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## Attitudes, Clinical Practices, and Perceived Advocacy Needs of Professionals With Interests in Personality Disorders

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## **ATTITUDES, CLINICAL PRACTICES, AND PERCEIVED ADVOCACY NEEDS OF PROFESSIONALS WITH INTERESTS IN PERSONALITY DISORDERS**

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and the Board of Directors of the International Society for the  
Study of Personality Disorders

Experts in personality disorders (PDs) generally prefer dimensional diagnostic systems to categorical ones, but less is known about experts' attitudes toward personality pathology diagnoses in adolescents, and little is known about public health shortfalls and advocacy needs and how these might differ geographically. To fill these gaps, the International Society for the Study of Personality Disorders surveyed 248 professionals with interests in PDs about their attitudes toward different diagnostic systems for adults and adolescents, their PD-related clinical practices, and perceived advocacy needs in their area. Results suggested that dimensional diagnostic systems are preferable to categorical and that skepticism about personality pathology in adolescents may not be warranted. The most pressing advocacy need was the increased availability of PD-related services, but many other needs were identified. Results provide a blueprint for advocacy and suggest ways that professional societies can collaborate with public health bodies to expand the reach of PD expertise and services.

*Keywords:* personality pathology, evidence-based practice, diagnosis, treatment accessibility, public health needs

The field of personality disorders (PDs) has undergone several major developments in the past decade. The scientific conceptualization of PDs has been challenged in many ways, resulting in some wholesale changes and reinvigorated debate. One major change has been to the diagnostic nomenclature:

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After many years of research supporting a conceptualization of personality pathology that is dimensional rather than categorical, the eleventh edition of the *International Classification of Diseases (ICD-11)* adopted a dimensional scheme for PD diagnosis (World Health Organization, 2018). Likewise, the Personality Disorders Work Group for the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)* (American Psychiatric Association, 2013) proposed a hybrid model, representing a blend of prototypal and dimensional assessment, that was ultimately relegated to Section III (Skodol et al., 2013) but continues to be the focus of much research (Zimmermann et al., 2019). The scientific rationale for dimensional PD diagnosis and its likely effects have been debated (Herpertz et al., 2017; Hopwood et al., 2018), and research into the *DSM-5* Section III PD system continues as well.

Another major change has been the growth of research into the adolescent developmental roots of PDs. Even though PDs were originally defined as disorders of adulthood, on the basis that personality itself has yet to consolidate through adolescence into early adulthood, research now suggests a basic continuity between adult PDs and personality disturbance in adolescence (Chanen et al., 2017; Chanen & McCutcheon, 2013; Sharp & Fonagy, 2015). Research also counters the notion that PD-like behavioral disturbance in adolescence resembles normative developmental processes (Cardona et al., 2021) and supports both the reliability of assessment of personality pathology in adolescent individuals (Guilé et al., 2018; Kaess et al., 2014; Sharp, Kerr, & Chanen, 2021) and the predictive validity of PDs in adolescence (Wertz et al., 2020). Together, these findings have stimulated treatment development and evaluation for adolescent personality pathology (see Jørgensen et al., 2021, and Wong et al., 2020, for meta-analytic reviews). Despite these advances, several barriers to treatment of adolescent personality pathology remain, resulting in continued failure of mental health systems to intervene early where problems in personality development are detected (Chanen & Nicol, 2021; Wall et al., 2021).

Intervening early is particularly important against the background of accumulating evidence regarding the heavy consequences of PDs to public health. PDs are highly prevalent in community settings worldwide (Winsper et al., 2020), are associated with high risk of completed suicide and early mortality (Fok et al., 2012; Temes et al., 2019; Tyrer et al., 2021), and are associated with heavy service utilization costs (Quirk et al., 2016; Wagner et al., 2022). PDs are also deleterious to individuals and their support system in the long term, even in comparison with other severe mental and physical illnesses (Bailey & Grenyer, 2014; Hastrup et al., 2022; Seigerman et al., 2020). Despite this, the availability of suitable treatments for PDs is low relative to demand in many areas of the world (Dale et al., 2017; Hermens et al., 2011; Iliakis et al., 2019; Paris, 2020; Tusiani-Eng & Yeomans, 2018). There is also a dearth of linguistically and culturally sensitive methods of assessing PDs in many parts of the world (Balaratnasingam & Janca, 2017; Ronningstam et al., 2018). And, as noted above, adolescents may face particular barriers to effective care (Wall et al., 2021). Thus, clinical services and other social supports for PDs lag behind their heavy public health impact, and there is an imperative to understand what kinds of assistance for PD patients and their caregivers are most needed.

In short, the rapidly shifting research landscape, changes in diagnostic nomenclatures, and ongoing shortfalls in PD-related clinical services raise several questions that should be answered in order to know how best to advance research into personality pathology and the clinical care of individuals with personality pathology. Do researchers and practitioners focused on PDs share a consensus view of personality pathology, its assessment, and its treatment? How might these views differ by discipline and geographical region, given the global importance of PDs and the professional diversity of those who study and treat them? To what degree are these experts practicing high-quality, specialty care for individuals with personality pathology? What advocacy steps are most immediately important for stakeholders in the field? The International Society for the Study of Personality Disorders (ISSPD) undertook a survey to investigate these questions, focusing on the current practices and attitudes of a broad spectrum of professionals with regard to personality disorders as they relate to the unmet global health needs related to PDs (Ronningstam et al., 2021). The survey updated and expanded upon surveys conducted by Bernstein and colleagues (2007) and Morey and Hopwood (2020), who asked personality disorder experts about their opinions on categorical and dimensional diagnostic systems for personality disorders. In both reports, a large majority of respondents preferred a dimensional diagnostic system to the categorical one. The current survey goes beyond these earlier studies by considering expert attitudes toward PD diagnosis in adolescents, as well as perceived public health needs related to personality pathology.

## METHOD

### RECRUITMENT

A survey appeal was sent by e-mail to the membership of the ISSPD on October 16, 2019. The e-mail was sent to 239 individuals and invited recipients to respond to a survey “about perceived education, training, and advocacy needs related to PDs.” The appeal occurred during the biennial ISSPD Congress, and the presidential address (Huprich, 2019) at this meeting also referred to this e-mail and asked attendees to respond. Members of the ISSPD Executive Board also distributed the survey link to listservs and professional groups in order to reach a broad set of respondents with a research, clinical, or training interest in personality disorders.

### SURVEY

*Attitudes and Practices About Personality Disorders.* Respondents were first asked to characterize the clinical utility of screening for and diagnosing personality disorders, the utility of categorical and dimensional PD diagnoses, and the clinical utility of specialized treatments for personality disorders. For each of these general questions, respondents were asked to indicate separate responses for adults and adolescents. Respondents were also asked to rate the opinion of the typical professional in their locations on these questions of clinical utility. Each rating was made separately on a scale from 1 (*Not at all Useful*) to 7 (*Very Useful*).

Respondents were also asked about their clinical practices with individuals with personality disorders, including whether they applied specialty screening and diagnostic tools and specialty treatments for personality disorders. If respondents answered “yes,” they were directed to indicate which tools and treatments they employed. Respondents were also asked whether they routinely communicated a personality diagnosis to the patient when it was made, and whether the typical professional in their area communicated a PD diagnosis when necessary.

*Availability of PD-Related Clinical Tools, Services, and Advocacy Groups and Advocacy Needs.* Finally, participants were asked about the availability of clinical services in their area related to personality disorders. Respondents reported on the most common “first-line” treatment for individuals with personality disorders; the availability of specialty treatments, screening and diagnostic instruments with adequate validity evidence and utility for the local population; the availability of funding for PD-related clinical services; and the existence of organized patient advocacy groups for PDs in their area.

Respondents were also asked about their perceptions of advocacy needs related to PD services in their area, including the needs of current patients, service availability and accessibility, coverage for PD-related services, scientific/research needs, and advocacy around the utility of a PD diagnosis. Finally, respondents were asked about their PD-related training, including their training in the assessment, diagnosis, and treatment of personality disorders.

## RESULTS

The e-mail appeal to ISSPD membership during the 2019 Congress resulted in 68 unique responses, and an additional 180 individuals completed the survey through other recruitment channels. Thus, the final sample consisted of 248 completers (mean age = 43.7,  $SD = 12.7$ ).<sup>1</sup> Table 1 presents demographic and professional information for the sample. Respondents came from 21 different countries, and nearly all (218 of 226, 96.5%) were currently involved in professional practice activities across a variety of mental health disciplines. The most common practice setting was a psychiatric private practice, but many different practice settings were represented, including residential, school, and correctional facilities. The response rate from recruitment e-mails is difficult to determine due to overlap between ISSPD and listserv membership rosters and the impact of snowball sampling. However, the 68 responses from the 239 ISSPD members amounts to a 28.5% response rate.

## ATTITUDES AND PRACTICES

Of the 213 respondents who answered a question about their typical PD screening practices with adults, most indicated that they always (85, or 39.9%)

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1. An additional 67 individuals provided partial responses.

**TABLE 1. Demographic and Professional Characteristics of Sample**

Characteristic	<i>n</i> (%)
Region ( <i>n</i> = 228)	
Europe	94 (38)
North America	76 (31)
Australasia	31 (13)
South America	27 (11)
Gender ( <i>n</i> = 229)	
Male	84 (36.7)
Female	141 (61.6)
Prefer not to say	4 (1.7)
Profession ( <i>n</i> = 220)	
Psychology	140 (63.6)
Psychiatry	45 (20.5)
Social work	9 (4.1)
Nursing	9 (4.1)
Occupational therapy	6 (2.7)
Counseling	4 (1.8)
Degree ( <i>n</i> = 225)	
PhD	97 (43.1)
Master's degree	73 (32.4)
MD	29 (12.9)
Bachelor's degree	26 (11.6)
Practice setting ( <i>n</i> = 225)	
Psychiatric outpatient clinic	62 (27.6)
Individual private practice	48 (21.3)
Psychiatric hospital	39 (17.3)
Other	76 (33.8)
Populations served ( <i>n</i> = 293)	
Adults only	140 (47.8)
Adolescents only	36 (12.3)
Both adults and adolescents	106 (36.2)
Neither adults nor adolescents	11 (3.8)

or sometimes (93, 43.7%) screened for the presence of personality disorders. The tools used for this purpose varied widely; the most common were PD screeners or self-report PD questionnaires (73 respondents of the 178 who screened for PDs, or 41.0%), questions within clinical interviews (37, or 20.8%), and personality assessment instruments (27, or 15.2%). Notably, respondents could, and often did, report using more than one screening instrument. The picture was similar for the 211 individuals who responded to a similar question about their practice with adolescents; most indicated that they always (84, or 39.8%) or sometimes (90, 42.7%) screened for PDs with

these patients. The screening tools for adolescents varied more than those for adults; nonetheless, the most commonly used tools for adolescents were similar to those used for adults: PD screeners or self-report PD questionnaires (36 respondents, or 20.7%), clinical interviews (18, or 10.3%), and personality assessment instruments (11, or 6.3%).

A majority of respondents also conducted diagnostic assessments for PDs with adults always (84 out of 211, or 39.8%) or sometimes (90, 42.7%). The most common tools used to diagnose PDs in adults were semistructured diagnostic interviews (54 out of 174 respondents who diagnosed PDs, or 31.0%), personality assessment measures (47, or 27.0%), and clinical interviews (32, or 18.3%). A similar majority made diagnostic assessments for PDs with adolescents always (48 of 130, or 36.9%) or sometimes (52, or 40.0%). As with adults, the most common tools used to diagnose adolescents were semistructured diagnostic interviews (30 out of 100, or 30%), clinical interviews (16, or 16%), and personality assessment instruments (14, or 14%). More than two thirds of respondents (181 of 269, or 67.3%) indicated that they routinely communicated a PD diagnosis to an adult patient when it was made, whereas just over half (93 of 177, or 52.5%) communicated a PD diagnosis to an adolescent patient when it was made.

Respondents were generally positive about the utility of screening for, diagnosing, and treating personality disorders in adults and adolescents (Table 2). In each case, they thought that the typical professional in their area had less favorable views about PD screening, diagnosing, and treating PDs than they did. In terms of actual practice, most of the sample reported using a specialized treatment for personality pathology with adults (145 of 199, or 72.9%) and with adolescents (85 of 128, or 66.4%). As with screening measures, respondents reported using a very wide variety of treatments for personality pathology, and most used more than one; only 59 (33.1%) of those who reported any specialized intervention for adults with PDs used only one such treatment. The numbers were similar for treating adolescents; a minority (47 respondents, or 41.2%) who reported using any specialized treatment used only one in their practice. The most commonly used specific specialty treatments were dialectical behavior therapy (for adults, 104 respondents of 145, or 72%; for adolescents, 63 of 85, or 74%), mentalization-based treatment (for adults, 48 respondents, or 33%; for adolescents, 29, or 34%), cognitive therapy (for adults, 42, or 29%; for adolescents, 21, or 25%), good psychiatric management (for adults, 40, or 28%; for adolescents, 26, or 31%), and transference-focused psychotherapy (for adults, 30, or 21%; for adolescents, 14, or 16%).

We conducted a series of analyses of variance to investigate the attitudes of respondents with respect to categorical versus dimensional assessment of personality disorders in patients of different ages, examining the predictive value of respondent profession and respondent region. There was a main effect of diagnosis type,  $F(1, 106) = 18.89$ ,  $p < .001$ , partial  $\eta^2 = .15$ , such that dimensional assessment systems were seen as more clinically useful than categorical ones. There was also a main effect of patient age,  $F(1, 106) = 15.55$ ,  $p < .001$ , partial  $\eta^2 = .13$ , such that a personality disorder diagnosis was seen as more clinically useful for adults than for adolescents. However, there was



**TABLE 2. Respondents' Views and Perceptions of Other Professionals' Views of the Utility of Clinical Services for PDs**

	Respondent's View	Perceived View of Typical Professional	<i>t</i> test	Hedges's <i>g</i>
	<i>M</i> ( <i>SD</i> )	<i>M</i> ( <i>SD</i> )		
Screening for PDs				
Adults	6.00 (1.44)	5.11 (1.61)	$t(270) = 9.28, p < .001$	0.563
Adolescents	5.55 (1.71)	4.49 (1.70)	$t(180) = 8.16, p < .001$	0.605
Diagnosing PDs				
Adults	5.86 (1.48)	5.17 (1.46)	$t(269) = 7.45, p < .001$	0.453
Adolescents	5.37 (1.83)	4.27 (1.72)	$t(179) = 7.84, p < .001$	0.583
Treatment for PDs				
Adults	5.85 (1.42)	5.33 (1.55)	$t(267) = 6.86, p < .001$	0.419
Adolescents	5.69 (1.56)	5.17 (1.60)	$t(176) = 4.97, p < .001$	0.373

Note. Responses were given on a scale from 1 (*Not at all useful*) to 7 (*Very useful*).

also a three-way diagnosis type  $\times$  age  $\times$  profession interaction,  $F(1, 106) = 5.70$ ,  $p = .019$ , partial  $\eta^2 = .05$ . Figure 1 shows the pattern of results pertaining to this interaction. The tendency to favor a dimensional diagnosis over a categorical one pertained especially to psychologists and to adolescent patients. As the figure shows, this interaction effect seems to be driven largely by relatively unenthusiastic attitudes toward categorical PD diagnosis for adolescents among psychologists, rather than an especially favorable attitude toward dimensional PD diagnosis for adolescents among psychologists. All other effects in this model (the main effect of discipline and two-way interactions) were not statistically significant at the .05 level. Respondent region (North America, South America, Europe, and Australasia)<sup>2</sup> did not affect the perceived utility of diagnosing personality disorders, either as a main effect or in interaction with other predictor variables.

## PERCEIVED ADVOCACY NEEDS AND AVAILABILITY OF SERVICES

There were no significant differences between PD-related advocacy needs for adults and adolescents in paired *t* tests (all *p* values  $> .09$ ). For both adults and adolescents, the greatest perceived need for advocacy related to personality disorders was for the availability and accessibility of PD-related clinical services, followed by a need for advocacy related to scientific research (Table 3). The lowest perceived advocacy need was for financial coverage for PD-related services. However, as expected, there were regional differences in respondents' perceived need for better third-party coverage,  $F(3, 200) = 17.42$ ,  $p < .001$ ,  $\eta^2 = .21$  for adults;  $F(3, 132) = 7.63$ ,  $p < .001$ ,  $\eta^2 = .15$  for adolescents. Bonferroni-corrected follow-up tests suggested that European respondents perceived less of a need for advocacy for insurance coverage for adults

2. These regions were coded from self-reported country data and follow the regional definitions used by ISSPD and its associated regional societies and groups at the time.

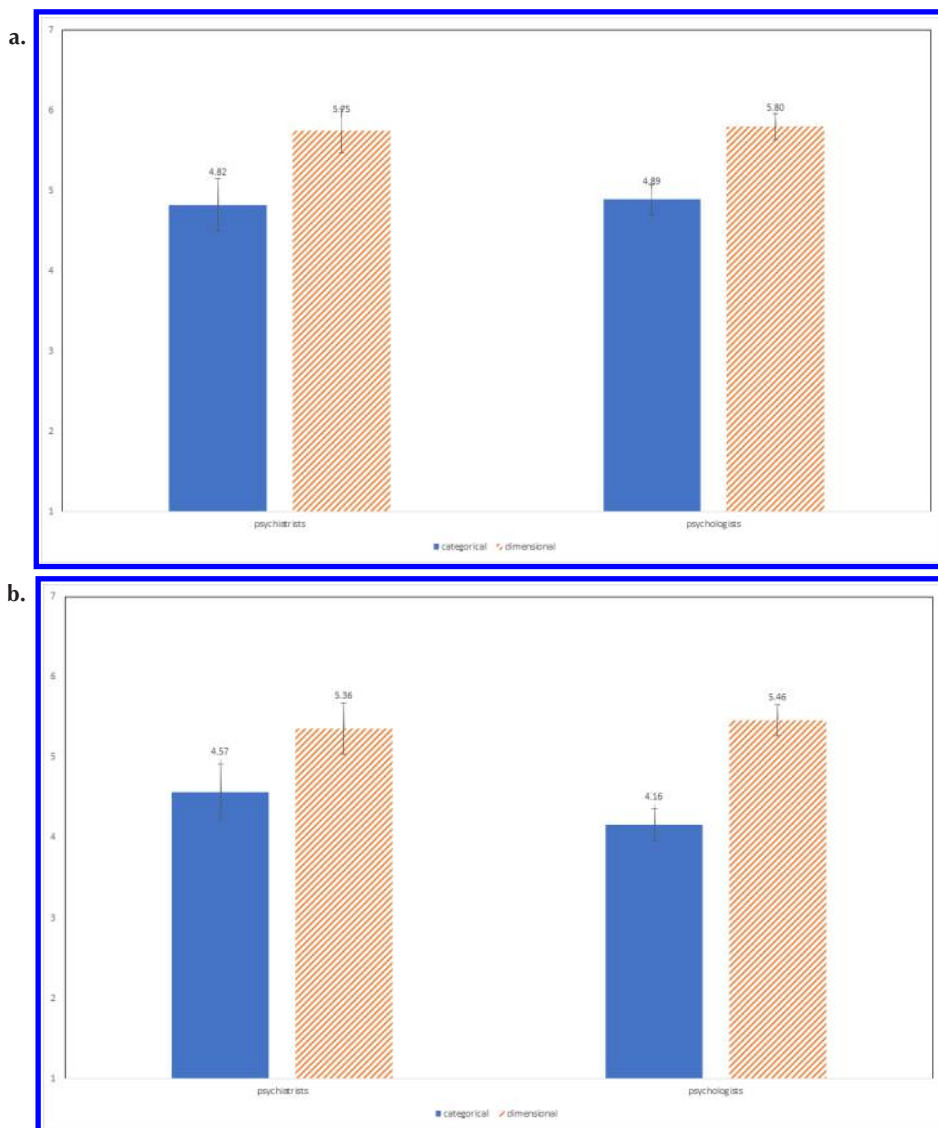


FIGURE 1. (a) Clinical utility of categorical and dimensional PD diagnoses of adults by profession; (b) clinical utility of categorical and dimensional PD diagnoses of adolescents by profession. Error bars reflect standard errors of the mean.

than respondents from North America ( $p < .001$ ), South America ( $p < .001$ ), and Australasia ( $p = .017$ ), and no other pairwise regional differences were statistically significant. For adolescents, European respondents perceived less of a need for advocacy for insurance coverage than did respondents from North America ( $p < .001$ ) and South America ( $p = .002$ ), but not Australasian respondents ( $p = .20$ ).

Consistent with the high degree of perceived need for advocacy related to the availability of PD-related services, respondents reported a rather low

**TABLE 3. Perceived Advocacy Needs Related to Personality Disorder Practice**

	Adults			Adolescents		
	<i>n</i>	<i>M</i>	<i>SD</i>	<i>n</i>	<i>M</i>	<i>SD</i>
Patients' needs	275	6.09	1.22	178	6.17	1.35
Service availability and accessibility	275	6.26	1.25	178	6.30	1.33
Insurance coverage	263	5.55	1.95	174	5.60	1.92
Funding for research	273	6.15	1.20	176	6.14	1.41
Promoting utility of PD diagnosis	271	5.84	1.40	176	5.84	1.52

Note. Sample sizes differ slightly because some respondents did not answer every question. Respondents used a 1 (*Not at all*) to 7 (*Very Much*) scale to answer whether better advocacy was needed for personality disorders in these domains.

availability of these services in their areas. On a scale from 1 (*Not at all available*) to 7 (*Routinely available*), the availability of specialty treatment services for adults did not differ for respondents from North America ( $M = 4.32$ ,  $SD = 1.82$ ), Europe ( $M = 4.26$ ,  $SD = 2.02$ ), Australasia ( $M = 3.77$ ,  $SD = 1.70$ ), and South America ( $M = 3.35$ ,  $SD = 1.96$ ),  $F(3, 202) = 2.11$ ,  $p = .10$ ,  $\eta^2 = .03$ . Similarly, the availability of adolescent services for PDs was not seen as significantly different by respondents from North America ( $M = 3.64$ ,  $SD = 1.72$ ), Europe ( $M = 3.80$ ,  $SD = 2.02$ ), Australasia ( $M = 3.90$ ,  $SD = 1.64$ ), and South America ( $M = 2.74$ ,  $SD = 2.00$ ),  $F(3, 121) = 1.73$ ,  $p = .16$ ,  $\eta^2 = .04$ . However, there were regional differences in the availability of assessment instruments for both adults,  $F(3, 196) = 4.15$ ,  $p = .007$ ,  $\eta^2 = .06$ , and adolescents,  $F(3, 118) = 2.87$ ,  $p = .04$ ,  $\eta^2 = .07$ . Bonferroni-corrected follow-up tests showed that respondents from South America ( $M = 3.08$ ,  $SD = 1.38$ ) found assessment tools for adults less available than respondents from North America ( $M = 4.54$ ,  $SD = 2.01$ ),  $p = .006$ , and Europe ( $M = 4.45$ ,  $SD = 1.88$ ),  $p = .009$ . The same was not true for assessment tools for adolescents; respondents from South America did not perceive these to be less accessible than respondents from Europe ( $p = .12$ ), but there was a significant difference between South and North America ( $p = .03$ ).

## DISCUSSION

The results of this study clarify the current attitudes and practices of a diverse set of PD experts and other stakeholders across 21 different countries. In general, the results suggest several themes in continuity with prior surveys of PD experts and other stakeholders. First, results suggested that respondents continued to favor a dimensional over a categorical diagnostic system, even though the categorical system was perceived as having moderate utility as well. This finding is consistent with earlier surveys of experts by Bernstein and colleagues (2007) and Morey and Hopwood (2020). It is also consistent with findings from clinicians without specific PD expertise, both in surveys and in ratings of actual patients or vignettes (Bach et al., 2015; Bornstein & Natoli, 2019; Garcia et al., 2018; Morey & Hopwood, 2020). The lack of a

difference between psychologists and psychiatrists in views of a dimensional versus categorical system for PDs is also largely consistent with these earlier studies. Thus, it does seem that the field is coalescing around the idea of a dimensional approach to conceptualizing PDs, despite the long history of categorical PD diagnosis in the *DSM* and *ICD*. Notably, the current survey did not ask about prototype-matching diagnostic systems (Spitzer et al., 2008); future research will be needed to ascertain how favorably PD experts view this kind of system.

Encouragingly, results also suggested that prior skepticism regarding the utility of PD diagnosis for adolescents relative to adults (Laurensen et al., 2013; Miller et al., 2008) is beginning to wane. Results revealed little evidence of a categorical objection to diagnosing and treating PDs in adolescents, even if the perceived utility of doing so was smaller than in adults. In addition, although there was a reluctance among psychologists to assign categorical PD diagnoses to adolescents, this was a small effect. It is possible that this effect reflects a reluctance by some professionals to assign to a young person a potentially stigmatizing diagnostic label. This may be especially true given that making a categorical PD diagnosis for an adolescent might not help in accessing appropriate treatment: There was a clear general view among respondents to this survey that increased PD-related services for adolescents are needed from health systems, further suggesting a decrease of professional objections to the notion of PD in individuals under 18 years of age (Chanen, 2015). It should be noted, however, that research evidence for the validity of PDs in adolescence, and for the efficacy of PD-focused treatments for adolescents, is not as extensive as such evidence for adults, and we expect that these attitudes will change as the evidence base for adolescent personality disorder expands. Specifically, there continues to be a significant knowledge–practice gap in terms of the care provided to adolescents. For instance, utilizing a standard patient-centered conceptual framework for barriers to care, Wall, Kerr, and Sharp (2021) discuss how barriers at each level of the care continuum continue to prevent early intervention for young people with problems in personality functioning. Chanen and Nicol (2021) expand on this by identifying five challenges in the care of young people with personality challenges: identification, access to treatment, research translation, innovation, and functional recovery. These analyses emphasize that continued efforts from personality disorder experts to educate and disseminate this evolving research base will be needed (Sharp, Chanen, & Cavelti, 2021).

Across all categories, respondents reported that they held more favorable views of the utility of PD-related services for both adults and adolescents than the typical practitioner in their geographical location. This is not surprising, as the respondents were members of a professional society devoted to the study of personality disorders and/or attendees at an international PD conference, or else they had a professional connection to initial recipients of the survey appeal. Respondents therefore were a selected set of practitioners. This is consistent with the relatively high frequency with which respondents reported screening for and diagnosing personality pathology, and the high rate of use of empirically supported treatments for personality disorders, none of which would likely be the case in a more globally representative sample of

practitioners. Indeed, the substantial gaps between respondents' own attitudes and the views they ascribe to the typical professional highlight the gap between mental health professionals whose activities focus on PDs to some degree and other practitioners. Outreach to other professional groups and organizations; advocacy for the importance of screening, diagnosing, and treating PDs according to the research evidence; and better support for PD-related clinical training may be crucial steps in expanding access to appropriate services for adults and adolescents with personality pathology.

Consistent with this, respondents reported a number of pressing advocacy needs around PD-related clinical services. The most pressing need was promoting the broader availability of PD-related services, both specialty treatments and tools for screening, diagnosis, and assessment. There were some important regional differences; for instance, South American respondents particularly highlighted the poor availability of validated assessment tools for their patients. This suggests that linguistically and culturally validated PD measures may be an immediate priority for the field, because access to adequate treatment depends on identification of those individuals most likely to benefit. It is also important that there were many countries with no respondents represented in the survey, and there were no respondents from the African continent. Given the likelihood that this reflects a general lack of accessible services in many areas of the world, it is especially important to expand the reach of high-quality services to underserved regions. Likewise, although expanded insurance coverage for PD-related services was one of the lowest needs reported in general, there were regional differences. Very likely these differences reflect discrepancies in how mental health treatment in general is funded. These differences suggest that political advocacy efforts in North and South America and Australasian countries might be important in expanding PD services to a larger group of individuals.

Indeed, initiatives to support the spread of PD services are already underway. For instance, in Europe, the European Society for the Study of Personality Disorders (ESSPD) has initiated an alliance of PD experts to disseminate knowledge about treatment, contribute to the training of PD-competent clinicians, and help guide policy (Mehlum et al., 2018). Likewise, the ISSPD itself aims to bolster connections with other professional organizations (e.g., the World Psychiatric Association and the World Health Organization) to promote the availability of training materials and expand outreach to areas of the world that have little access to high-quality PD assessment and treatment (Ronningstam et al., 2021). The current study suggests that these outreach efforts are vitally important and should focus on expanding access to, funding for, and the use of appropriate tools for diagnosing and treating personality pathology.

The current study has a number of limitations. First, the sample was not systematically derived and in some respects may not accurately represent professionals with PD interests. For instance, the fact that many respondents were attending a scientific conference on personality disorders likely biased the sample toward individuals with certain views—especially a favorable view of PD services and a need for more support for such services from health care systems. There are also many individuals with research or clinical interests in personality pathology who do not have professional connections with ISSPD

and who may not have received the survey appeal, and their views may differ systematically from those represented here. Second, the survey did not include any free-response questions. Therefore, the information gathered here was limited by the structure of the questions asked. Any perceived advocacy needs outside of the specific ones asked here, for instance, would not have been easy to report and may have been missed. Future studies, especially qualitative ones, will be needed to explore the wider variety of perceived needs for PD services among the worldwide community of researchers and practitioners.

Despite these limitations, the current study gives a coherent picture of the consensus views of professionals with research and clinical interests in personality disorders. These professionals regard dimensional and, to a lesser degree, categorical diagnostic systems for PDs as having good clinical utility. A majority also report that they use specialized treatment services for PDs with both adults and adolescents. Nonetheless, they report that other professionals in their area have less favorable views of the clinical utility of PD-related services, and they note that expanded access to these services is a pressing need, especially for adolescents. The ISSPD recognizes the substantial challenges in supporting access and availability to clinical care for PDs. It also recognizes that still more needs to be done to better disseminate developmental research to inform current thinking and clinical practice. The lack of PD-related services may be especially acute in regions where there are few ISSPD members or personality disorders specialists, and indeed, outreach efforts to these regions will be needed to ensure that the scientific advances of the past 30–40 years have their due impact.

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