



VIEW POINT

Borderline personality disorder management - a descriptive online survey of indian psychiatrists

Lakshmi Venkatraman¹, Janaki Rajagopalan^{2*}, Ashlesha Bagadia³, Siddhika Ayer⁴ and Jothilakshmi Durairaj¹

¹Department of Psychiatry, Schizophrenia Research Foundation, Chennai, India

²Department of Psychiatry, Promed Hospital and Gleneagles Clinic, Chennai, India

³Department of Psychiatry, The Green Oak Initiative, Bengaluru, India

⁴Department of Psychiatry, Gleneagles Health City, Chennai, India

***Correspondence:**

Janaki Rajagopalan,
janaki.mamc@gmail.com

Received: 21 January 2026; **Accepted:** 04 March 2026; **Published:** xx April 2026

Background: Borderline personality disorder (BPD) is increasingly being recognized in clinical practice in India. This study aims to understand the diagnostic and management practices of psychiatrists in India concerning BPD. We also examined the practice of sharing the diagnosis with patients and caregivers and the factors influencing this.

Methods: The study was conducted as an online cross-sectional survey using a convenience sampling method among practicing psychiatrists across India. A purpose-built online questionnaire was designed and circulated by email and social media groups.

Results: 296 psychiatrists completed the survey. The reported diagnostic and management practices were consistent with the latest guidelines. The psychiatrists felt confident in diagnosing BPD but less confident in managing it. While most of them gained experience in diagnosing and managing the disorder during their training period, they also gained skills and knowledge through other means like continuing medical education events and workshops. The participants of the survey strongly believed in a need for specialized services and more focused practical training in this field.

Conclusions: The discrepancy between confidence in the diagnosis and management of BPD indicates the need for hands-on training in management practices.

Keywords: borderline personality disorder, India, psychiatrist, online survey, diagnosis and management

Introduction

The Diagnostic and Statistical Manual of Mental Disorders the fifth edition (1) describes Borderline personality disorder (BPD) as “a pervasive pattern of instability of interpersonal relationships, self-image, and marked impulsivity, beginning in early adulthood and present in a variety of contexts.” BPD is diagnosed in about 6% of primary care patients (2) and in community-based samples with a prevalence of 15–20% of patients in psychiatric hospitals and outpatient clinics (3).

Despite increased awareness, evidence suggests that a sizable proportion of individuals with BPD remain misdiagnosed, undiagnosed, and under-treated (4, 5). Studies show that persons meeting symptoms of BPD and seeking psychiatric treatment may be diagnosed and treated for Axis I comorbidity alone or are told that they have a disorder other than BPD, such as bipolar disorder (4).

The importance and relevance of disclosing the diagnosis is immense. One study found that when individuals diagnosed with BPD are educated about the disorder and given new coping strategies, the severity of symptoms decreases over 16 weeks (6).



111 There have been few studies investigating the extent to
112 which psychiatrists disclose a diagnosis of BPD to their
113 patients. A study examined how psychiatrists disclosed
114 several psychiatric diagnoses and showed that there was a
115 reluctance to disclose BPD compared to other conditions,
116 such as bipolar, panic, and depressive disorders (7).
117 A study by Clafferty and colleagues (8) compared disclosure
118 practices across several diagnoses and found that 90–98%
119 felt comfortable disclosing unipolar depression, bipolar
120 disorder, anxiety disorder, and substance use disorders.
121 However, only a minority (42%) revealed the diagnosis of
122 personality disorder.

123 Studies on personality disorders have come a long way
124 from justifying their existence in the Indian context (9) to
125 disorders that are acknowledged to be causing significant
126 morbidity (10). However, research into personality disorders
127 in India is still at a nascent stage. In the International
128 Pilot Study of Personality Disorders (IPSPD), the personality
129 disorders frequently seen in the clinical sample in South India
130 were schizotypal (19.1%) and borderline (14.7%) (11). To
131 our knowledge, there are no studies on the diagnostic and
132 management practices for BPD in India as yet.

133 This study aims to understand the BPD diagnostic and
134 management practices and the practice of sharing diagnoses
135 with patients and caregivers by psychiatrists in India,
136 including the factors influencing this.

137 **Material and methods**

138 **Study design and setting**

139 An online cross-sectional descriptive survey was conducted
140 among practicing psychiatrists and psychiatry trainees
141 across India. The data was collected from August
142 to November 2021.

143 **Sample**

144 Practicing and trainee psychiatrists currently working in
145 India were invited to participate and complete the survey
146 after giving online consent.

147 **Questionnaire**

148 A brief survey (version 1) was designed based on a
149 literature review, which was modified (version 2) after
150 discussion amongst the research team. The version 2 survey
151 was piloted with 17 clinicians with expertise in BPD.
152 With their feedback, the survey was further revised and
153 finalized (version 3) for circulation. The survey contained 30
154 items, including demographic details, clinical practice details,

155 borderline personality diagnostic and management practices,
156 and participants' perception of the need for further training.

157 **Study procedure**

158 An email explaining the study and a link to the
159 SurveyMonkey form were sent to psychiatrists across
160 the country using as many forums as possible (e.g., 5,000
161 email addresses from the Indian Psychiatric Society (IPS)
162 Directory, psychiatrists registered in a Google group, and
163 reaching out to psychiatrists through various social media
164 groups). All the members listed in the directory were sent the
165 survey along with subsequent reminders. Weekly reminders
166 were sent for 4 weeks, inviting participants to participate in
167 the research. The participants were also requested to share
168 the survey link with their contacts to maximize reach.

169 **Consent for the study**

170 The online survey form had a face sheet providing the study
171 description, confidentiality, and the right to withdraw. The
172 participants were asked to 'click-if-you-agree' to participate
173 before completing the survey.

174 The Survey Monkey account was password protected,
175 and data was extracted and stored on password-protected
176 computers, and data access was available only to the research
177 team. SurveyMonkey also did not allow duplicate entries
178 thereby reducing the risk of this affecting the data.

179 The study was approved by the Institutional Ethics
180 Committee. The study was approved by the Institutional
181 Ethics Committee of Schizophrenia Research Foundation
182 (India) with ethics approval number: SRF-CR/12/JUL-2021.

183 **Statistical analysis**

184 Demographic data was analyzed using descriptive statistics,
185 including the mean with standard deviation (SD) for
186 continuous variables and frequencies and percentages for
187 categorical variables. The chi-square test was performed
188 to determine the association between categorical variables
189 and the outcome (e.g., sharing a diagnosis with persons:
190 Yes vs. No groups). Continuous variables were compared
191 across the groups using an independent t-test. Data was
192 analyzed using STATA version 16.1 software (12).

193 **Report writing**

194 We used the STROBE checklist (13) when writing our report.

Results

A total of 302 participants completed the online survey. Six responses were excluded as the participants were not currently practicing in India.

Table 1 describes the demographic and clinical practice details of the participants.

The respondents had a mean age of 40.93 ± 10.56 with a slight male preponderance (54.7% male), with 13.97 ± 10.53 years being the mean duration of clinical practice. Only 6.1% were trainees, and the rest were all practicing psychiatrists. As seen in the figure (see supplementary material), many participants were from the states of Tamil Nadu, Karnataka, Kerala, and Maharashtra, which are in the southern half of India.

Current borderline personality disorder diagnostic and management practices

The psychiatrists reported using clinical history from the person or the family or both as the most common way of arriving at a diagnosis of BPD. One-third of the psychiatrists

TABLE 1 | Participant demographics and clinical practice details.

	N = 296
Age mean \pm SD	40.93 \pm 10.56
Gender n (%)	
Male	162 (54.7)
Female	133 (44.9)
Prefer not to say	1 (0.3)
Work status	
Trainee in psychiatry n (%)	18 (6.1)
Practicing psychiatrist n (%)	278 (93.9)
Qualifications n (%)	
MD	198 (66.9)
DPM	35 (11.8)
DNB	37 (12.5)
Foreign qualifications	8 (2.7)
Trainee in psychiatry	18 (6.1)
Duration of experience in years mean \pm SD	13.97 \pm 10.53
Percentage of borderline personality disorder (BPD) in the caseload reported by the participants	13.4 \pm 24.5
Practice setting - rural vs urban	
Rural	5.7%
Urban	76%
Both	18%
Type of clinical practice	
Teaching	126 (42.6%)
Non-teaching	170 (57.4%)

TABLE 2 | Diagnosis sharing practice.

Timing of sharing diagnosis	N (%)
In the first visit	44 (15)
After a few visits	180 (61.4)
After psychometric tests	63 (21.5)
Sharing diagnosis with families	
Mostly	212 (72.1%)
Sometimes	59 (20.1%)
Rarely/never	23 (7.8%)
Sharing diagnosis with persons with BPD	
Mostly	164 (56.4%)
Sometimes	98 (33.7%)
Rarely/never	29 (10%)

also use psychometric testing to help diagnose BPD. The psychiatrists mostly shared the diagnosis with the persons and their families after a few visits, and they shared the diagnosis almost equally with persons and families, as seen in **Table 2**.

Reasons for sharing/not sharing diagnosis

The commonest reasons reported by the participants for sharing the diagnosis with persons and families are for families to support persons better (255/296), explain the need for follow-up and long-term treatment (243/296), help persons understand what is happening to them (237), discuss management (227), and for medicolegal reasons (67).

The three most commonly cited reasons for psychiatrists not sharing diagnoses in descending order of frequency are uncertainty about diagnosis (119/296), worry about misuse of diagnosis by persons with BPD and families (80/296), and stigma (64/296).

Management practice

Medications (86.1%) and psychological therapies (86.8%) are the most commonly used treatment options, followed by the respondents. Psychiatrists provide self-harm management (73.3%) and crisis management (70.9%). Inpatient treatment (27.7%) and referral to other practitioners (8.8%) are the other management practices adopted by the psychiatrists.

Therapies

Psychiatrists have various options to choose from for therapies like supportive psychotherapy (n = 189; 63.9%), dialectical behavior therapy (DBT) (n = 177; 59.8%),

cognitive behavior therapy (CBT) (n = 133; 44.9%), and family therapy (n = 126; 42.6%). Eclectic therapy (n = 87; 29.3%), mentalization based therapy (MBT) (n = 41; 13.9%) and psychodynamic psychotherapy (n = 41; 13.9%) are also available. Just under 50% of the participants (n = 143) reported that therapies were delivered by both themselves and the psychologists. Other respondents either delivered therapy themselves (n = 61; 20.6%) or referred to a psychologist (n = 85; 28.7%) for therapy.

Confidence level of psychiatrists in diagnosing and management of BPD

The psychiatrists who completed the survey were more confident in diagnosing BPD compared to managing BPD, as shown in [Table 3](#).

Challenges encountered by psychiatrists when managing persons with BPD that affect their diagnostic and management practice included dysfunctional coping (72%), self-harm (69.6%), family conflicts (67.6%), countertransference (48%), and mistrust (42.9%). The other less reported challenges include idealization (23.6%), splitting staff (25%), devaluing people (29.4%), and trauma (26.4%).

Expectations regarding future for borderline personality disorder services and training

Many respondents (88.5%) felt the need for specialized services for managing persons with BPD.

The experience that the respondents gained in diagnosing and managing BPD was reported to be mainly during postgraduate training (68.2%) and through clinical experience (81.8%). Conferences (30.7%), workshops (21.3%), and continuing medical education programs (36.1%) were the other sources of training. The participants

TABLE 3 | Confidence level of psychiatrists in diagnosing and management of BPD.

Extent of confidence	N (%)
Confidence in diagnosing BPD	
Extremely/very	192 (65.5)
Somewhat	91 (31.1)
Not confident	10 (3.4%)
Confidence in managing BPD	
Extremely/very	85 (29%)
Somewhat	136 (46.4%)
Not confident	72 (24.6%)

preferred future training to be practical, of whom 74.7% reported wanting practical workshops and 60.1% wanted more hands-on practical training during postgraduation. Participants also wanted more case discussion forums, training programs in specific therapies for BPD, and continuing medical education lectures on BPD management.

As shown in [Table 4](#), psychiatrists who reported sharing the diagnosis tended to report greater perceived helpfulness of disclosure and higher confidence in diagnosing and managing BPD ($p < 0.001$). Other characteristics such as age, gender, years of practice, and proportion of BPD cases in clinical practice did not show meaningful differences between the groups.

Discussion

To the best of our knowledge, this is the first study in India to explore the diagnostic and management practices of psychiatrists for BPD. While there are reservations about using online surveys (14), this was the best way to reach out to psychiatrists in different parts of the country, given the limitations of having a contact list for all the psychiatrists in the country in one place. Further restrictions were posed by the COVID-19 pandemic, rendering postal services unreliable for the study.

The clinical practice guidelines (15) advise using structured interviews or assessment scales to diagnose personality disorders. Our study shows that around one-third of psychiatrists use psychometric tests to diagnose, while the remaining rely on clinical history from the patient and their family. The guidelines also say that psychotherapeutic options should be at the center of the management of patients with BPD. Our survey shows that psychiatrists do use psychotherapeutic modalities themselves or practice collaboratively by referral to psychologists. Because most respondents were from an urban background, access to resources like psychologists might have been better. MBT and psychodynamic psychotherapy are reported to be used less commonly compared to other therapies like DBT. The lesser use of the above therapies might be due to the non-availability of certified professionals, lack of training, and cost and time involved in training and delivering the interventions. Uptake of therapies, even if available, might also have been a challenge.

The report of the use of medications in persons with BPD appears relatively high. The reasons for the higher use of medications will need to be explored through further studies to understand the reasons behind this. They could be addressed through specific training in BPD assessment and management.

While the clinicians appear to be very confident in diagnosing BPD, the confidence seems to be less in managing the disorder. The clinicians who participated in the study reported that their main training in BPD was during the

TABLE 4 | Association and mean comparison between the share diagnosis groups (yes/no) and independent variables.

Variables	Share diagnosis with patient		p-value
	Yes N (%)	No N (%)	
Gender			
Male	138 (55.4)	13 (46.4)	0.365
Female	111 (44.6)	15 (53.6)	
Psychiatrist category			
Trainee in psychiatry	14 (5.3)	5 (17.2)	0.03
Practicing psychiatrist	248 (94.7)	24 (82.8)	
Location of practice			
Rural	15 (5.7)	2 (6.9)	0.641
Urban	201 (76.7)	20 (69)	
Both	46 (17.6)	7 (24.1)	
Timing of diagnosis sharing			
In the first visit	41 (15.8)	3 (10.3)	<0.001
After a few visits	164 (63.1)	13 (44.8)	
After psychometric tests	55 (21.2)	7 (24.1)	
Never	0 (0)	6 (20.7)	
Perceived need for specialized BPD services			
Yes	234 (90)	24 (82.8)	<0.001
No	26 (10)	5 (17.2)	
Practice of sharing diagnosis with families			
Mostly	198 (75.6)	13 (44.8)	<0.001
Sometimes	55 (21)	3 (10.3)	
Rarely/never	9 (3.4)	13 (44.8)	
Practice of sharing diagnosis with patients			
Mostly	164 (62.6)	0 (0)	<0.001
Sometimes	98 (37.4)	0 (0)	
Rarely/never	0 (0)	29 (100)	
Perceived helpfulness in sharing diagnosis			
Extremely/very	163 (62.2)	7 (24.1)	<0.001
Somewhat	89 (34)	9 (31)	
Not so/	10 (3.8)	13 (44.8)	
Confidence in BPD diagnosis			
Extremely/very	180 (69.2)	10 (34.5)	<0.001
Somewhat	73 (28.1)	16 (55.2)	
Not so/	7 (2.7)	3 (10.3)	
Confidence in managing BPD			
Extremely/very	83 (31.9)	2 (6.9)	<0.001
Somewhat	125 (48.1)	7 (24.1)	
Not so/	52 (20)	20 (69)	
	Mean ± SD	Mean ± SD	
Age	41.1 ± 10.3	38.1 ± 10.6	0.143
Number of years of practice as a psychiatrist	14 ± 10.2	12.5 ± 12.2	0.468
Reported average number of patients of all diagnosis	292.2 ± 573.2	252.9 ± 291.6	0.721
Reported average number of patients with BPD	12.7 ± 18.8	8.8 ± 12.1	0.279
Proportion of BPD in percentage (BPD caseload/all diagnosis caseload*100)	13.4 ± 24.2	14.9 ± 29.4	0.768

Note: p-values indicate statistical significance. Results were significant at $p < 0.001$.

psychiatry residency period. As postgraduate trainees report less adequate training and supervision in BPD (16), this might be why the confidence level in management could be lower in the study respondents.

The Clinical Practice Guidelines for Assessment and Management of Patients with BPD (15) also recommends that sharing a diagnosis is important for a therapeutic relationship and to support psychoeducation. With collaborative decision-making and a patient-participatory approach to treatment being recognized as necessary, the findings of our study indicate that psychiatrists in India are sharing diagnoses with their patients most of the time in keeping with the guidelines. Psychiatrists who are more confident in diagnosing and managing BPD and when they perceive the sharing to be helpful are more likely to share the diagnosis with patients. Clafferty et al. (8) found the rate of disclosure of personality disorder as a diagnosis was 42% as compared to 90-98% of other Axis 1 psychiatric illnesses. Studies done by McDonald-Scott in 1992 (7) reported that 55% of American psychiatrists and 16% of Japanese psychiatrists would inform patients of a BPD diagnosis. The disclosure rates in our study are similar to those of American psychiatrists (56.4%).

The significant reasons indicated as to why the diagnosis could not be shared were uncertainty about the diagnosis, stigma, and worry about misuse of the diagnosis by persons with BPD and their families. A survey of 134 psychiatrists conducted in the US (2) found that uncertainty about diagnostic validity and stigma were the two leading causes of not disclosing or documenting a diagnosis of BPD. A review of literature by Lequesne et al. (17) done in 2003 reported that uncertainty regarding the validity of the BPD diagnosis, the feeling that the diagnosis is too negative to divulge (stigma), and worries that such a diagnosis would have deleterious effects on the patient's health and morale were major reasons for not disclosing the diagnosis. While the factors cited by psychiatrists in our study are not dissimilar to other studies, the unique factor of worry about misuse of diagnosis by families is reflective of the cultural aspects of medical care in India.

The surveyed psychiatrists are seeking increased emphasis on practical hands-on workshops aimed at the diagnosis and management of BPD in the future. Masland et al. (18) found that even a 1-day training event on general psychiatric management changed the attitude of clinicians towards BPD.

While many surveyed psychiatrists expressed a demand for specialized services to handle BPD cases, the small number of respondents necessitates further surveys among psychiatrists and psychiatric trainees to know if this need is widely felt.

Limitations

Key limitations of the study include reliance on self-reported data from the participating psychiatrists, a primarily

551 regional focus on the southern states leading to issues
 552 with generalizability to the whole of India, and a potential
 553 selection bias due to the respondents' urban background
 554 and their interest in BPD, which may explain the high
 555 level of confidence and access to therapies. The authors
 556 acknowledge that a study of this nature requires multiple
 557 sources of contact, which introduces these biases. Responses
 558 may be indicative of people who are more confident with
 559 BPD thereby adding to the bias.

560
 561

562 Conclusions

563
 564

565 This study contributes to the BPD research about Indian
 566 psychiatrist practices in diagnosis and management. The
 567 discrepancy in the confidence level of diagnosing and
 568 managing BPD can be bridged by conducting good
 569 quality practical hands-on workshops focussed on the
 570 management of BPD for trainees and practising psychiatrists.
 571 Practical workshops will ensure that psychiatrists are able
 572 to provide good quality care to persons with BPD. As
 573 the responses predominantly reflect practices in South
 574 India, further studies are required to determine whether
 575 patterns are similar in other parts of India. Future research
 576 should also explore patient perspectives on diagnosis and
 577 management practices.

578
 579

580 Data availability

581
 582

583 The data supporting the findings of this study are available
 584 from the corresponding author upon reasonable request.

585
 586

587 Ethics statement

588
 589

590 SRF-CR/12/JUL-2021

591
 592

593 Author contributions

594
 595

596 All authors have contributed significantly to this work.

597
 598

599 Consent to participate and publish

600
 601

602 Obtained electronically from all participants.

603
 604

605 Funding

606
 607

608 This research received no specific grant from any funding
 609 agency in the public, commercial, or not-for-profit sectors.

Acknowledgments

606

607 The authors thank all the experts and participants of the pilot
 608 and main survey.

609
 610

611 Conflict of interest

612

613 The authors declare that the research was conducted in the
 614 absence of any commercial or financial relationships that
 615 could be construed as a potential conflict of interest.

616
 617

618 AI declaration

619

620 Grammarly was used solely for spelling and grammar checks.
 621 The authors take full responsibility for the content.

622
 623

624 References

625

- 626 1. American Psychiatric Association. *Diagnostic and Statistical Manual of*
 627 *Mental Disorders*. American Psychiatric Association Publishing (2022).
 628 doi: 10.1176/appi.books.9780890425787
- 629 2. Gross R, Olfson M, Gameroff M, Shea S, Feder A, Fuentes M, et al.
 630 Borderline personality disorder in primary care. *Arch Intern Med.* (2002)
 631 162(1):53–60. doi: 10.1001/archinte.162.1.53
- 632 3. McLean Hospital, Sisti D, Segal AG, Siegel AM, Johnson R, Gunderson
 633 J. Brief report diagnosing, disclosing, and documenting borderline
 634 personality disorder: a survey of psychiatrists' practices. *J Person*
 635 *Disorders.* (2015) 71(1):26–31.
- 636 4. Zimmerman M, Ruggero CJ, Chelminski I, Young D. Psychiatric
 637 diagnoses in patients previously overdiagnosed with bipolar
 638 disorder. *J Clin Psychiatry.* (2010) 71(1):26–31. doi: 10.4088/JCP.08m
 639 04633
- 640 5. Zimmerman M, Mattia JI. Differences between clinical and research
 641 practices in diagnosing borderline personality disorder. *Am J Psychiatry.*
 642 (1999) 156(10):1570–4. doi: 10.1176/ajp.156.10.1570
- 643 6. Zanarini MC, Frankenburg FR. A preliminary, randomized trial of
 644 psychoeducation for women with borderline personality disorder. *J*
 645 *Person Disorders.* (2008) 22(3):284–90.
- 646 7. McDonald-Scott P, Machizawa S, Satoh H. Diagnostic disclosure: a tale
 647 in two cultures. *Psychol Med.* (1992).
- 648 8. Clafferty RA, McCabe E, Brown KW. Conspiracy of silence? Telling
 649 patients with schizophrenia their diagnosis. *Psychiatr Bull.* (2001)
 650 25(9):336–9. doi: 10.1192/pb.25.9.336
- 651 9. Pinto C, Dhavale HS, Nair S, Patil B, Dewan M. Borderline personality
 652 disorder exists in India. *J Nerv Ment Dis.* (2000) 188(6):386–8. doi:
 653 10.1097/00005053-200006000-00012
- 654 10. Choudhary S, Gupta R. Culture and borderline personality disorder
 655 in India. *Front Psychol.* (2020) 11:714. doi: 10.3389/fpsyg.2020.0
 656 0714
- 657 11. Loranger AW, Janca A, Sartorius N, World Health Organization.
 658 *Assessment and Diagnosis of Personality Disorders: The ICD-10*
 659 *International Personality Disorder Examination (IPDE)/edited by*
 660 *Armand W. Loranger, Aleksandar Janca and Norman Sartorius.*
 Cambridge: Cambridge University (1997).
- 661 12. StataCorp. *Stata Statistical Software: Release 16*. College Station, TX:
 662 StataCorp LLC (2020).

- 661 13. von Elm E, Altman DG, Egger M, Pocock SJ, Gøtzsche PC,
662 Vandenbroucke JP, et al. The strengthening the reporting of
663 observational studies in epidemiology (STROBE) statement: guidelines
664 for reporting observational studies. *Lancet*. (2007) 370(9596):1453–7.
665 doi: 10.1016/S0140-6736(07)61602-X
666
- 667 14. Andrade C. The limitations of online surveys. *Indian J Psychol Med*.
668 (2020) 42(6):575–6. doi: 10.1177/0253717620957496
669
- 670 15. Sharan P, Das N, Hans G. Clinical practice guidelines for assessment
671 and management of patients with borderline personality disorder.
672 *Indian J Psychiatry*. (2023) 65(2):221–37. doi: 10.4103/indianjpsychiatry.
673 indianjpsychiatry_495_22
674
- 675 16. Nithianandan M, Heidari P, Broadbear J, Rao S. Confidence of psychiatry
676 trainees in meeting the needs of borderline personality disorder in
677 comparison with schizophrenia. *Australas Psychiatry*. (2021) 29(6):690–
678 4. doi: 10.1177/1039856221992650
679
- 680 17. Lequesne ER, Hersh RG. Disclosure of a diagnosis of borderline
681 personality disorder. *J Psychiatr Pract*. (2004) 10(3):170–6. doi:
682 10.1097/00131746-200405000-00005
683
- 684 18. Masland SR, Price D, MacDonald J, Finch E, Gunderson J, Choi-Kain
685 L. Enduring effects of one-day training in good psychiatric management
686 on clinician attitudes about borderline personality disorder. *J Nerv Ment
687 Dis*. (2018) 206(11):865–9. doi: 10.1097/NMD.0000000000000893
688
- 689
- 690
- 691
- 692
- 693
- 694
- 695
- 696
- 697
- 698
- 699
- 700
- 701
- 702
- 703
- 704
- 705
- 706
- 707
- 708
- 709
- 710
- 711
- 712
- 713
- 714
- 715
- 716
- 717
- 718
- 719
- 720
- 721
- 722
- 723
- 724
- 725
- 726
- 727
- 728
- 729
- 730
- 731
- 732
- 733
- 734
- 735
- 736
- 737
- 738
- 739
- 740
- 741
- 742
- 743
- 744
- 745
- 746
- 747
- 748
- 749
- 750
- 751
- 752
- 753
- 754
- 755
- 756
- 757
- 758
- 759
- 760
- 761
- 762
- 763
- 764
- 765
- 766
- 767
- 768
- 769
- 770