy. The McLean Borderline Personality Disorder Training Institute and UCLA Borderline Personality Disorder Initiative have made that training available in the United States. The availability of training opportunities pales in comparison to DBT, however, which radically limits MBT's implementation and expansion.

Transference-Focused Psychotherapy

TFP is a manualized, psychoanalytically oriented psychotherapy based on the conceptualization of *borderline personality organization* introduced by Otto Kernberg in the 1960s. According to Kernberg, a number of severe personality disorders are categorized under the rubric of borderline personality organization, including borderline, histrionic, narcissistic, and antisocial personality disorders.[60] Personality functioning in all these disorders at borderline-level organization can be characterized by the following: identity diffusion (poor sense of self and poor formation of healthy outlets to build

a sense of self); underdeveloped defense mechanisms (e.g., splitting); unstable reality testing, with variable capacities for empathy and tact; aggression (self-, other-directed, or both); and confused internal working models of relationships. BPD results from the combination of temperamental factors, such as propensity for negative affect and low effortful control, and early adverse relational contexts (e.g., separation, neglect, abuse, high household conflict or instability). Like MBT, TFP integrates a wide base of current scientific understandings of affect, attention regulation, and social cognition with psychoanalytic understanding of personality functioning. TFP's major strength is its more well-developed and comprehensive explanations of personality in general—that is, of both normal, mature variants and underdeveloped, pathological variants. For this reason, TFP presents clinicians with a framework relevant to a larger range of personality disturbance than the other EBTs examined here.

The goal of TFP is that patients and therapists discuss both the problematic interpersonal dynamics recurring in the patient's life and the associated intense affects. The individual therapy work is more intensive than with the other EBTs: two individual sessions weekly without group therapy. Within the individual therapy, a safe context is created for the patient and therapist to analyze relational patterns, revealing the patient's internal object relations, both in relationships in the patient's outside life and in interactions with the therapist. The way that the patient's object relations play out with the therapist in the transference are fully examined using techniques of clarification, confrontation, and interpretation, with the goal of helping the patient resolve the splits between good and bad, thereby achieving a more balanced and coherent way of thinking about herself and others.

In a trial comparing TFP, DBT, and supportive therapy, all three therapies showed efficacy in reducing symptoms of depression and anxiety while increasing global functioning and social adjustment.[17] The two specialists treatments, TFP and DBT, reduced suicidality more significantly than supportive therapy. Only TFP significantly reduced irritability as well as verbal and physical assault—which makes sense in view of its unique focus on aggression.[17] Finally, in an analysis of attachment and reflective functioning (a measure of mentalization), only TFP showed significant changes, demonstrating that, beyond symptom reduction, internal changes occurred in the psychology of the subjects.[61]

A major strength of TFP is that its approach to treating personality is more deeply focused on character and less driven by symptoms. This difference is especially important in treating more severe forms of dysfunction, including borderline, narcissistic, and antisocial personality disorders, often with features of other disorders, including schizoidal, avoidant, and obsessive-compulsive. As the only treatment of the four founded on a broader understanding of different types of personality dysfunction, TFP provides an explicit framework for understanding overlaps and divergences between personality diagnoses. This feature of TFP makes for an explicitly more nuanced and complex attitude toward the typical patient who presents with personality disorder features spanning different diagnostic codes. The training is therefore more rigorous and involved, and appears better suited for more experienced clinicians with significant psychodynamic psychotherapy training. Some training programs are now employing TFP as an elective course, with efforts to implement it in the general psychotherapy curriculum.[62] Few supervisors are adequately trained in this sophisticated modality, however, which limits its spread within training settings.[63]

General Psychiatric Management

In the 1970s, John Gunderson reviewed the extant literature on BPD,[64] constructed a reliable diagnostic interview for it,[65] and operationalized his findings into the first set of diagnostic criteria incorporated into the third, 1980 edition of the *Diagnostic and Statistical Manual of Mental Disorders*.[66] He then wrote *Borderline Personality Disorder*,[55] a comprehensive clinical guide that has since become a core textbook on the disorder. About three decades later, Paul Links converted Gunderson's clinical guide into a manualized treatment approach called General Psychiatric Management to serve as a comparison treatment in the largest published outpatient trial of DBT.[20] One of the primary goals of that study, by McMain, Links, and colleagues, was to demonstrate DBT's effectiveness compared to a systematic, well-informed general treatment. The unexpected finding of McMain's trial was that GPM—a less intensive, nonspecialist treatment—proved to be as effective as DBT over 12 months treatment and in 24 months follow-up,[20,40] with fewer dropouts among subjects with higher degrees of Axis I comorbidity.[67] These results conveyed the optimistic message that a treatment by a well-informed generalist, accomplished with less-intensive contact and training, could match the efficacy of the standard, intensive package of DBT.

What distinguishes GPM from the other EBTs presented here is that, while it is psychotherapeutically oriented, its main thrust is not psychotherapy but, instead, "good" psychiatric case management employed by a generalist mental health clinician who knows basics about BPD's course, core symptoms, vulnerabilities, and response to treatments, as derived from both traditional wisdom and current scientific knowledge about the disorder. Weekly therapy is advocated if the patient makes good use of it—that is, if the patient actually shows behavioral, functional, and psychological changes. But weekly contact is not required in this model. A strong emphasis is placed on offering treatment only if it seems to be associated with clinical improvement, thereby militating against dependence on treatments that are either harmful or ineffective.

Gunderson's primary formulation of BPD is that its core is interpersonal hypersensitivity[52] (Figure 2). This model explains the changing phenomenology of BPD symptoms in

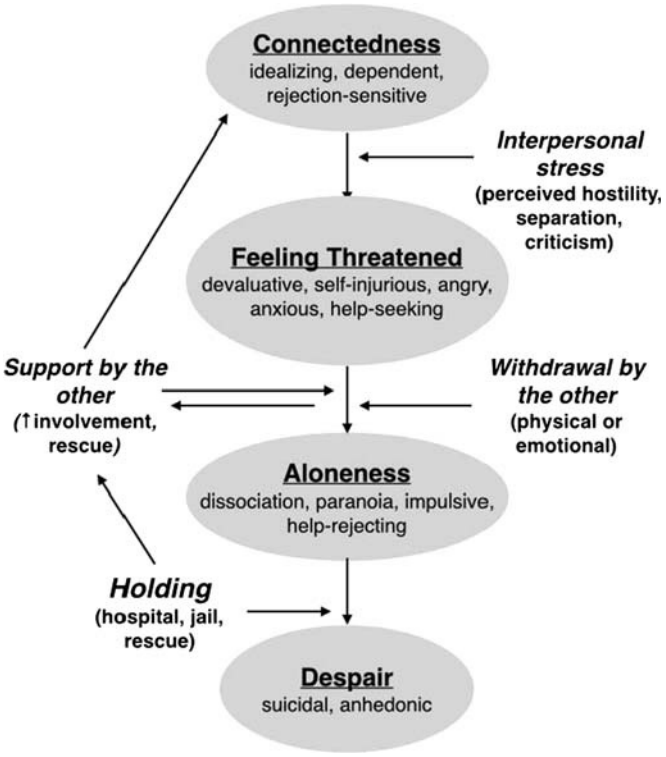

Figure 2. GPM's model of BPD's interpersonal coherence.[52]

terms of interpersonal events. When a patient with BPD is feeling connected to an important relationship, like the one with her clinician, she will present as anxious, help seeking, dependent, and idealizing. Upon real or perceived threat—whether it be abandonment or rejection—the patient becomes angry, devaluing, and self-harming. Usually, this presentation elicits rescue or increased involvement by others, edging the patient back to a "held" state. It can also trigger withdrawal by others, to which the patient responds by becoming more dissociated, unresponsive, and suicidal. A holding environment—which inpatient, residential, intensive outpatient treatments and even jail offer—can restore a BPD patient to a more engaged state (Figure 2).

GPM teaches the clinician to expect these vacillations as part of the illness, rather than to personalize them. The goal is to help the patient understand the vulnerabilities that drive these cycles of instability, so that she can start to think and communicate rather than react. Informed by longitudinal research suggesting that the natural course of the disorder predicts eventual remission, GPM instructs the clinician to remain engaged, interested, and focused on the interpersonal effects that the patient has on the clinician and vice versa. Intersession availability is neither encouraged nor discouraged. When the patient shows improvement with simple contact, the GPM clinician notices that, and casts into doubt whether that is a reliable means of managing one's well-being. If the patient shows excessive reliance on intersession contact, that, too, is examined and collaboratively navigated in a way that aims to help the patient develop increasing awareness and control over her interpersonal hypersensitivity.

A cornerstone of GPM is psychoeducation—a simple, cost-effective means of treatment that can be delivered by any generalist.[68] Clinicians teach patients about their illness, examines the way that their symptoms evolve, and encourages adaptation and planning ahead. Empirically informed management of medication treatment and comorbid disorders is a unique component that is integrated in GPM. In the Gunderson-Links manual on GPM,[22] getting the patient to work as part of treatment—to enhance functioning and self-reliance—is a newer emphasis, not originally incorporated into the empirically validated form studied by McMain.[20,40] GPM's focus on getting a job is consistent with its interpersonal hypersensitivity formulation. Often patients with BPD do not work but become dysregulated in volatile relationships. GPM advises that BPD patients work first, and once they develop a more independent source of self-direction and identity, they are likely to be more stable in the context of relationships. Moreover, GPM's focus on work and functioning also serves to address longitudinal findings that subjects with BPD will largely remit from the disorder's major symptoms but often not change in functional status.[4,7,40]

The GPM manual for BPD is the shortest of the manuals for the EBTs presented here.[22] It is complete with clinical vignettes demonstrating the application of its principles and with online video clips illustrating different technical aspects of treatment. The training course for GPM is available in a one-day format, which is offered at low cost or even free. Studies on the effects of the one-day training have shown a change in clinician attitudes to align with GPM's framework, clinical approach, and purpose, underscoring GPM's potential to address population-level needs pertaining to BPD.[69] In addition, a two-day training is available for trainers of GPM; aimed at faculty at psychiatry residency-training programs, the program for trainers requires participants to teach components of the course live and also to practice mock supervision sessions. GPM presents a reasonable option as a basic standard for care at entry level for BPD. While its superiority to other structured approaches to BPD is not empirically established, it is good enough and already packaged in a published manual and as a training course that are accessible to clinicians in general practice.

GPM's major limitation vis-à-vis the other major EBTs presented here is that its goals and format are less ambitious. The specialists EBTs are, by definition, more detailed and comprehensive, and they aim for deeper mechanistic changes. By contrast, GPM aims to be the treatment of choice for generalists at the front line who can diagnose, manage symptoms and comorbidity, and optimize function in the face of specific interpersonal vulnerabilities. One salient message of GPM is inherently Hippocratic: to do less harm since BPD is a disease that has a high likelihood of eventual remission. This message is paired with the imperative to improve functional living to

optimize quality of life, which is good general psychiatric management for any disorder.

NAVIGATING THE SEA OF OPTIONS: A PROPOSAL FOR SELECTING MODES OF IMPLEMENTATION

The good news about the state of BPD treatments in 2016 is the availability of an abundance of evidence-based options.[13] Despite these multiple possibilities, however, guidelines for finding the optimal fit between EBT, therapist characteristics, patient characteristics, and clinical setting have yet to be published. The age of "horseracing," where different camps vied to demonstrate their superiority to other camps, seems to have largely subsided.[70,71] The growing consensus affirms the aphorism that many roads lead to Rome, and it is likely that the commonalities between the treatments known to work can be distilled into treatments that are less resource intensive and consequently more available.[71,72]

Nevertheless, efforts to define standards for EBTs and to require certification in them for insurance reimbursement threatens the growth of treatment availability for BPD.[73] In particular, the movement to make DBT a single reimbursable standard for treating BPD has mixed implications.[23] While DBT is an effective and clear treatment system with indisputable evidence backing its use, its applicability to all settings, populations, and clinician types is questionable. No treatment presented in this article is well suited to every patient or every practitioner. What likely lends to the efficacy of these treatments is the clarity with which they conceptualize the problems for patients with BPD, the connection between formulation and technique, and the shared language with which clinicians and patients can collaborate in the endeavor of recovery. Among the factors shared by the BPD treatments reviewed here (see Tables 2 to 4), one of the most important is a clearly defined treatment framework that stabilizes the therapeutic work with patients known for their interpersonal, behavioral, and emotional storms.[72] In this context, DBT and its call for strict adherence to empirically validated formats has genuine merit. The science of therapies for BPD confers stability into the therapeutic process, whereas the previous, unstructured treatments that were used were both ineffective and potentially harmful.

We propose a number of ways to think about implementation of EBTs for BPD, ranging from adherence to a single model to informed integration that includes the distillation of common elements. In addition, we will propose a stepped-care model of distributing care according to presentation, as suggested by Paris[16] and by Chanen and Thompson.[30,74] In order to understand, compare, and extract important shared features of the EBTs presented in this article, we refer to Tables 2, 3, and 4, outlining the common components of the various approaches and also the therapeutic stance and core techniques of each particular approach. What follows here is a summary of strategies for implementing effective treatment: single model, integration, and distillation.

Table 2
Treatment Agreements

	Dialectical behavioral therapy	Mentalization-based treatment	Transference-focused psychotherapy	General Psychiatric Management
Goals	Get out of hell Effectiveness Build life worth living	Stabilize mentalizing and attachment functioning	Integrate split object relations Achievement of depressive position (i.e., capacity to tolerate loss of ideal objects)	Self-reliance Work first, then love
Priorities	Suicidality Treatment-interfering behaviors Quality of life–interfering behaviors	Interpersonal affect focus	Transference Split object relations	Focus on interpersonal interactions and effects
Management of suicidality	Diary cards Chain analysis	Chain analysis	Interpretation of motives and distortions	Risk assessment Chain analysis
Paging availability	+++	+	–	++
Crisis plan	Independent skills use, then skills coaching Aim to minimize use of ER	Business hours = mentalizing team on call After hours = ER	Use of ER	Intersession contact algorithm or crisis plan

ER, emergency room.

Table 3
Treatment Components

	Dialectical behavioral therapy	Mentalization-based treatment	Transference-focused psychotherapy	General Psychiatric Management
Case management	++	++	+	+++
Psychoeducation	+	++	+	+++
Group therapy	Essential	Essential	None	Encouraged
Individual therapy	Once weekly	Once weekly	Twice weekly	Once weekly/PRN
Family therapy	Family connections[75]	MBT-Family Multi-family Group Therapy[76,77]	None	Family psychoeducation

MBT, mentalization-based treatment.

Single Model

The simplest, most empirically supported implementation of these treatments is using a single model of care for BPD, with one particular EBT to be used by the entire treatment team. This approach provides the clearest, most coherent framework for the treatment team to deliver unified messages, collaborate, manage differences of opinion, and reduce the detrimental effects of expected disagreements and splitting characteristic of BPD. Since patients with BPD suffer from problems of confusion and unstable representation of their own and others' minds, having a single way of thinking about BPD's problems within a treatment team helps to stabilize the patient.

DBT and MBT have been studied in larger multidisciplinary treatment teams than have TFP and GPM, making them prudent options for inpatient, residential, and intensive outpatient units. DBT's well-developed supply of didactic and skills-application materials lends well toward intensive, longer-term residential treatments, in which patients participate in numerous groups daily (e.g., skills-training, psychoeducational, and interpersonally focused groups), providing structure and supporting interaction. DBT, MBT, and GPM use multiple treatment components, such as family treatment[75–77] and case management (Table 3); these components can enhance usual outpatient levels of care. By contrast, TFP is often employed in private practice, single-clinician settings. Its lack of group, family, and case-management formats lends toward a less intensive treatment package, and yet leaves the patient more likely to be actively symptomatic in the therapy, which tends to generate more robust material for transference analysis in the patient-therapist dyad.

Integration

Given that integration of different EBT models has not been studied, it is proposed with caution. Thoughtful pairings of different models, integrated through clear rationales and case formulations, may prove to enhance treatment for more

Table 4
Therapeutic Stance

	Dialectical behavioral therapy	Mentalization-based treatment	Transference-focused psychotherapy	General Psychiatric Management
Active	+++	+++	+++	+++
Nondefensive humility	Therapy-interfering behavior	Therapist mistakes	Negative transference	Doubt about dependency
Self-disclosure	Reciprocal communication	Alternative perspective	Transference relationship	Interpersonal focus
Support and challenge	Validation Irreverence	Empathy/support Challenge	Clarification Confrontation Interpretation	Support Doubt
Supervision	Consultation team	Mentalizing team	Individual or group supervision	PRN individual or peer supervision

complex patients who have failed single-mode treatments. If the integration of EBTs is eclectic, reactive, and haphazard, however, it may prove to be murky and unmanageable for both patients and clinicians. Of the four EBTs, GPM and MBT most openly invite combination with other treatment approaches.[22,53] One of the authors (LW C-K) has published a report suggesting how MBT can complement DBT therapy.[59] Mentalizing is inherent in all psychotherapeutic approaches, and many elements of DBT already incorporate strategies or techniques similar to those of MBT, including mindfulness (especially beginner's mind), validation, therapist nondefensive humility, self-disclosure, and chain analysis (Table 4).[59] TFP is the most complex and rarified of the four treatments, making simultaneous integration with other models challenging and likely to be undesirable.

Three possible modes of integration are proposed here. One approach is to combine these treatments in a *stepwise progression* using specific EBTs either to target different symptoms or as phases of treatment in sequence. The next approach is *technical eclecticism*, in which a formulation of the patient's problems coupled with structured goals for treatment provides the rationale and focus for which techniques are used, and when. A third approach is a *distillation* model in which clinicians consider features shared by the four EBTs to anchor their work and to develop a stable and productive working alliance with BPD patients.

Stepwise progression The first mode of integrating EBTs for BPD is by stepwise progression. While we do not suggest that patients with BPD rotate through every EBT described here, the first priority would likely be to address the patient's most behaviorally destructive tendencies with DBT if reflective functions are unsteady and under stress. Once the behavioral problems of BPD stabilize (with the consequence that treatment is not repeatedly interrupted by ongoing crises), deeper psychological work regarding emotions related to attachment and interpersonal patterns might be possible. While DBT treatments can then continue with patients as a means of enhancing self-awareness and mastery, it is also possible to switch to a more interpersonally focused modality like TFP. A different approach is to use GPM to manage patients with BPD until they are more organized, accepting, and aware of their problems. Once that occurs, they may be more in a position to profit from a more resource-intensive or specialist psychotherapy like DBT, MBT, or TFP. Finally, after a patient's most serious symptoms have remitted, and after the patient, potentially through rehabilitation, has recovered some functional involvement in the community, GPM offers a low-intensity, low-frequency modality of care. For maintenance, those who graduate from DBT, MBT, or TFP can continue with a GPM clinician monthly or even less frequently.

Technical eclecticism The second method of integrating the four EBTs is through technical eclecticism. This approach is proposed by both Livesley[72,78] and Clarkin[79] in their observation that general principles common to all of these treatments can be employed by clinicians in a way that is tailored to the presentation of the patient and grounded in the presenting symptoms and the problems that she brings into therapy.[72,78,79] The major limitations of the manualized approaches presented here is that none of them is flexible enough to accommodate the heterogeneity of BPD presentations—the complex etiologies plus wide-ranging comorbidities. The advantage of clinical eclecticism is that patients can benefit from broad exposure to the best elements of various manualized treatment approaches, thereby diminishing the problems of a one-size-fits-all mindset. The major challenge is that this process of combining techniques requires both a clear formulation for each patient and a careful effort to choose techniques that advance the desired therapeutic goals. Livesley and Clarkin suggest different means of achieving structure in the midst of this proposed eclecticism. Basic therapeutic tasks common to all organized therapies include assessment, case formulation, treatment structure, monitoring of the therapeutic relationship, and defining phase-specific goals or problems. These fundamental therapeutic tasks help clinicians manage the confusion and reactivity generally arising in the treatment with borderline patients, regardless of which manualized treatment approach is applied. When clear and coherent case formulation, treatment goals, and treatment structure can be established between the patient and the clinician to ground the therapeutic process, any eclectic combination of techniques derived from the specific EBTs can be anchored upon this basic foundation. This broad, though flexible and undogmatic approach, nevertheless requires more advanced knowledge and experience than any of the EBTs discussed here.

Distillation The last of the integrative approaches is distillation of the common factors that are the likely sources of efficacy in the various EBTs for BPD. As mentioned, treatment structure and organization function to stabilize treatment to all of those EBTs. Once clinicians depart from the coherent package of a single manual, they need to establish and maintain structure, predictability, and protocol in order to address predictable concerns—for both patients and clinicians—such as safety, treatment responsibilities, and intersession availability. Against that background, a number of different stylistic and technical common factors can be identified.

The four EBTs for BPD share striking similarities in therapist attitude and focus. All four treatments instruct practitioners to be active and collaborative in discussing problems, to eschew long silences, and to avoid depending too heavily on patients to organize their own discussion of problems. One way in which clinicians are active in all four EBTs is that they adopt a stance of nondefensive humility that allows patients to relate openly using their native interpersonal operations (Table 4). DBT therapists, for instance, will self-disclose their own contributions to therapy-interfering problems, their tendencies to burn out and be ineffective, and the way they use

skills application themselves to solve problems in their own lives. This allows the therapist to normalize and validate the patient's problems by reflecting a genuine sense of personally benefitting from the use of DBT skills. By contrast, MBT therapists are taught to use self-disclosure of their own point of view to enlarge the patient's perspective of an interpersonal situation, thereby illustrating that there are various ways in which interpersonal events can be interpreted, resulting in more productive or less destructive responses by the patient. TFP therapist openly engage themselves in the BPD patient's fluctuating split-object dynamics and communicate their own experience of the relationship (i.e., transference) with the patient, thereby helping the patient to work toward a better understanding and integration of the way she relates to, and conceives of, others. The TFP therapist thus seeks to engage in the more negative forms of transference, which, although intense and challenging, are key to integrating strong emotions and social cognition in the BPD patient. Finally, in GPM, clinicians openly discuss the effect that the patient has on them and vice versa as a means of helping the patient learn about her oscillating ways of depending on, and reacting to, important relationships.

Another form of clinician activity in all four treatments is the balance of support and challenge. Both DBT and MBT incorporate warmth, empathy, and validation before challenging the patient with change-oriented strategies such as irreverence or challenge. TFP employs different levels of questioning, starting supportively with clarification, which constitutes the bulk of interventions, building to and more judiciously employing confrontation and interpretation to push the patients to think more broadly about the contradictions in how they relate to others. Finally, GPM clinicians are taught to be available and supportive, while also expressing skepticism about the patient's level of dependency on the relationship. All of these therapeutic stances and techniques strive for balance, dialectical thinking, and integration.

This sort of distillation of common factors may be too vague and unstructured for the inexperienced clinician but may appeal to the senior clinician. The beauty of the EBTs for BPD is that they provide a coherent framework that clinicians of all stripes can rely on for stability and focus.[79] This stabilizing coherence helps clinicians expect and cope with the interpersonal difficulties so that they can continue not only to tolerate, but also enjoy, their relationships with their patients. Without a stabilizing framework, clinicians can feel blamed, helpless, burdened by responsibility, and insecure—which is probably what fed the previously rampant tendencies to stigmatize patients with BPD and to feel aversion toward them. By the same token, practitioners' interpersonal skills and their stability—that is, their capacity to maintain empathy, communicate their reasoning and intentions, and keep a steady interpersonal connection—determine the quality and impact of that clinical alliance.[80–84] In primary care research, the quality of patient-clinician relationships influences outcomes; it is likely that the strength of the therapies for BPD derives in some substantial part from an organizing framework that allows patient and clinician to develop a stable working alliance.

Of the three modes of integrating treatments, both technical eclecticism and distillation require the clinician to have substantial experience and clinical wisdom in order to synthesize and apply techniques derived from the four EBTs. For the more experienced and specialized clinician, these two integrative approaches may provide the freedom and flexibility required to treat complex patients with heterogeneous presentations. Such synthesis and flexible application of divergent treatment approaches may be beyond the practical capacities of clinicians at the front lines in high-demand, low-resource environments, however, and it is not clear how these integrative approaches would be taught to trainees and administrated in treatment systems that are less specialized.

Given that the four EBTs discussed here are so expensive in their standard form as to be unaffordable by most patients, we need to develop some other way of providing access to the demonstrated benefits of these clinical interventions. Single-model implementation of specialized, resource-intensive EBTs is too expensive to be considered a realistic standard of care, whereas integrative approaches are less clear, require more expertise and experience, and would require intensive training protocols that are still in the earliest stages of discussion and development. We therefore propose a model of stepped care to guide a global approach to locating where patients should generally enter treatment. In an era of scarce care and infrequent recognition of the need to reimburse effective treatments for BPD, a more practical, flexible, and less resource-intensive scale of interventions needs to be outlined for the majority of mental health professionals to be adequately guided in providing the care required.

A PROPOSAL FOR STEPPED CARE

All of the EBTs for BPD presented here have merits and differing contributions to our understanding and treatment of patients with BPD. The three psychotherapies, however—DBT, MBT, and TFP—are intensive and lengthy. All four EBTs also have been empirically validated in yearlong to 18-month formats. In clinical reality, these treatments can take patients in for long cycles, often with lengthy waiting lists. A more organized, scaled, or stepped system of care[16] is needed for broader distribution of clinical resources for this patient group, which suffers high rates of disability and of both medical and psychiatric morbidity.[5,21,85,86]

Both Paris[16] and Chanen and Thompson[30] have cited "Berkson's bias," a tendency (in this situation) for practitioners to see chronic or less treatment-responsive patients, since those who have milder symptoms and more immediate responses to treatment will leave a clinician's caseload. This bias leads the field to assume that all patients with a particular diagnosis (here, BPD) are severe and require intensive intervention, leading to a practice

of therapeutic overkill.[87] No evidence indicates, however, that longer treatments for BPD are superior to shorter ones.[16,88] Additionally, the available evidence suggest that a majority of gains from DBT occur in six months. Stanley and colleagues[89] found that women who participated in a six-month, abbreviated course of DBT experienced significant decreases in self-harm, suicidality, depression, and hopelessness. The study's 95% retention rate underscores the effectiveness of this compressed version of DBT. While the generalizability of these findings remains limited by the lack of a comparison group or follow-up study, the results suggest that studying the three empirically validated psychotherapies in shorter formats will serve the greater public health need.

Length of treatments is one factor that limits the availability of treatment. Linehan's component analysis of DBT[44] suggests that skills training combined with case management yields comparable results to the standard intensive package of DBT. Case-management approaches have been compared to EBTs but represent variable treatment components.[18,20,90] Case management remains an understudied but important clinical approach that might do more to help BPD patients' functions than any manualized psychotherapy alone. This idea is the core of the GPM approach, and both DBT and MBT adapt case-management concerns and strategies into their systems of care. Case management might serve as a container for BPD dysfunction and, like supportive therapies, may help patients with BPD optimally function without an intensive emphasis on deeper psychological exploration and change.[21]

Chanen and Thompson[30] have outlined a clinical-staging approach to managing young patients with evolving mood and BPD symptoms. We adapt that model to propose that initial encounters with patients with high probability of, or vulnerability to, BPD should be focused on psychoeducation and case management— generalized and cost-effective strategies with proven impact[44,68]—but that more-severe cases that either present with high levels of self-destructiveness or have remained unresponsive to lower levels of care should be assigned to the more lengthy, elaborated EBTs discussed here. See Table 5 for a description of the stepped-care algorithm, which requires piloting and further study.

If we can use generalist approaches such as psychoeducation, case management, and supportive treatments as a first line of treatment, many more patients with BPD can be served and likely be helped. Redistributing the bulk of BPD care to the generalist mental health professionals seems to be the first step. Simple evidence-based interventions at lower levels of symptom severity, which presumably occur

Table 5

Stepped Care for BPD Algorithm

Clinical stage	Severity	Definition	Potential interventions
Preclinical	Subthreshold	↑ risk for BPD (e.g., family history, childhood adversity, attachment instability) Mild or nonspecific self-regulation problems Subthreshold BPD: 3–5 criteria + self-harm − suicidality	Psychoeducation for patient and families Focus on supportive counseling and problem solving
Early-mild	1st episode of threshold BPD	+ self-harm − suicidality	GPM Case management DBT skills group
Sustained moderate	Sustained threshold-level symptoms	Unresponsive to basic treatment + self-harm + suicidal gestures	GPM with medication management DBT skills training Single-model EBT (DBT, MBT, or TFP)
Severe	Remitting and relapsing	+ severe self-harm + potentially fatal suicide attempts	GPM-informed medical management Higher level of care (e.g., residential or intensive outpatient) Change single-model EBT *or* integrate EBTs
Chronic persistent	Unremitting disorder Unresponsive to intervention	Unresponsive to interventions from previous stages	GPM Supportive therapy

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

early in the course of illness, are crucial for that to be accomplished. Early detection at preclinical or subthreshhold levels of BPD, where some criteria are met without the more acute problems of self-harm or suicidality, might allow for simpler interventions to help patients and families to curb the likelihood of progression to full-scale BPD. Most generalist clinicians can and should manage these patients early, in these less severe stages. When self-harm combines with the requisite five symptoms to meet diagnostic criteria for BPD for the first time, GPM combined with case management (to allow for ongoing functionality) and a DBT skills group might offer a structured treatment plan that still uses generalist care, led by a psychiatrist to manage medications. Such a plan for the "early mild" stage of BPD would emphasize functionality and building a life, paired with the opportunity for the patient to be among relatable peers in a DBT skills group—and without the major costs involved in standard DBT treatment. Linehan's findings[44] suggests that the simple addition of a skills-training group, which enables a single clinician or pair of clinicians to treat a larger number of patients, can be effective.

When patients recurrently present in crises and meet the threshold level of BPD symptoms, including engagement in self-harm or suicidality, at a "sustained moderate" severity, evidence-based specialist models such as DBT, MBT, and TFP can be offered in time-limited frameworks, where the length of treatment is modeled on what has been found empirically effective in treatment trials. An adherent single-model approach is appropriate to engage at this level, and GPM-informed case and psychopharmacologic management can be added at either this stage of BPD severity or the next. If patients do not respond, and they move to the "severe" stage of BPD, escalating the level of care to residential or partial hospitalization may be indicated. Switching intensive specialist approaches might be tried here, but revolving through the treatments at this stage can be iatrogenic in some cases and beneficial in others.

Finally, when patients are chronic in their presentations—that is, "chronic persistent" per Table 5, demonstrating a lack of treatment response to any of the above—a less intensive and less change-oriented approach using GPM and supportive orientations might be optimal. This different focus eases off resource-intensive modalities that may stress both the patient and clinical team without much yield in clinical improvement. Ongoing assessment for readiness to return to change-oriented treatments can be done, but the goals would be modified to take into account prior experiences. Longitudinal care is essential in organizing a stepwise process that is systematic and comprehensive while also being attentive to the severity, chronicity, and responsiveness to treatment. In this stepped-care model, the expertise of single adherent, integrated, and distilled forms of more specialized, experienced, or expert care can then be preserved for those more complex and severe cases, rather than simply those who can pay the highest price.

CONCLUSION

In this article we have reviewed four of the well-studied EBTs for BPD, compared the intensiveness of their clinical resource and training demands, outlined approaches to implementation, and proposed a model of stepped care. Our goal is to encourage critical and broadminded evaluation of the lessons we have learned from the body of treatment trials for BPD. Now that we know that BPD can have a good prognosis and response to a large range of interventions, it is time to improve systems of allocating care so that "good enough" treatment becomes the new standard for care. More needs to be done to further elucidate the most important ingredients of the treatments that lead to symptomatic reduction. Moreover, the field needs to make a shift away from simple symptom reduction toward greater functionality. The next era of providing the best standard for the largest number of patients should focus on building more generally deliverable, less-intensive treatments that keep patients functional, rather than pouring our limited intellectual, scientific, and clinical resources into enhancing the quality of resource-intensive treatments that most patients cannot even afford.

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