ESSPD Academy Newsletter, February 2019

Dear ESSPD members and colleagues,

The year 2019 will be one full of activities of our academy: We are preparing the workshop conference in Budapest on June 6-8 (see p. 13 of this newsletter) and the first ESSPD summer school in the most beautiful location in Switzerland in August (p. 14). Moreover, we started to establish sections within our academy. The first two of them resumed their work, the one on social neurosciences is being presented in this newsletter on p. 9 by Chiara De Panfilis, Stephanie Lis, and Zsolt Unoka. The other one on psychopathy was already introduced in our last newsletter. Our sections represent a fantastic forum for our scientific work.

Stephan Doering

ICD-11 is going to be presented to the public this year. Bo Bach is telling us about the latest developments in the section on personality disorders on p. 3 of this newsletter, before three comments on the new system follow, one by Mike Crawford, who was a member of the group who advised the WHO on the development of the ICD-11, another one, which is somewhat critical by Giancarlo Dimaggio and Angus Macbeth, and a third one by Elfrida Hartveit Kvarstein - a highly interesting ongoing discussion.

We are sad about the loss of John Gunderson, who died in January. He was one of the most important researchers, clinicians, and influencers in our field. You find an obituary on the next page.

Our next membership assembly will be held electronically at the Budapest workshop conference in June – you will receive a separate invitation for this. A number of new members will be suggested to be elected as new Board members.

Finally, I would like to ask you to nominate new members for our academy, who are outstanding researchers, clinicians, teachers, or otherwise (e.g., politically) contributing to our field. You will find the nomination form at the end of this newsletter.

Sophie Liljedahl provides us with the most exciting results of the latest research on personality disorders (pp. 15-20), which once again demonstrate that our field is one of the most lively and innovative in psychiatry, psychology, and psychotherapy.

I wish you a beautiful spring.

Yours,

Stephan Doering, MD
President of the ESSPD

Obituary for John Gunderson

Dear ESSPD members,

With great sadness we have received the message of John Gunderson´s death on January 11, 2019. Our scientific community owes him greatest respect and gratitude for his invaluable contributions to the field of diagnosis and treatment of borderline personality disorder (BPD).

Throughout his career as a researcher and psychiatrist, John Gunderson was committed to improve health care for patients with borderline personality disorder – and he succeeded in many ways. During the last years he developed a unique treatment program for borderline patients at McLean Hospital in Boston, which provides his own approach, General Psychiatric Management (GPM), as well as a variety of other treatments (DBT, MBT, TFP) according to the patient´s specific indication and needs. His unprejudiced and incorruptible attitude towards every effort to develop and implement empirically-validated therapies made him one of the most serious, most effective, and most dedicated advocates of patients with BPD.

John Gunderson

In Europe we met John Gunderson at the ISSPD conference in Heidelberg in September 2017, where many of us might have heard him for the last time as a key note speaker and discussant. With intensity, wisdom, creativity, and benevolence he taught us about his life experience and motivated us to continue his dedicated struggle for the improvement of mental health care for BPD patients.
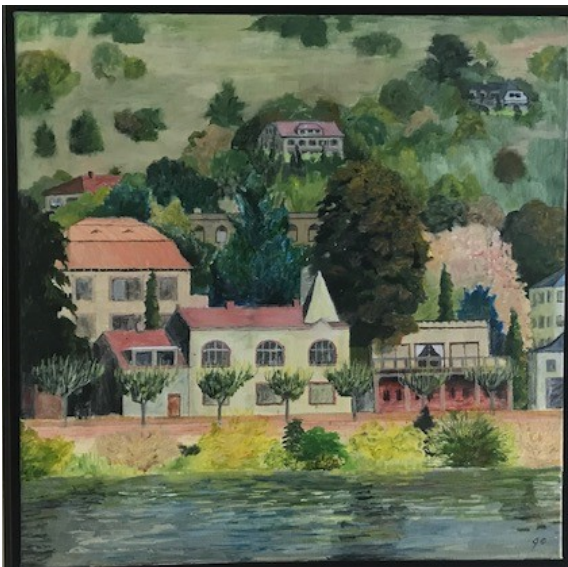
In Heidelberg 2017 John Gunderson painted a beautiful picture of a view over the river Neckar, which Mrs. Perry Hoffman shared with us.

I would like to encourage you to read John Gunderson´s inspiring books and his seminal papers again. On the McLean website you will find an extensive obituary for John Gunderson as well as links to a more detailed description of his work:

https://www.mcleanhospital.org/news/memoriam-john-g-gunderson-md

We will miss John Gunderson and preserve the most vivid, appreciative, and grateful memory of him.

Stephan Doering, MD
President of the ESSPD

The Upcoming ICD-11 Classification of Personality Disorders: Opportunities and Challenges for Implementation in Europe

This section of the ESSPD Newsletter provides a short presentation of the upcoming ICD-11 Classification of Personality Disorders introduced with a brief record of how it was finally agreed upon. In response to this, three European PD experts have been invited to provide their comment on this topic, including their perceived opportunities and challenges with the upcoming ICD-11 model.

Bo Bach

A final draft version of the ICD-11, including a fundamentally new classification of Personality Disorders (PD), was released in June 2018 (electronic version). According to WHO, this release serves as an advance preview that will allow member states to plan how to use it, prepare translations, and train health professionals. Eventually, the ICD-11 will be presented to the World Health Assembly in May 2019 for adoption by all member states[1], and it is scheduled to come into effect in January 2022. Notably, Europe is anticipated to be the first to implement this new diagnostic system, and therefore it now seems timely for European clinicians and researchers to discuss and prepare for the upcoming ICD-11 classification of PDs.

From controversies to a final compromise

It is no secret that the process of shaping the ICD-11 classification of PDs has been characterized by controversies and compromises. For a historical documentation of these matters, I refer to Herpertz et al.[2], Hopwood et al.[3], and Huprich et al.[4], of which the latter reflects status quo. Prior to the ISSPD Congress in Heidelberg (Germany, September, 2017), ESSPD representative Martin Bohus joined the productive discussions with NASSPD representative Carla Sharp, and ISSPD representatives Sabine C. Herpertz and Stephen Huprich along with the ICD-11 PD workgroup, which providentially resulted in an agreed upon proposal for the ICD-11. The outcome was later presented in a panel discussion involving Geoffrey M. Reed (ICD-11 Senior Project Officer), Martin Bohus, Lee Anna Clark, Andrea Fossati, Sabine Herpertz, Steven Huprich, and Carla Sharp. A subsequent letter by Reed[5] briefly summarizes the outcome of this meeting and presents essential features of the revised and expanded PD model. In the very final process before its release, Lee Anna Clark (acting on behalf of the ICD-11 workgroup) and Michael B. First (chief technical and editorial consultant for ICD-11) have made major contributions to the PD diagnostic guidelines in terms of structure, definitions, and clinical utility.

In comparison to the more simple but criticized model that was originally proposed for ICD-11[6], the now released model incorporates both self- and interpersonal functioning, a richer and more clinically informative operationalization of PD severity, and a richer and more clinically informative operationalization of trait qualifiers. Importantly, it also offers the option of using a "borderline pattern qualifier" which might be clinically useful to facilitate the identification of individuals who may respond to certain psychotherapeutic treatments. Encouraged by Reed, a paper has been published by Bach and First[7], which provides an overview of the ICD-11 PD classification and illustrates how it may be used in practice.

Essential features of the ICD-11 classification of personality disorders

As already disclosed, the upcoming ICD-11 introduces a fundamentally different approach to PDs by focusing on classification of severity (i.e., Mild, Moderate, Severe) along with the option of specifying one

specifying one or more trait domain qualifiers that contribute to the individual expression of personality dysfunction (i.e., Negative Affectivity, Detachment, Dissociality, Disinhibition, Anankastia). Additionally, within the diagnostic guidelines for PDs, the user is also allowed to code sub-threshold Personality Difficulty (resembling ICD-10 Z73.1 accentuated personality traits), and a Borderline Pattern qualifier (resembling DSM-IV/5 Borderline PD).

Classification of global severity:
The focus on global personality functioning (versus 10-12 distinct ICD-10 categories) allows clinicians to concentrate on core capacities and problems that are characteristic for PDs in general. For example, the patient's sense of self may range from somewhat contradictory or inconsistent (Mild PD) to highly unstable or internally contradictory (Severe PD). Likewise, the patient's situational and interpersonal appraisals may involve problems ranging from some distortions but with intact reality testing (Mild PD) to extreme distortions under stress often including dissociative states or psychotic-like perceptions (Severe PD). As a final example, the classification of PD severity also incorporates harm to self and/or others ranging from no significant harm (Mild PD) to severe and often dangerous harm (Severe PD). One major reason for focusing on global PD severity rather than different PD types, is that the severity of impairment has been found to predict various clinical outcomes over and beyond specific PD types[8]. Accordingly, knowing whether the patient has a Mild, Moderate, or Severe PD may provide important information about prognosis and intensity of clinical management. In other words, placing severity of personality dysfunction at the center of the diagnostic process may help service providers to distinguish those patients who have the greatest level of disturbance from those who do not, and thereby help services to target their interventions more effectively, including differentiating patients who may best be treated by specialist mental health services (i.e., Severe PD) from those who may be sufficiently helped in primary care (i.e., Mild PD).

Trait Domain Qualifiers:
Given that personality functioning might be impaired in different ways, the trait domain qualifiers are available to describe the specific pattern of traits ("style") that contribute to the global personality dysfunction. For example, it makes a great difference whether the impairment is related to being very self-centered and dominant (e.g., Dissociality) or overly insecure and avoidant (e.g., Negative Affectivity and Detachment). Those two different trait expressions may inform different treatment foci and style.

A Borderline Pattern qualifier:
In contrast to the ICD-10 operationalization of F60.3 Emotionally unstable PD (including F60.30 impulsive and F60.31 borderline subtypes), the ICD-11 Borderline Pattern qualifier is characterized by the nine familiar DSM-IV/5 features including a more clear definition of the ninth feature: "Transient dissociative symptoms or psychotic-like features (e.g., brief hallucinations, paranoia) in situations of high affective arousal." In supplement to these nine features, the user is also provided with three additional manifestations of BPD (e.g., negative self-view, a sense of alienation or loneliness, rejection sensitivity, problems with trust, and misinterpretation of social signals), which may be of help in both diagnostic decisions and treatment planning.

Bo Bach, PhD, Senior Research Associate
Psychiatric Hospital Slagelse, Region Zealand, Denmark

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Comments on the upcoming ICD-11: Steps in the Right Direction

Mike Crawford

In the absence of reliable biological correlates it seems likely that the nosological status of mental disorders will continue to be contested. This is especially true for personality disorder where the extent of heterogeneity limits the reliability of inferences about prognosis and the impact of treatment. Having said that, there are important distinctions to be made between personality disorders and other mental health conditions and, for many patients, failure to recognise personality disorder can lead to people being given treatments that don't work or may even cause harm. What people with personality problems want is an understanding of their difficulties and help to ameliorate them. To assist this clinicians need to see beyond diagnosis and work to understand the psychological and social problems that people experience, so that these can either be solved or people can be helped to find ways to live better with their problems.

As a member of the group that advised WHO on the development of ICD-11, I believe that this new system of classification provides a more accurate and clinically useful way of describing the problems and experiences of people with personality disorder. For the reasons that Bo Bach describes in his article, ICD-11 should provide a better way of differentiating those with mild, moderate and severe personality dysfunction and make it more likely that clinicians working in general health

settings will consider the role that personality impacts on a person's mental health and their use of services. By focussing on trait domains ICD-11 provides a better description of the patterns of personality dysfunction seen in both communities and clinical populations [1,2]

It is hoped that ICD-11 will also have direct benefits for patients. The inclusion of the sub-threshold coding for 'Personality Difficulty' emphasises how the struggles that people with PD have are an accentuated form of difficulties that most people experience. By including thresholds for mild, moderate and severe personality disorder patients and clinicians will be able to track changes in health and functioning over time in ways that are more meaningful than a dichotomous distinction between meeting or not meeting criteria for personality disorder.

The development of ICD-11 also presents opportunities for new research including testing hypotheses about the role of severity in predicting the clinical and cost effectiveness of psychological and psychosocial interventions (these are as yet still hypotheses). By examining the biological and psychological correlates of trait domains there are also opportunities for further refining the assessment, diagnosis and treatment of personality disorder.

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Mike Crawford, Professor of Mental Health, Imperial College London and Chair of WPA Section on Personality Disorder

Comments on the upcoming ICD-11: What is neglected in the ICD-11 classification of personality disorders

The revised classification of personality disorders (PD) for the ICD-11 gives clinicians and researchers in the field a new nomenclature. It contains welcome additions to the previous diagnostic guideline. However, some aspects may risk obscuring our understanding of PD.

Giancarlo Dimaggio

Opportunities: Severity as a bridge to better treatment
Classifying PDs by severity, similar to DSM-5, is a positive development - refocusing the core impairment in PD from behavioral descriptions to self and interpersonal features. This more closely aligns with European clinical practice, facilitating more effective treatment for these individuals. The nomenclature enables clinicians to describe individuals' capacity to set and maintain long-term goals, and the degree to which individuals maintain a coherent/consistent sense of self-worth.

Assessing severity explicitly includes aspects of mentalizing or metacognition [1,2]; e.g. awareness of one's own emotions and appreciating others' perspectives. This moves diagnostics closer to the core mechanisms clinicians need to be aware of to formulate treatment. Individuals with PD have difficulties in describing what they think or feel. Consequently, treatment needs to promote this awareness,

Angus MacBeth

prior to fostering other types of change e.g. behavioral change. Patients need to know what they think and feel (recognizing the negative impact of these patterns) before adopting different, more adaptive perspectives. It is promising that ICD-11 addresses metacognitive difficulties.

Challenges: To trait or not to trait?

However, a problem emerges around how clinicians specify the kind of self and interpersonal problems an individual is affected by. Whereas severity is firmly grounded in core disturbance of self/other-related aspects of identity, precipitating clear cognitive, affective and behavioral sequelae, the trait markers have less coherence. The operationalization of these traits generates a confused mixture of predominantly behavioral manifestations of dysfunction, some affective experience and some cognitive descriptors; without the same logic seen for the severity marker. This inhibits their utility as tools informing a fine-grained case formulation.[3]

For example, "Detachment" denotes tendencies to maintain interpersonal distance and to avoid social interactions, resulting in features such as lack of friendships, being reserved or aloof; and limited emotional expression. However, there is an absence of cognitive aspects of detachment and a description of maladaptive interpersonal schemas. [4] Individuals comprehend their social interactions according to pre-formed ideas including: core wishes and needs (e.g. being cared for or valued); core self -schema (e.g. lovable/unlovable, worthy/unworthy, vulnerable/strong); and appraisals of others: (caring/ neglecting; critical/admiring; friendly/threatening etc.). These schemas have trait-like properties - stability over time and across situations - but, unlike ICD-11 traits, they describe the patient via cognitive-affective constructs used by the individual for meaning making in social relationships. This primes specific therapeutic stances e.g.: "You want to be appreciated but think others will criticize you. You feel ashamed because you yourself hold the idea you are unworthy". Developing PD nomenclature is an iterative process, and subsequent editions of the ICD PD classifications can further refine these criteria, perhaps classifying traits in terms consistent with internalized patterns of interaction.

Challenges: Borderline versus other PDs

We have reservations about the implications of retaining, and highlighting the diagnosis of Borderline PD, via the Borderline pattern qualifier. The stand-alone nature of the qualifier risks further reinforcing the heuristic that, to non-specialists, when we say PD we mean only Borderline PD. Clinicians may well be pressured to further focus only on that pattern, which is already subject to numerous well-documented treatment protocols. This may occur at the expense of other much more prevalent PDs that feature over-regulation, social inhibition and other equally debilitating facets. Individuals presenting with avoidant, obsessive-compulsive, and dependent features urgently need specialized treatment protocols. By spotlighting the borderline qualifier, we fear ICD-11 inadvertently may further neglect these other presentations.

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Giancarlo Dimaggio, M.D., Center for Metacognitive Interpersonal Therapy, Rome, Italy

Angus MacBeth, PhD, Lecturer in Clinical Psychology University of Edinburgh, Scotland, UK

Comments on the upcoming ICD-11: Thoughts and views on the upcoming ICD-11

The upcoming ICD-11 includes a fundamental revision of the way to classify personality disorders (PDs). A revision was certainly due. Research has provided substantial grounds for revising systems that define and restrict identification of personality pathology within separate categories.

Classification by PD categories alone may not be informative enough for providing adequate health care. Categories closely resemble a prototypical understanding of PD. Although clinicians often enjoy prototypes, they have limited relevance for complex disorders with characteristics across such "typical types". Prototypes may evoke rigid, possibly stigmatizing opinions, oversimplifications or generalizations, and represent clinical misfits. Research suggests that PDs are indicated within core domains of personality functioning across categories. Overall dysfunction is not captured well within a single prototype. Individually tailored descriptions may be better. I believe this is an important message that can be conveyed to clinicians. The upcoming ICD 11 represents such a possibility.

Elfrida Hartveit Kvarstein

In large-sampled clinical studies from the Norwegian Network for PDs, poorer functioning and more severe symptom distress was strongly associated with increasing PD traits across specific disorders. The total number of diagnosed PDs or the number of PD traits explained more variability of functioning than specific PDs alone, specific comorbid symptom disorders alone or the total number of comorbid symptom disorders. [1] Such results support a greater emphasis on overall severity.

Based on clinical treatment studies, severity across PD category emerges as an indicator of treatment format or approach. In an outpatient group therapy trial comparing long and short-term treatment, patients with PD features had greater benefit of the long-term treatment. Other studies of outpatient group psychotherapy comparing different PD conditions, favor simple formats for the mild to moderate PD conditions (classified within PD NOS). Studies of the highly specialized PD treatment program, Mentalization-based treatment (MBT), indicate that patients with severe conditions (several PDs), have particular benefit of MBT. [2] Patients with only borderline PD and a capacity for regular treatment commitment, may be treated in simpler treatment formats. Specialized approaches would thus seem highly indicated for patients with severe problems of commitment, attachment, and self-destructive behaviors. In large clinical samples, PD categories of paranoid and dependent are found to be infrequent as separate categories, but frequent as comorbid conditions together with borderline and/or avoidant PD. Avoidant PD is a condition with comparable clinical prevalence and severity as borderline PD. It has been termed "the forgotten disorder". Evidence-based specialized treatments are, as yet, not available, although research results are emerging . [3] An "ICD 11 qualifier" was only developed for borderline PD. Concern therefore needs to be raised in order to ensure identification of the more introvert and possibly also, alexithymic problems within the new classification system.

Clinicians in Norway have over several years, been recommended to report personality pathology in a more dimensional way. Clinical instruments have been developed to visualize patient profiles indicating all PD categories, the number of fulfilled criteria within each category, and the total number of criteria across categories. With such an approach, the conversion to ICD 11 may not be so fundamental.

As a fruit of increasing implementation of structured, evidence-based treatments for borderline PD, together with Norwegian health authority's requirements for treatment priorities and systematic progress evaluations, it is a clinical experience that measures of personality functioning and discriminations between mild, moderate, and severe conditions are becoming increasingly relevant. In addition, and most importantly, the motivation for understanding and treating PDs within health services is highly dependent on the validity and clinical utility of classification method. ICD 11 has promising potentials.

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Elfrida Hartveit Kvarstein Head senior consultant, Section for Personality Psychiatry and specialized treatments, Oslo University Hospital and Associate professor, Institute for Clinical Medicine University of Oslo, Norway

Can social neurosciences contribute to improve our understanding and treatment of interpersonal functioning in personality disorders and reconcile different theoretical approaches?

Social dysfunction represents an enduring and difficult to treat aspect of Personality Disorders (PD) psychopathology, which does not seem to be significantly affected by symptomatic improvement over time. Thus, identifying the mechanisms underlying interpersonal difficulties in PD and developing appropriate foci of intervention is a major task for both researchers and practitioners.

However, clinicians and researchers often have different ways to pursue this goal. Clinicians typically refer to various influential theories and related psychotherapy models for PD, each proposing different "key" mechanisms of PD pathology as the target of treatment. Conversely, the Research Domain Criteria initiative focuses on definite systems and circuitries involved in social processing to empirically investigate dysfunctional mechanisms in that domain. Importantly, both these approaches have upsides and downsides. The clinical approach meets the important clinical need to rely on an unitarian and coherent view of PD during therapy, but is mainly driven by theoretical models influenced by specific schools; the research approach seeks to provide the empirical basis for the development and testing of theories, but often fails to link findings to every-day functioning. Moreover, a patient's subjective experience and interpersonal difficulties as a whole can be assumed to be based on the complex interplay of many processes, since they represent mixtures of thoughts, emotions and behaviours that do not necessarily parallel in any straightforward way to single functional systems.

Chiara De Panfilis

Stefanie Lis

This clinical / research dualism definitely needs to be reconciled in order to fully understand and effectively treat PD patients' long-lasting social dysfunction. The DSM-5 Alternative Model for PD takes an important step forward toward this direction by explicitly stating that PD are characterized by impairment in the Self and Interpersonal Domains and that evaluating the level of functioning across these domains is central to make any PD diagnosis. This view provides important clues for understanding the mechanisms of psychopathology and of change with the final goal to improve treatment. While past research efforts extensively focused on issues of behavioural and affective regulation, it is now time to provide clinicians with empirical evidence about the mechanisms underlying their patients' view of self and others and their pattern of interpersonal functioning. Social-cognitive research represents a powerful tool in this respect. Social Cognition (SC) is the sum of those mental processes underlying every social interaction - one's own way of perceiving, interpreting, and responding to the intentions, attitudes and behaviours of the others. There are several advantages in studying PD patients' interpersonal functioning through the lens of SC.

Zsolt Unoka

First, it might disentangle the specific mechanisms beyond a seemingly similar interpersonal behaviour at the symptom level. For example, social isolation may be driven by different impairments in processing social cues (i.e., paranoid thinking, fear of humiliation, a misinterpretation of social signals resulting in perceived rejection, indifference to social feedback, or altered social norms). This may account for the inter-individual variability in response to specific treatments across different PD.

Can social neurosciences contribute to improve our understanding and treatment of interpersonal functioning in personality disorders and reconcile different theoretical approaches?

Second, exploring SC can also clarify the marked intra-individual variations in behaviour across contexts that are often observed over the course of PD. For instance, patients with borderline PD may react with aggression/rage in response to perceived rejection, but then suddenly shift to a submissive or even ingratiating attitude when feeling accepted; patients with narcissistic PD might claim indifference to criticism but then react with intense anger in response to interpersonal injuries; those with obsessive-compulsive PD might be well-functioning at work but feel unease in close relationships.

Third, social-cognitive research encourages discovering PD patients' peculiar ways of processing of social cues, rather than just focusing on their supposed weaknesses or dysfunctions. For instance, evidence suggests that patients with borderline PD might have an uncanny ability to detect subtle signs of emotions in others (the so-called borderline empathy paradox) or might be particularly concerned about injustice. In contrast, individuals high in narcissism might be particularly good at identifying neutral facial expressions. Since these strengths differ from 'normal processing', they may result in unexpected behaviors and hence in disruptions of the flow of social interactions.

Last but not least, SC research provides knowledge on interpersonal functioning based on a broad range of studies in healthy individuals covering areas such as personality and social psychology. This can help understanding interpersonal impairments that may result in a strength of clinical relevance. Moreover, SC may provide a common language that allows to bridge seemingly existing gaps between different psychotherapy approaches.

Given the centrality of interpersonal dysfunction in worsening the long-term outcome of PD, there is a clear need to develop a shared, evidence-based model of interpersonal functioning in PD. Insight into PD unique social-cognitive patterns may offer clinicians belonging to different theoretical orientations new ways to discuss this issue with patients and, importantly, will help them to tailor interventions on the individual patient's specific difficulties (but also strengths) in navigating the inner and interpersonal world.

We are now excited to announce that the ESSPD has kindly agreed to support a Section for the Study of Interpersonal Functioning and Social Cognition in PD. It will represent a great opportunity for different clinical and research groups to join their efforts to examine in depth PD patients' unique patterns of relating with others. We hope that this will help to create a common language across professionals, which could inspire effective treatment strategies to finally improve the long-term functional outcome of individuals suffering with PD. We are honored for being asked to introduce this Section and we look forward to start discussing with the ESSPD Board the upcoming initiatives and activities. In the meantime, we invite all ESSPD members that are interested in being part of this network to contact us at chiara.depanfilis@unipr.it.

Can social neurosciences contribute to improve our understanding and treatment of interpersonal functioning in personality disorders and reconcile different theoretical approaches?

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Chiara De Panfilis, MD, Assistant Professor in Psychiatry, Department of Medicine and Surgery, University of Parma, Italy; and Research Coordinator, Personality Disorders Lab, Italy

Stefanie Lis, PhD, Central Institute of Mental Health, University of Heidelberg, Germany, Institute for Psychiatric and Psychosomatic Psychotherapy

Zsolt Unoka, M.D., PhD, assistant professor at Semmelweis University, Department of Psychiatry and Psychotherapy, Hungary

The next ESSPD Workshops on personality disorders will take place in Budapest, June 2019

Dear Colleagues,

It is a pleasure to invite you to the next ESSPD Workshops on personality disorders: *Skills Training for Effective Treatments* to be held from 6 to 8 June 2019 at Budapest, Hungary. The venue of the workshop will be at the Department of Psychiatry and Psychotherapy, Semmelweis University, at the centrum of the beautiful Budapest. Previous workshops in Tallin and Krakow were highly successful.

At Budapest workshops, excellent researchers and clinician trainers from different schools of evidence-based psychotherapy of personality disorders will give lectures and workshops. Arnoud Arntz will give a lecture about schema therapy of borderline personality disorders and deliver a workshop on basic skills of schema therapy. Anthony Bateman's lecture and workshop will focus on MBT for Narcissistic Personality Disorder comorbid with Antisocial Personality Disorder. Martin Bohus during his lecture and workshop will present the newly developed Dialectical Behavior Therapy module for Complex PTSD, which is a multicomponent program to treat the sequelae of interpersonal violence during childhood and adolescence. The title of Lars Mehlum lecture is *The treatment of self-harm behavior in adolescents – what works?* In his workshop, he will teach the core treatment skills of self-harming adolescents with Borderline Personality Disorder. Stephan Doering will give a lecture with the title of *Introduction to Transference-Focused Psychotherapy*, and his workshop is about the *Mechanisms of Change in Transference-Focused Psychotherapy*." Finally, the title of Ad Kaasenbrood's lecture is Social *Psychiatry for people with a personality disorder.*

The participants of these lectures and workshops will get an introduction to the most important evidence-based psychotherapeutic intervention from excellent teachers in three days.

Best regards,

Zsolt Unoka, MD., PhD., local organizer

**ESSPD Workshops on Personality Disorders
Skills Training for Effective Treatments
ESSPD Műhelyek a személyiségzavarokról
Hatékony kezelések készségfejlesztő tréningjei**

|| 6 – 8 June 2019 / Budapest, Hungary ||

**Semmelweis University
Department of Psychiatry and Psychotherapy**

Selected Sessions and Workshops
Elsőrangú előadások és műhelyek

Arnoud Arntz
Schema therapy for borderline personality disorder
A borderline személyiségzavar sématerápiája

Anthony Bateman
Mentalizing and narcissistic personality disorder comorbid with antisocial personality disorder
Mentalizáció és az antiszociális személyiségzavarral komorbid nárcisztikus személyiségzavar

Martin Bohus
DBT for Complex PTSD A multicomponent program to treat the sequelae of interpersonal violence during childhood and adolescence
A komplex PTSD Dialektikus Viselkedésterápiája - Gyermek és kamaszkori társas erőszak következményeinek többkomponensű kezelési programja

Stephan Doering
Introduction to transference-focused psychotherapy. Mechanisms of change in transference-focused psychotherapy
Bevezetés az áttétel fókuszú pszichoterápiába. A változás mechanizmusai az áttétel fókuszú pszichoterápiában

Ad Kaasenbrood
Social psychiatry for people with a personality disorder
Személyiségzavarban szenvedők szociálpszichiátriai kezelése

Lars Mehlum
Treatment of self-harm behaviour in adolescents – what works? Treatment of self-harming adolescents with Borderline Personality Disorder
A kamaszkori önsértő magatartás kezelése -mi az, ami használ? Borderline személyiségza-varban szenvedő kamaszok önsértő magatartásának kezelése

Registration open
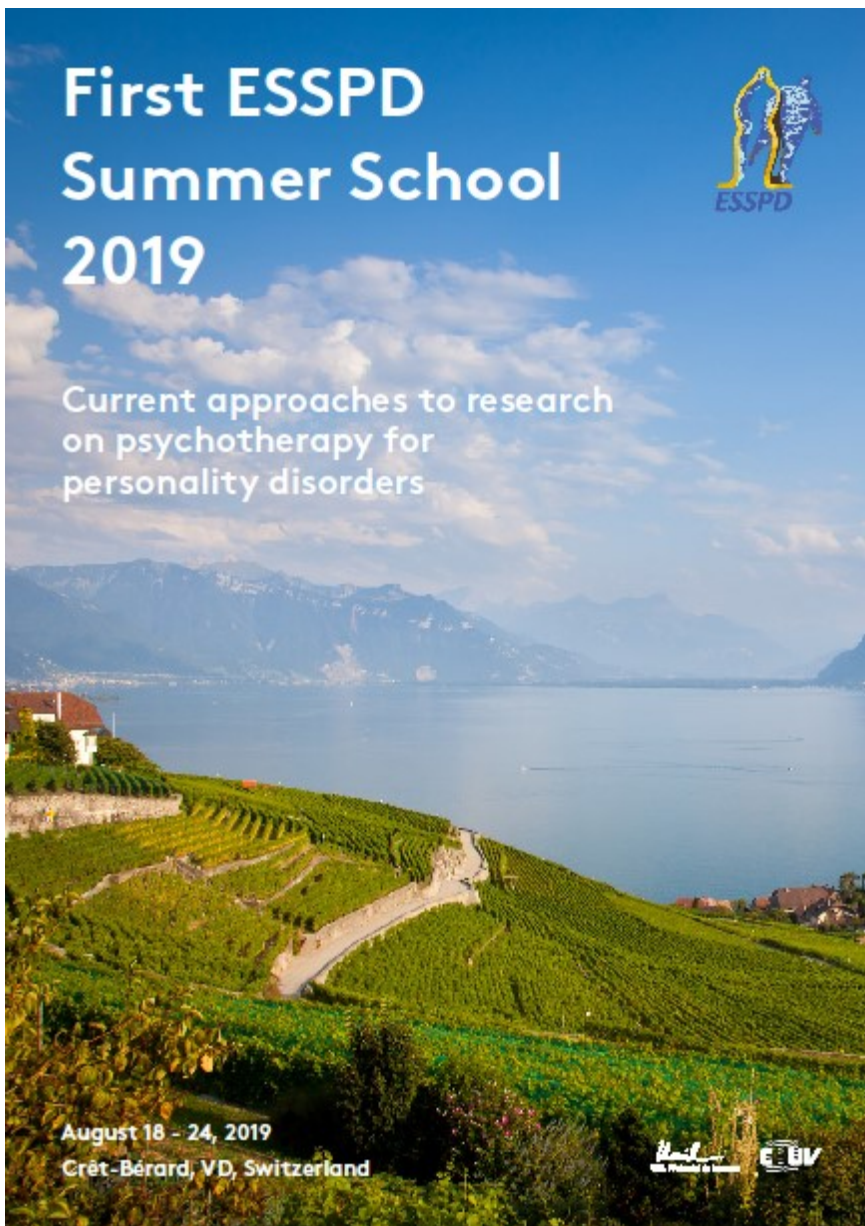Regisztráció megnyílt

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Zsolt Unoka

First ESSPD Summer School 2019

Current approaches to research on psychotherapy for personality disorders

August 18 - 24, 2019
Crêt-Bérard, VD, Switzerland

The European Society for the Study of Personality Disorders (ESSPD), together with the University of Lausanne, Switzerland (Department of Psychiatry), invites young researchers interested in psychotherapy research for patients with personality disorders to apply for the 2019 Summer School.

This first ESSPD Summer School provides an opportunity to learn directly from the experts in psychotherapy research. Participants will learn about the sometimes hidden nuts and bolts of a clinical trial. We will focus on how to integrate neurobiological questions in a psychotherapy trial and how to study the therapeutic relationship and other mechanisms of change on the level of the therapeutic interaction. We will also explore how to include larger-scale variables   in the examination of treatment change in patients with personality disorders.

We are very lucky to be hosted by Crêt-Bérard, a retreat center famous in the region for unique encounters and in-depth and focused work in a picturesque and calm context amidst nature. Perched over one of Europe's largest lakes and not far from busy Riviera cities like the Jazz metropole of Montreux and the Olympic capital Lausanne, we found Crêt-Bérard is the perfect place to take a step back and learn on how patients with personality disorders change through treatment.

Application is competitive and participants from Eastern European countries are explicitly encouraged to apply. Please note that the deadline for applications is now **31 March 2019**. For more detailed information see the flyer at https://www.med.uio.no/klinmed/forskning/sentre/nssf/aktuelt/arrangementer/2019/first-esspd-summer-school-2019.html
or contact summerschool@esspd.eu for more information.

See you in August 2019!

Ueli Kramer and Babette Renneberg

Ueli Kramer   **Babette Renneberg**

ESSPD Research Update

This quarterly newsletter is focused upon the theme of *pharmacological and psychotherapy research in personality disorders* and contains a review of the five most innovative contributions to the literature in the recent months.

The corresponding scientific writer is Sophie Liljedahl, Ph. D.,

Email: dr.s.liljedahl@gmail.com

Sophie Liljedahl

The clinical effectiveness and cost-effectiveness of lamotrigine in borderline personality disorder: A randomized placebo-controlled trial

Aim: To evaluate by randomized controlled trial (RCT) whether the mood stabilizer lamotrigine is clinically effective and economically feasible in the treatment of individuals diagnosed with borderline personality disorder (BPD).

Background: BPD is characterized by difficulties with emotion regulation resulting in core domains of instability. These are affective instability, relationship instability, and behavioural instability, the latter of which is often observed in the form of impulsivity and behavioural dyscontrol. Rates of substance use disorders, self-harm and completed suicide are high amongst individuals diagnosed with BPD. Their suffering is often prolonged and acute.

Due to the rapid shifting of mood and other core features of instability observed in individuals diagnosed with BPD, there has been scientific interest in the prospect of treatment with mood stabilizers. A study reporting positive outcomes of lamotrigine in the treatment of rapidly-cycling bipolar disorder created interest in testing its effects in the treatment of BPD. Existing trials have been limited by short-term studies precluding evaluation of long-term effects, as well as small sample sizes and strict exclusion criteria.

Current BPD practice guidelines support the use of mood stabilizers for self-harming behaviours as well as core features of the disorder, despite the fact that "no medications have been formally approved for the treatment of BPD." (p. 756.)

Method & Procedure: This RCT design was two-branched and double-blinded, comparing lamotrigine with placebo amongst participants recruited from multiple treatment settings in the United Kingdom. Eligibility criteria were: 1 Adult age (18 years +), and 2. SCID-II diagnosis of BPD.
Exclusion criteria were: 1. Co-occurring bipolar disorder, psychosis, existing prescription for mood

stabilizer, possible, planned or existing pregnancy and/or breastfeeding amongst female participants, history of kidney or liver disease and inability to give informed consent due to language barrier or cognitive impairment. Randomization was 1:1 to receive either a placebo or a maximum dose of 400 mg/day of lamotrigine, based on an internet-based randomizer. Participants received their treatment as usual over the course of the trial, which included psychological interventions and emergency hospitalization when deemed necessary. The only restriction was extra prescriptions for lamotrigine or other anti-convulsants. The principal outcome measure was performance on the Zanarini Rating Scale for BPD (ZAN-BPD) at the conclusion of the trial (52 weeks). Secondary outcomes evaluated were concerned with symptoms of depression, self-harm, social engagement and physical well-being, side effects, adverse events and costing.

Results & Discussion: A total of 296 individuals were screened for eligibility, 93.2% of whom met eligibility criteria (N=276). Of these, 195 (70.6%) were followed for 52 weeks. With respect to study retention there was a fairly even split of participants regularly taking lamotrigine (n=49, 36%) versus placebo (n=58, 42%). ZAN-BPD scores were not statistically different in either branch of the study, with scores dropping in both the lamotrigine group and the placebo group at 12 weeks and remaining relatively unchanged over the remainder of the trial. The absence of a treatment effect was a repeated finding from sensitivity analyses. Neither secondary outcomes nor costing analyses reached significance.

In sum, being prescribed lamotrigine did not lead to benefits in any aspect of treatment for individuals diagnosed with BPD, nor was it cost effective for the broader mental health system that serves them. The authors note that the study was well-powered to detect treatment effects if they existed. These findings are in contrast with two earlier small trials, both of which had smaller sample sizes, more exclusion criteria and ran for shorter durations. The authors urge clinicians to resist "considerable pressure" to prescribe at times of crisis given that, based on this large trial of relatively long duration, there was no therapeutic effect for lamotrigine in this sample.

Changing character: A narrative review of personality change in psychotherapies for personality disorder

Keefe, J. R., & DeRubeis, R. J. (2018).
Psychotherapy Research, https://doi.org/10.1080/10503307.2018.1425930

Aim: The authors aimed to review the literature with respect to personality constructs studied in the treatment literature leading to absolute improvement in functioning by way of producing lasting changes in personality.

Background: The authors propose that a possible reason for historically limited gains in the treatment of personality disorders (PDs) may be because core features of the personality driving the disorder do not receive special focus. They propose that longstanding and refractory difficulties in functioning – particularly amongst individuals with PD and co-occurring Axis 1 disorders – may be more specifically targeted in future treatment and related psychotherapy research.

Method & Procedure: Five studies were selected based upon possession of an empirical theory of personality function and dysfunction with accompanying treatments for the latter. Studies included were required to possess the following characteristics: 1. An operational definition of personality dysfunction or defense mechanism to which problematic behaviour is attributed, 2. A description of therapeutic strategies devised to target the aforementioned problems, 3. Formulation of mechanisms of change, and a description of how change would be apparent for the person in therapy. Emphasis was placed upon identification of proposed problematic personality constructs responsible for both the disorder and positive change in therapy.

Based on the narrative review, four personality constructs were identified and evaluated in relation to problematic functioning and remediation among individuals diagnosed with PD. These were: 1. Attachment representations, 2. Mentalization/Reflective Functioning, 3. Core beliefs, and 4. Personality organization/Use of defenses.

Results & Discussion: Improvements in attachment status were associated with related improvements in the individuals' relationship with themselves and others. These improvements could be linked to improved global personality function, which is an encouraged line of future evaluation and research.

Significant limitations in RF were proposed as a marker of PD. RF improved in RCTs in which it was targeted compared to TAU, resulting in reductions in both PD symptoms and problem behaviour. Future research would usefully investigate whether improved RF translates into improved interpersonal functioning.

The authors state that there is an absence of data regarding how core beliefs are changed in treatment for PD, as well as how changes in core beliefs relate to improvement in personality functioning. Evaluating both change of problematic core beliefs and relation to personality function were areas encouraged for future research.

Defense mechanisms can be a barrier to treatment response as well as a symptom of PD due to their distinctiveness. While predictions of PD based on defense mechanisms have been published in qualitative clinical research, they have not yet been tested empirically. Focusing upon PD-matched defensive style in therapy could be useful and pragmatic towards generating lasting change. All studies reviewed indicated that maturation of defense mechanisms translated into improvements in personality functioning. In the case of all four personality constructs the authors recommended that future research focus upon mediators of response to psychotherapy (Kazdin, 2007).

Key Reference
Kazdin, A. E. (2007). Mediators and mechanisms of change in psychotherapy research. *Annual Review of Clinical Psychology, 3,* 1-27.

Diagnosis and treatment of schizotypal personality disorder: evidence from a systematic review

Aim: To give clinical guidance based on a review of the literature on diagnosis, treatment and course of schizotypal personality disorder (STPD).

Background: Lack of agreement exists in diagnostic systems regarding the diagnostic formulation of STPD, with the International Classification of Diseases (ICD) classifying the disorder as a schizophrenia spectrum disorder, while the Diagnostic and Statistical Manual of Mental Disorders (DSM) classifies STPD as a personality disorder. Further, a significant proportion (between 20 to >40%) of individuals diagnosed with STPD convert to schizophreniform disorders depending on how long they are followed. The systematic review was recommended by the Preferred Reporting Items for Systematic Reviews and Meta-Analyses group to evaluate different aspects of the clinical literature generated by individuals seeking treatment for STPD.

Method & Procedure: Searches were conducted in PubMed/MEDLINE databases by two separate reviewers, with data selected by which component of the clinical literature was being evaluated. For diagnostic instruments the authors evaluated papers that tested diagnostic criteria, diagnostic questionnaires, and established questionnaires. For drug trials the authors included prospective double-blind, placebo-controlled trials, double-blind treatment control trials, single-blind, placebo-controlled trials, open label trials, retrospective studies and case reports. Studies were evaluated by Level of Evidence (LoE grading). For papers on psychotherapy the authors included RCTs, uncontrolled trials, and case reports. For papers on the course of STPD the authors evaluated clinical cohort studies, including studies with mixed clinical and non-clinical cohorts if they predicted STPD development over the lifecourse or the conversion rate of STPD to psychosis.

A total of 94 articles met eligibility criteria, and were assessed in full-text. Of these, 54 studies were evaluated. A total of 18 were based upon diagnostic measures, 22 were based upon psychopharmacology, 3 were based upon psychotherapy and the final 13 were based upon the course of STPD over time.

Results & Discussion: With respect to screening instruments evaluated, the authors endorsed the PDQ-4+ and the SPQ. For diagnosing STPD they endorsed the SIDP, SIDP-R, and the SCID-II. With respect to psychopharmacology they principally recommended risperidone and second-generation antipsychotic medication more generally. Regarding the course of the disorder, the authors stated that remission was most typically described as moderate, accompanied by the possibility of transformation of STPD to forms of psychosis. The literature was characterized by small sample sizes with considerable heterogeneity, making evidence-based recommendations for treatment not possible at this juncture. Accordingly, larger treatment studies are a requirement for future research with an aim to generating evidence-based treatment recommendations.

How to assess recovery in borderline personality disorder: Psychosocial functioning and satisfaction with life in a sample of former DBT study patients

Zeitler, M.- L., Bohus, M., Kleindienst, N., Knies, R., Ostermann, M., Schmahl, C., & Lyssenko, L. (2018).
Journal of Personality Disorders, 32, 394

Aim: To evaluate how symptom remission from BPD, as measured by no longer meeting DSM-IV diagnostic criteria, was associated with other measures of recovery. These were observer-based functioning (determined by Global Assessment of Functioning: GAF scores) and satisfaction with life (SWL) scale scores that were self-rated. Symptom remission was evaluated alongside other aspects of recovery, such as self-esteem, dissociation, social support and emotion regulation.

Background: Longitudinal study of how individuals diagnosed with BPD fare over time shows heterogeneity with respect to DSM symptom remission. This is in part due to differing definitions of symptom remission, different study designs employed by different research groups and variation in the characteristics of individuals studied. Accordingly, symptom remission may not be a reliable indicator of recovery from BPD. Similarly, the GAF score introduced by the American Psychiatric Association (APA) in 1987 with DSM-III-R has shown sufficient problems with reliability as to be dropped in DSM-5 (APA, 2013). The SWL scale has promise as a valid index of recovery since it is generated by individuals themselves in relation to their lived experience, without the aforementioned limitations of other traditional measures.

Method & Procedure: A total of N=58 participants were recruited from treatment studies at a German University 12-18 years after they had been conferred diagnoses of BPD in those initial studies. Exclusion criteria for participation in this study were alcohol or drug intoxication, active mania, psychosis or severe depressive episode. Participants had a mean age of 43.51 (SD=8.87) and fulfilled an average of 2.28 (SD=2.22) diagnostic criteria for BPD diagnoses based on IPDE.

Results & Discussion: Of the total sample, 81% achieved symptomatic remission. Recovery criteria in a similar study were defined by symptomatic remission (<5 DSM-IV criteria), good functioning in work-life and social domains, and a GAF score of >60 (Zanarini et al., 2012). Based on these criteria, 36% of the sample in the current study achieved this status. GAF scores ranged considerably, with M=44.45 (SD, 7.75) for the unremitted BPD group, M=49.35, SD=6.89) for the symptomatically remitted group, and M=70 (SD=7.87) for the recovered group.

Self-rated recovery was determined by <5 DSM-IV criteria and a SWL scale score within one standard deviation of norms based on demographic characteristics. Based on these parameters, recovery was present amongst 39% of the total sample (49% based on SWL scale score alone). These results have important implications with respect to the limitations of relying on DSM symptom remission and GAF scores as indicators of recovery for individuals diagnosed with BPD. Replacing GAF scores with participants' self-reported SWL scores reveal a more nuanced depiction of their recovery, and may accordingly be more useful in future studies amongst BPD individuals recovery followed over time.

Key references:
Zanirini, M. C., Frankenburg, F. R., Reich, D. B., & Firzmaurice, G. (2012). Attainment and stability of sustained symptomatic remission and recovery among patients with borderline personality disorder and axis II comparison subjects: A 16-year prospective follow-up study. *American Journal of Psychiatry, 169 (5),* 476-483.

Dialectical behavior therapy for men with borderline personality disorder and antisocial behavior: A clinical trial

Aim: To test the clinical usefulness of a 12-month DBT program for men with BPD and antisocial behaviour, the latter of which resulted in contact with the corrections system in Stockholm, Sweden. Effect of treatment was evaluated within a sample of 30 men. This was the first study to evaluate DBT in a completely male BPD sample.

Background: Despite the fact that BPD has historically been formulated as a disorder affecting mostly women, research has demonstrated that it is as prevalent amongst men (Grant et al., 2008). Given that women are diagnosed with BPD 75% of the time (APA, 2013), men with BPD at risk of criminal offending may represent an under-served population in need of diagnostic recognition and effective treatment. Given the lack of male representation in most BPD treatment settings, it is uncertain at this juncture what clinical services may be effective for them in reducing both BPD symptoms and antisocial behaviours.

Method & Procedure: The sample was comprised of 30 men, referred from either probation or psychiatric services, with criminal behaviour defined by having committed offenses in the past year that could have resulted legal consequences if prosecuted. Exclusion criteria were schizophrenia spectrum disorders, severe substance dependence needing immediate treatment and cognitive impairment. Diagnostic status was determined by clinical interview (SCID-II and MINI). Treatment was comprised of individual DBT, 2.5 hours of skills training per week, with completion defined by engaging in 9 months of therapy (75%). Primary outcomes were suicide attempts, self-harm, property offending, drug offending, and violent offending as measured by the Timeline Followback Method (TLFB). Behaviours targeted in therapy were measured using standardized interviews, measures and diary cards.

Results & Discussion: Symptoms of BPD and depression were substantially reduced post-treatment. A number of problem behaviours targeted in therapy showed significant reductions from pre-to-post-treatment. The most dramatic reductions included self-harm (50% pre-treatment, 14% post-treatment) Verbal and physical aggression and other specific forms of criminality were also substantially reduced. Participants indicated that they were satisfied with treatment at 12-month follow up. Attrition was 30%. This preliminary study indicates that DBT may be a good clinical option for men with BPD and antisocial behaviour. The authors state that replication under higher constraints would be useful in future investigations of clinical interventions for this population.

Key References:
Grant, B. F., Chou, S. P., Goldstein, R. B., Huang, B., Stinson, F. S., Saha, T. D., . . . Ruan, W. J. (2008). Prevalence, correlates, disability, and comorbidity of DSM-IV borderline personality disorder: Results from the Wave 2 National Epidemiologic Survey on Alcohol and Related Conditions. *Journal of Clinical Psychiatry, 69,* 533-545.

Membership Nomination Form

Nominee's name:			
Title:			
Affiliation:			
Email:	City:	Country:	

PROFESSIONAL BACKGROUND (psychiatrist, psychologist, nurse, social worker, other):

NOMINATION CATEGORY *(mark with X)*

Researcher		Clinician		Teacher		Other, specify		

MAIN FIELD(S) OF INTEREST (NEUROSCIENCES, ASSESSMENT, TREATMENT, PREVENTION, OTHER)

ACHIEVEMENTS, ACCOMPLISHMENTS, INNOVATIONS, DISCOVERIES *(list 3 most important)*

-
-
-

PUBLICATIONS *(list 3 most important last 5 years)*

-
-
-

HONORS, AWARDS *(list 3 most important)*

-
-
-

leadership roles *(list 3 most important current or past roles)*

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-
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What you believe nominee will be able to contribute to the ESSPD

-
-
-

Names of two nominators (printed letters):	Signatures of two nominators:
Place	*Date*

Theresa Wilberg

Newsletter Submissions

Submissions to the *ESSPD Newsletter* are accepted on an ongoing basis. Subject areas may include issues from clinical practice, views and comments on current development within PD, reports from affiliated societies, member information, national and international events and conferences, research updates on personality disorders and more.

We are interested in submissions from practitioners and researchers from within and outside of Europe. The length of submissions should be from 300-800 words and formatted in Word. We suggest that the authors limit their use of references. Please enclose author photos with the text.

Submissions should be emailed to Theresa Wilberg (Editor) at: **uxthwi@ous-hf.no**

The corresponding scientific writer is Sophie Liljedahl, Ph. D., Email: **dr.s.liljedahl@gmail.com**