ESSPD NEWSLETTER

ESSPD | European Society for the Study of Personality Disorders

Dear Colleagues,

Lars Mehlum

As the new president of the ESSPD, it is a pleasure for me to inform you about some important recent developments in our society. Based on the mandate given us by our membership at the annual meeting in Vienna in September last year, the ESSPD is now making changes to the membership structure. We wish to reach out to all colleagues who are well reputed for their scientific, policymaking, clinical and/or educational contributions in the field of personality disorders and invite them to join what we intend to build as an academy of excellence. You, our current members are, of course, a backbone in this endeavour. Since new memberships of the ESSPD will now be based on nominations from existing members (see more information on our website) and invitations from the ESSPD Board, we encourage you all to consider nominating colleagues you think will be eligible. There is no membership fee, only benefits we hope to increase even more with the help from you, our members.

Among the core activities of the ESSPD are congresses and workshops. The board is currently working hard to prepare several new opportunities for our members to meet and share knowledge and experience. The first of these, the 2nd ESSPD Workshop on Personality Disorders, is taking place 6 –8 April 2017 in Cracow, Poland with an extensive programme delivered both in English and Polish language. The fifth in the row of the ESSPD very successful biennial International Congresses on Borderline Personality Disorder and Allied Disorders will take place in beautiful Sitges in the outskirts of Barcelona, Spain 27-29 September 2018 in an extremely well suited congress venue. Save the dates for these events – and we will soon get back with more information!

Many of you have heard about the recent proposal from the ICD-11 Personality and Personality Disorder Work Group to eliminate all distinct categorical personality disorder diagnoses and replace them with a simple severity gradient ranging from personality difficulties to severe personality disorder and five domains representing personality traits, described as negative affectivity, dissocial, disinhibition, anancastic and detachment traits. We think this is a very unfortunate proposal and have thus teamed up with the ISSPD and contacted the WHO and expressed our serious concerns in a letter you will find printed in extenso in this newsletter. At the moment we are exploring possibilities of discussing these concerns with the WHO to seek better solutions than the ones that are at the moment on the table. We will keep you informed about the developments when we know more.

As usual you will find a new selection of some of the most innovative contributions to the PD research literature in the recent months excellently summarized for the ESSPD by Dr Sophie Liljedahl. If you have studies you would wish to highlight in our newsletter, don't hesitate to let us know!

Lars Mehlum, President of the ESSPD

ESSPD Letter from Martin Bohus and Lars Mehlum to the WHO regarding ICD-11

Problems with the ICD-11 Personality and Personality Disorder Work Group Proposal: Mental or Behavioural Disorders Section Personality Disorders and Related Traits.
Letter of Concern from the ESSPD

Dear Dr. Reed

I am writing on behalf of the executive board of the European Society for the Study of Personality Disorders (ESSPD). The ESSPD represents the community of European researchers and clinicians studying and working with personality disorders. The executive board of the ESSPD has carefully reviewed the proposal for changes in the ICD -11; 06 “Mental or Behavioral Disorders section Personality Disorders and Related Traits”.

According to our understanding, the current proposal (31.12.2016) eliminates all distinct categorical personality disorders and replaces them by a simple severity gradient ranging from personality difficulties to severe personality disorder and five domains representing personality traits, described as negative affectivity, dissocial, disinhibition, anancastic and detachment traits (Tyrer, Reed, Crawford, 2015).

This attempt is contrary to our basal understanding of psychiatric classification. From our perspective, objectives of classification should meet the following three criteria:

• Classification has to guide clinicians' diagnostic decision making.
• Classification has to create reliable diagnoses underlying communication among clinicians, between clinicians and their patients, and between clinicians and health insurances and commissioners.
• Classification serves as a research framework to better understand etiology of psychiatric disorders and to improve treatment.

Comments on the current proposal for ICD-11; 06 Mental or Behavioral Disorders section Personality Disorders and Related Traits

We have serious concerns, arising from the following reasons:
• The proposed ICD-11system currently relinquishes all established specific categorical personality disorders and replaces them with a single category and 5 domains without a solid evidence base.
• Any future classification in psychiatry will be measured against its potency to provide a suitable tool for selecting treatment / constructing individual treatment plans. High order, highly stable personality dimensions are of limited clinical utility with regard to the selection of treatment or the prediction of treatment response. In fact, we are not aware of any guidelines in the clinical or empirical literature that documents how broad trait domains can be utilized in clinically meaningful ways (see Clarkin & Huprich [2011] and Meehan & Clarkin [2015] for a further discussion of these issues).
• The magnitude of the changes is unjustified: the rationale is both incomplete and inadequate. The only empirical validation trial published so far (Kim et al. 2014, 2015) is not representative, (e.g. the trial was carried out in one country, Korea, and in a small sample not representative of the broad range of psychiatric diagnoses and did not reveal confirmatory data).
• And even more, the proposed system ignores 20 years of disorder specific research which has provided clear evidence for both clinical and economic efficacy of specifically tailored treatment programs (e.g. borderline personality disorder [BPD], antisocial personality disorder, and avoidant personality disorder).
• In particular the revisions for BPD are unwarranted and unnecessary. They undermine the hard-won scientific gains about this disorder`s etiology, course, and treatment. Worse, they undermine the trust and hopes that patients, families, and clinicians have learned about this diagnosis.

• Patients with BPD, who represent about 3% of the European population and utilize about 15% of the costs for mental health care in Europe, will in some countries have serious difficulties accessing adequate evidence=based treatments if the diagnosis disappears. Treatment costs will hardly be covered by insurance companies if there exist no specific diagnosis at which the treatment is targeted.
• Only relatively recently have PDs, and particularly BPD, become recognized as highly prevalent and diagnosable disorders associated with increased long-term impairment, morbidity, and mortality among adults (Quirk et al. 2016; Fok et al. 2014) and adolescents (Björkenstam et al. 2015). This recognition has had a strong and positive impact on the development, adaptation and implementation of treatments for patients, particularly in adolescents. We fear that the proposed changes in the ICD 11 could lead to a loss of focus and a serious setback in this important field.
• Neither validity, nor reliability is likely to be attained due to the rough definition of degrees of impairment in the ICD-11 proposal and the use of domains without facet specification. This will lead clinicians to potentially equate negative affectivity with 'what we used to call borderline personality disorder', for example.
• The proposed revision has been intensively criticized at several international congresses by the leading experts of the field, without any written response or insight by the representatives.
• The critiques on categories of personality disorder put forward by the ICD-11 working group on personality disorder (high concurrent and sequential comorbidity, heterogeneity of diagnoses, arbitrary diagnostic thresholds etc.) are critiques against psychiatric nosology in general. Thus, the current discussion on a dimensional vs. categorical classification of personality disorders reflects a discussion needed in psychiatry in general and a discussion that needs time (Chanen 2011).
• Psychiatric classification should not be changed in a revolutionary way but in an incremental way not to run the risk of leaving affected people without society's help. Overturning diagnostic traditions has major impact on health care services and, by extension, millions of people.
• Personality disorders are, or at least should be, an equal partner with other mental disorders. The classification of PDs should be constructed in an analogue way to the other psychiatric disorders, and any move to dimensions should be a meta-decision for the whole of ICD.

In summary, we believe the current proposal and changes are:
1. too radical for clinicians to follow;
2. not based on adequate scientific evidence;
3. likely to be destructive, leading to serious problems in the mental health care system.

Suggestions
We urge the WHO to make a revision of the current proposal. We strongly suggest keeping to established diagnostic categories of PDs until a new, sufficiently theoretically and empirically grounded, clinically useful classification for psychiatry has not been finalized. Our suggestion is to follow the long and hard achieved compromise elaborated by the DSM-5 Personality and Personality Disorders Workgroup which has established the "Alternative DSM-5 Model for Personality Disorders". This model differentiates impairments in personality functioning and pathological personality traits in addition to preserving some specific personality disorder diagnoses such as Borderline, Antisocial, Avoidant and Narcissistic personality disorders which are defined by typical impairments in personality functioning (Criterion A) and characteristic pathological personality traits (Criterion B).

We call upon the ICD-11 PD Work Group to actively seek feedback from the international medical and psychological associations on personality disorders and the international clinical community. Without integrating that feedback into a revised proposal, field trials cannot hope to address the issues that are relevant to progress in our field.

Amsterdam, 31.12.2016, Martin Bohus, MD: President; ESSPD and Lars Mehlum, MD; President-Elect; ESSPD

This quarterly newsletter focused upon the theme of Diagnostics and Comorbidity in its selection of the five most innovative contributions to the literature in the recent months.

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Three cases of narcissistic personality disorder through the lens of the DSM-5 alternate model for personality disorders

Pincus, A., L., Dowgwillo, E. A. & Greenberg, L. S. (Sep 2016)
***Practice Innovations, 1,* 164-177 http://dx.doi.org/10.1037/pri0000025**

Aim: The goals of the article were to briefly introduce practitioners to the DSM-5 Section III alternative model for personality disorders (AMPD) and to present its utility by demonstrating sensitivity to clinically relevant differences amongst three cases of individuals with Narcissistic Personality Disorder (NPD).

Background: It has been argued that DSM-IV/5 diagnostic criteria can be problematically narrow by not sufficiently covering the breadth of personality impairment associated with pathological narcissism. The authors propose that the AMPD more effectively characterizes the heterogeneity in presentation of narcissism. The AMPD joins two domains of personality pathology. The first domain involves disturbances in self (identity and self-direction) and interpersonal (empathy and intimacy) functioning as assessed by the Level of Personality Functioning Scale (LPFS). The second involves a dimensional model of personality traits which are organized into five broad trait domains comprised of 25 specific trait facets. The AMPD domains are derived from major contributions in psychiatry, clinical psychology, and empirically based personality assessments. The article focuses on the relevance of distinguishing levels of personality functioning and pathological personality traits.

Procedure: Three individuals demonstrating pathological narcissism were evaluated using DSM-5 AMPD after the beginning of psychotherapy. The participants were recruited from an outpatient community treatment centre. Participants also completed an extensive intake assessment battery that was administered as part of routine care within the setting. Only one of the three patients met full criteria for a DSM-IV/5 NPD at intake.

Results and Discussion: Results generated distinguishing profiles with respect to the nature and severity amongst the cases. The authors suggest that the AMPD's sensitivity generalizes with fidelity to the clinician experience of patients with pathological narcissism in clinical practice. More specifically, the AMPD improves upon the narrowly defined DSM-5 section II NPD by including criteria for self and interpersonal impairments, and by explicitly specifying that grandiosity, a core feature of NPD, may be overt or covert. They also discuss how the AMPD definition of NPD might be improved to better account for narcissistic vulnerability, another central aspect of the disorder. They suggest that the clinical relevance of pathological traits in psychotherapy differs as a function of severity of personality impairment, and that the AMPD provides a clinically important dimension of severity of personality impairment that has important implications for treatment planning.

Clinical vs. DSM diagnosis of bipolar disorder, borderline personality disorder and their co-occurrence

Bayes, A. J., & Parker G., B. (Mar, 2017)
Acta Psychiatrica Scandinavica, 135, 259-265. **DOI: 10.1111/acps.12678**

Aim: To determine frequency and origins of discrepancies between clinical and DSM-based diagnoses of bipolar disorders (BPs), borderline personality disorder (BPD), and both disorders concurrently presenting. Clinically allocated diagnoses were those that took into consideration demographic and developmental factors as well as behavioural observation in formulating a diagnosis. DSM allocated diagnoses were based upon DSM-IV criteria sets for both disorders derived from a semi-structured interview administered by an experienced psychiatrist.

Background: BPs and BPD share many of the same presenting characteristics, such as impulsivity, lability of mood, emotion dysregulation and so on. Accordingly it may be difficult in clinical practice to distinguish one disorder from the other, and to determine in which individuals both disorders are present. Accurate diagnosis is vital as treatment recommendations are significantly different for BPs compared to BPD.

Participants and Procedure: Participants were adults (18 years and older) seeking mental health services for BPs and BPD. They were recruited from a number of clinical settings. Recruitment was also by invitation from a Volunteer Research Register as well as from online and newspaper advertisements. Participants' diagnostic status was evaluated alongside the method (clinical or DSM diagnostic criteria) to determine rates and reasons for diagnostic concordance and discordance.

Results and Discussion: Diagnostic discordance increased alongside relaxing the BP disorder duration criteria in clinical diagnostic allocation, resulting in clinical BP allocation for participants given unipolar depressive DSM diagnosis. Clinical versus DSM diagnostic allocation of BPD resulted in minor discordance, the greatest source of which was generated from clinically comorbid allocation of BP disorder and BPD DSM diagnosis. A finding at variance with the literature was that relaxing the BP disorder duration criteria did not influence rates of incorrectly diagnosing BPD. The DSM allocation tended to overestimate comorbidity between the two disorders, compared with rates of comorbidity derived from clinical allocation.

Short report: Clinically useful screen for borderline personality disorder in psychiatric out-patients

Zimmerman, M., Multach, M. D., Dalrymple, K., & Chelminski, I. (Dec, 2016)
The British Journal of Psychiatry. **DOI: 10.1192/bjp.bp.116.182121**

Aim: To increase screening for BPD using a single feature of the disorder, as BPD tends to be under-evaluated in non-specialized settings. Based on a large sample of evaluated outpatients, the affective instability criterion in DSM-IV's diagnostic nosology had the highest sensitivity (92.8%) of the nine BPD diagnostic criteria, suggesting that it could serve as a useful screening item in clinical practice.

Background: The authors' report from the Rhode Island Methods to Improve Diagnostic Assessment Services (MIDAS) project focused upon defining a "gate criterion" for BPD, by using a simple screener while assessing for other clinical syndromes. They shared the example of gate criteria being used to query anxiety in the presence of depression, and suggested that targeting an identifying feature of BPD for similar screening purposes could lead to better detection in clinical practice.

Participants: As part of standard clinical practice, 3674 individuals receiving community-based outpatient mental health services completed diagnostic assessment at intake using both a modified SCID and the BPD section of the Structured Interview for DSM-IV Personality (SIDP-IV). Participants were adults (mean age 38.8), mostly female (60.2%), and primarily white (87.1%)

Procedure: Diagnostic data were analysed to determine the sensitivity, specificity, positive and negative values of the diagnostic criteria comprised by BPD.

Results and Discussion: A diagnosis of BPD was present in 10.6% of the sample. In all analyses, the diagnostic criterion pertaining to affective instability had the highest sensitivity (>90% for both men and women) compared to the other eight diagnostic criteria for BPD. The next highest diagnostic criterion was anger. Used together (affective instability and anger), there was a minor increase in sensitivity (97.4% compared to 92.8%) over using affective instability alone. That said, affective instability was endorsed by >90% of individuals with BPD. The authors suggest beginning with affective instability as a gate criterion and then progressing to standard diagnostic practice for determining whether or not BPD is present amongst individuals who endorse this screening item.

Clinical importance of personality difficulties: Diagnostically sub-threshold personality disorders

Karukivi, M., Vahlberg, T., Horjamo, K., Nevalainen, M., & Korkeila, J. (2017)
BMC Psychiatry, **DOI 10.1186/s12888-017-1200-y**

Aim: To determine the presence and severity of diagnostically sub-threshold personality problems, using a four-level dimensional classification.

Background: The authors propose that personality has a dimensional nature, which can be misunderstood or poorly reflected in criterion-based personality disorder (PD) diagnostic formulations. Accordingly they state that adherence to traditional PD diagnostic cut-offs risks losing track of individuals with substantial personality impairment who may be sub-threshold with respect to criterion-based PD diagnostics. In the current study the authors used an adapted version of Tryer and Johnson's (1996) cluster method for assessing personality difficulties.

Participants: Adult recipients of mental health services were recruited to participate. A sample of 352 patients completed SCID-I and SCID II assessments as well as surveys regarding social functioning, validated symptom inventories, and a measure of childhood adversity.

Procedure: Following assessment participants were grouped into one of four categories based upon level of personality dysfunction with: 0 = nil, 1 = subthreshold personality difficulty, 2 = simple PD, 3 = complex/severe PD (two or more PDs or either BPD or antisocial PD).

Results and Discussion: The four-level classification rates were, by ranking of most frequent to least, no

personality disturbance (38.4%), complex/severe PD (24,4%), simple PD 19.9%), sub-threshold PD difficulty (14.5%). The no personality disturbance group was significantly differentiated from the rest of the sample (p. <0.05) based on mood, general functioning, and number of co-occurring Axis 1 disorders. The complex/severe group fared the worst across assessment measures including social dysfunction. The sub-threshold group also reported significant impairment consistent with that of individuals with full-blown PDs. These results highlight the authors' proposal that attending to subthreshold personality problems has clinical utility.

Key Reference: Tyrer P, Johnson T. (1996). Establishing the severity of personality disorder. *American Journal of Psychiatry*, *153,* 1593–1597.

What changes when? The course of improvement during a stage-based treatment for suicidal and self-injuring women with borderline personality disorder and PTSD

Harned, M. S., Gallop, R. J., & Valenstein-Mah, H. R.

Psychotherapy Research, **DOI: 10.1080/10503307.2016.1252865 (Nov, 2016)**

Aim: To determine the onset and progression of changes in functioning amongst individuals with borderline personality disorder (BPD) and PTSD over the course of a three-stage Dialectical Behavior Therapy (DBT) + DBT Prolonged Exposure (DBT PE) treatment compared with the progress of changes in functioning amongst individuals with the same diagnoses receiving DBT alone. A secondary aim was to observe clinical changes amongst those with BPD and PTSD receiving DBT, but not receiving PTSD-specific treatment.

Background: DBT PE is a treatment for individuals with concurrent BPD and PTSD, as well as self-harming and suicidal behaviours. The DBT PE treatment is staged, with first stage focused upon out-of-control behaviours, stage two focused upon trauma treatment, and stage three focused upon treating problems that remain outstanding. This integrated treatment facilitates working with multiple principle co-diagnoses while supporting the clinician to organize treatment over stages and targets. As with standard DBT, treatment is derived from principles that are tailored to the individual so that they move through treatment as they reach their goals. In the current study, outcomes are evaluated based on the type of treatment received, its course, and the onset of changes observed.

Participants and Procedure: The sample was comprised of 38 adult female participants with BPD and PTSD with self-harming and suicidal behaviours occurring within the past three months. The sample was divided into three treatment groups: DBT (n=8), DBT+DBT PE (n=18), and finally DBT-No DBT PE (n=12) which comprised patients who were offered but did not initiate DBT PE. The progression of changes over multiple outcomes emerging from the three stages of DBT PE compared with DBT was examined separately and in comparison. Data were collected during weekly individual sessions allowing for close tracking of change over time.

Results and Discussion: Participants in DBT + DBT PE persisted in their urges to self-harm and commit suicide in the first stage of treatment, although the frequency of engaging in self-harm and suicidal behaviours reduced significantly. Stage two marked the commencement of significant improvement in PTSD symptoms via the DBT PE treatment protocol, and stage three marked the commencement of significant reductions of state dissociation and BPD severity. Amongst participants receiving DBT+DBT PE compared to DBT and DBT-no DBT PE, outcomes amongst groups were similar for stage one. At stage two

and three, however participants in DBT+DBT PE demonstrated significant improvements in well-being, reduced BPD and PTSD severity and lower state dissociation in stage three compared to the other treatment tracks. Taken together these results suggest that the DBT PE protocol in addition to DBT may improve PTSD outcomes as well as address other co-occurring clinical syndromes by specifically working with PTSD.

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 all text.

Submissions should be emailed to Theresa Wilberg (Editor) at:
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