ANNALS OF CLINICAL PSYCHIATRY 2021;33(4):217-218 doi: 10.12788/acp.0043

GUEST EDITORIAL

Psychotherapy for personality disorders is underfunded

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Imagine there are evidence-based treatments for COVID-19 that nearly all clinicians agreed are safe, effective, and free of adverse effects. Imagine further that physicians choose not to diagnose COVID-19 because of stigma, that the treatments are poorly distributed, and that insurers—by and large—will not pay for their use. Most health care workers, members of the general public, and COVID-19 sufferers would march in the streets demanding action.

Yet, substitute "personality disorder" for COVID-19, and that's where we are: a disorder clinicians prefer not to diagnose that responds well to treatments not generally available, and for which insurers will not reimburse. Why does this situation exist, and how can it be allowed to continue?

The facts are clear: personality disorder are common in community and clinic settings. With borderline personality disorder (BPD) specifically, prevalence in the community is approximately 2%, and in clinics approximately 10% to 12%.[1,2] Not surprising, personality disorders often go unrecognized and undiagnosed, particularly when clinicians focus on the patient's comorbid depression or anxiety. Much of this has to do with stigma, because these patients are often viewed negatively by patients, the public, and even by mental health professionals. A recent survey of more than 700 clinicians found that 47% preferred not to care for patients with BPD.[3] While stigma may help explain the situation, it is never an excuse.

The facts are also clear about treatment. Specialized forms of psychotherapy are considered the treatment of choice by both researchers and expert clinicians, and the data are especially strong for BPD, for which meta-analyses support several programs.[4,5] Psychotherapy is also cost-effective.[6,7]

There is convincing evidence supporting treatment programs for BPD, including dialectical behavior therapy (DBT), mentalization-based treatment, general psychiatric management, and transference-focused psychotherapy.[8,9] Most therapies last for 1 year or longer, and are

expensive. An exception is systems training for emotional predictability and problem solving (STEPPS), which was developed for BPD in a 20-week format and is relatively inexpensive in terms of training and delivery.[10] There have been efforts to reduce the length of therapy. For example, DBT has been shown to be equally effective if offered for 6 months instead of 12 months.[11] An even shorter version, lasting 3 months, has been supported by effectiveness data.[12] Briefer options can be offered to patients as part of a stepped care program. With stepped care, most BPD patients would receive a briefer treatment, with longer therapies reserved for those who do not respond.[13]

Despite professional consensus of their value, psychotherapies are either poorly insured or not insured at all, not just in the United States, where insurance is a patchwork, but also in other developed countries, including Canada. One reason for a lack of coverage is the expense of these psychotherapies, particularly when they are lengthy. Yet, as noted, recent research supports briefer treatments, and it has not been shown that extending therapy over several years has any advantage, nor are all psychotherapies expensive.

While many clinicians accept that personality disorders are valid and treatable, they do not know where to refer their patients. Patients need better access to specialized teams in the public sector, as well as better insurance for management in the private sector. That support would make it possible to offer effective treatment to most patients with BPD by shortening therapy, while restricting the use of more expensive programs to the most severe cases.

How do we address this problem? First, clinicians and insurers should be educated about the importance of recognizing personality disorders and referring appropriate patients for specialized care. Second, those of us who diagnose and treat personality disorders must also do better. We would have more success in promoting coverage with insurers if we promoted briefer forms of therapy for most patients. Last, we must make sure that patients have access to evidence-based programs, and that they are widely disseminated. This means that therapists must be properly trained and supervised, and that requires sufficient financial support. Our patients deserve no less. ■

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