ESSPD | European Society for the Study of Personality Disorders

ESSPD Academy Newsletter, June 2020

Stephan Doering

Dear ESSPD members and colleagues,

I wholeheartedly hope that so far all of you were able to get through the Covid-19 crisis without severe illness of yourself and your beloved ones and without personal and severe economic losses. This crisis imposes manifold burdens on us, be it working in the first flight in hospitals and/ or with Covid-19 patients, be it the challenge of online consultations, treatments, and teaching, be it dealing with our patients´ fears, burdens, and emergencies. The lockdown does not only affect our clinical and educational work, it also restricts or even disrupts our scientific work; many of us cannot continue with the recruitment of patients for our studies, with their assessment, or with their regular study treatments. Many of us will suffer from losses of scientific output of one or the other kind.

A major loss is also the postponement of our 2020 conference in Antwerp. It was scheduled in September 2020 and is now moved to autumn of 2022 at the same place. We discussed to move it to spring or autumn 2021, but we immediately recognized that by doing this we would directly compete with to conference of our sister society, the ISSPD, which will take place in November in Oslo (see announcement in this newsletter). We took it for granted that we will adhere to our joint agreement that our societies will complement each other instead of engaging in a competition. Thus, we hope to see many of you next year in Oslo.

We decided to offer you at least one part of scientific and political content from our conference in an online format: a discussion of experts about euthanasia of patients with personality disorders. Together with the membership assembly 2020 this will be held in autumn; you will receive a separate invitation for that.

You will find another ESSPD initiative in the newsletter, a waiver for three publications in our society´s affiliated journal BPDED. We decided to support particularly our members from Eastern European countries, for whom we will pay the publication fee, if their submissions are accepted for publication and selected for a waiver by a committee.

A major part of this newsletter focuses on the treatment of patients with PDs in the Covid-19 crisis: Gitta Jacob, Michiel van Vreeswijk & Sally Skewes, Michaela Swales, Anthony Bateman, and myself present you different insights into the application of empirically-validated treatments in the time of Covid, which in large part means online therapy.

In addition, Ester di Giacomo, the representative of our Young Researchers Forum in the ESSPD Board sends greeting from our young colleagues, and in her well-established way, Sophie Liljedahl summarizes important scientific publications for us.

Finally, you will find a short report from our latest ESSPD publication in the BPDED, the upcoming summer school for young researchers, a book on BPD parent training, and a press release by the International Consortium for Health Outcomes Measurement (ICHOM).

I wish all of you primarily health and – as much as possible – a burden-free, beautiful, and relaxing summer.

Yours

Stephan Doering, MD
President of the ESSPD

Online Therapies for PD Patients: priovi, a schema-therapy based online self management program for people with borderline personality disorder

Gitta Jacob

Borderline Personality Disorder (BPD) is a common, severe and costly mental disorder. Even though effective psychotherapeutic approaches exist, few BPD patients have access to them. Internet-based self-management interventions (SMI) may be a suitable strategy to reduce this treatment gap, particularly in the current situation with the need for physical distancing.

So far, only very few SMIs have been developed, and most of them have been tested rather in small-scale pilot studies. Most SMI are targeting specific symptoms (such as heavy drinking or suicidal behavior) rather than the full range of BPD-related symptoms. Many of them are based in dialectical behavior therapy. Overall, there is still much room for improvement in this field both with regard to software development and with regard to effectiveness testing.

Priovi is a very broad and comprehensive program following the concept of schema therapy for BPD. In schema therapy, the different symptoms and problems of BPD patients are conceptualized as different "schema modes". A schema mode covers a personality state or facet and may be functional or dysfunctional. Most important modes of BPD patients are the vulnerable child mode (reflecting emotions like anxiety, loneliness or vulnerability), angry child mode (reflecting anger problems), punitive parent mode (reflecting self-devaluation and guilt), detached protector mode (reflecting emotion-avoidant behaviors such as numbing, dissociation, or other behaviors to avoid strong emotions), and the healthy adult mode (reflecting healthy, adult behaviors and feelings). Treatment is oriented alongside the current mode states of patients. As an example, if the patient is in a vulnerable child mode, they are soothed and helped to find a way into more pleasant emotional states. If a patient is self-devaluing herself in the punitive parent mode, therapist and patient work together to fight against these messages and replace them by healthy adult messages.

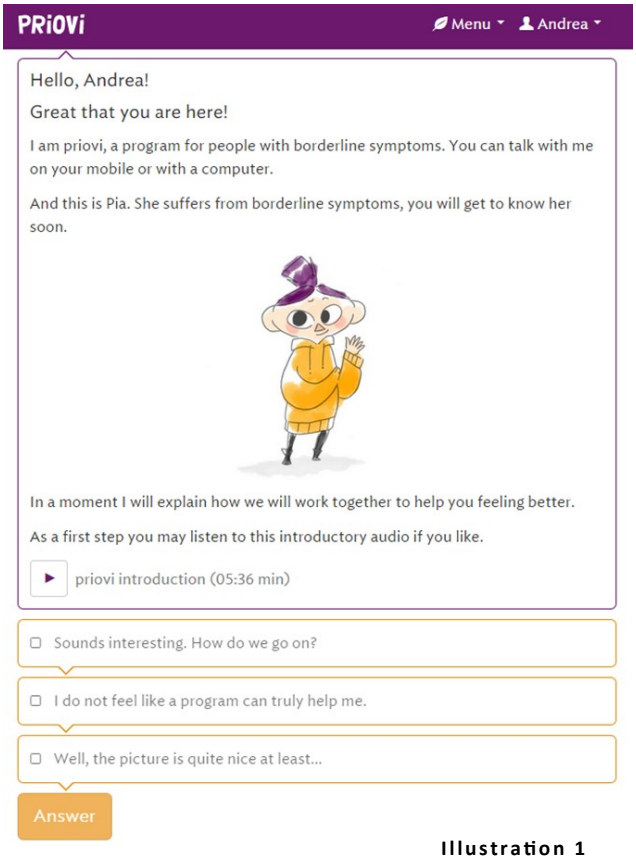

Illustration 1

Priovi is therefore highly tailored to the individual needs, modes, and mood states of patients and can be flexibly employed to meet the frequent shifts in symptoms in BPD patients. The dialogue-based structure fosters active involvement of the patient. Illustration 1 shows the welcome screen when users log in for the first time. Illustrations of Pia, a girl with BPD, guide the program.

Technically, priovi is usable on all online devices (i.e., desktop computers, laptop, tablet-PCs, or smartphones). It uses cloud computing with fast global access and is hosted on a software platform certified with regard to data protection and security. priovi integrates text, audio, illustrations, and pictures as well as outbound messages such as text messages or emails. It allows tracking of BPD symptoms, depressive symptoms, happiness, and everyday problems. With the so-called 'cockpit' function (explained below) therapists can monitor program usage of their patients.

The main components of priovi are dialogues ('chats'), exercises, and techniques, which are organized in two phases: Phase I: Psychoeducation and Phase II: Interventions and exercises. Users can pause and continue sessions anytime they want. All components can be repeated individually.

Phase I covers psychoeducation on BPD symptoms, human needs, childhood abuse, and BPD-specific modes and emotions. All content is offered playfully, through the use of explanatory text, case examples, games

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imagery exercises, comics, and illustrations. Illustration 2 shows a screenshot from a 'chat' on the detached protector mode as an example.

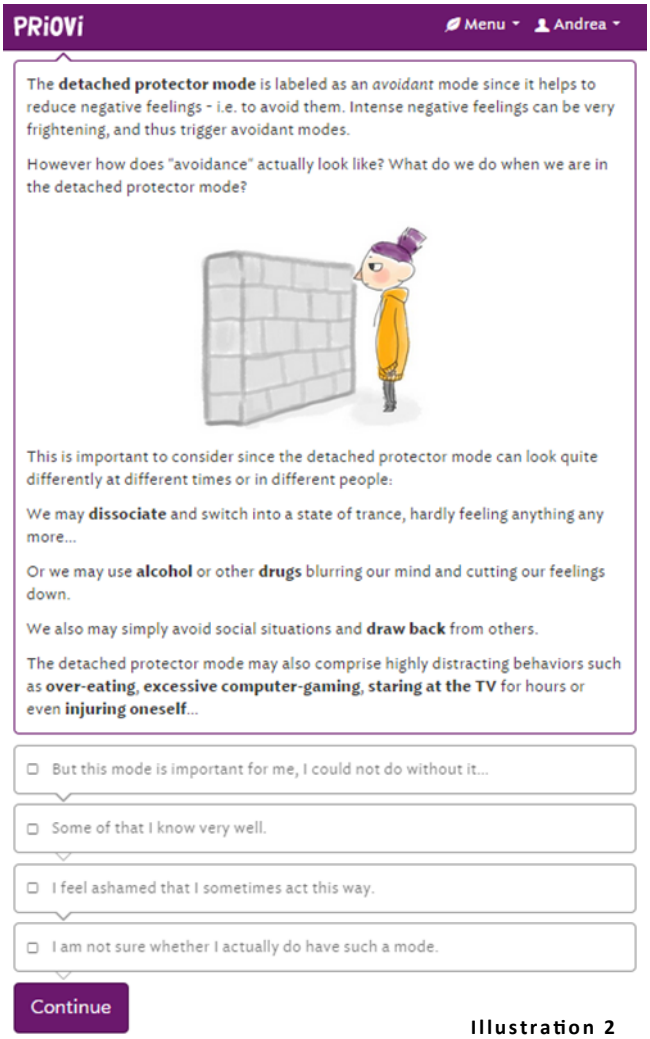

Illustration 2

Phase II contains many mode-specific exercises tailored to the needs of the user, including pro-con lists and similar cognitive techniques, work with case examples and one's own issues, imagery exercises, and affirmative audios. Exercises are increasingly demanding depending on the capacity of the user.

Priovi contains many additional components, such as an individual 'mode-toolbox' with helpful strategies for each mode, an 'Exercises' area for the training of already learned skills (see illustration 3), a 'glossary' with important terms and information, and the possibility for tracking BPD symptoms, depression, and mood on a regular basis. If users register for text message or email service they also receive daily messages from priovi.

If patients use priovi on a regular basis (e.g., two times a week for half an hour) they can work through all content in about six months. However, as repetition of content and especially of exercises is strongly recommended, we suggest using it at least for one year.

First pilot studies showed good feasibility and safety of priovi in combination with personal schema therapy (Fassbinder et al., 2015; Jacob et al., 2018). Therefore, we conducted a randomized-controlled trial (Klein et al., 2018), data analysis is currently under way. Overall, it seems that priovi might be a safe and feasible support for people with BPD.

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Online Therapies for PD Patients: The use of Secure Nest in (blended) schema therapy: an online tool for limited reparenting and bridging the gap between the therapist's room and the patient's daily life

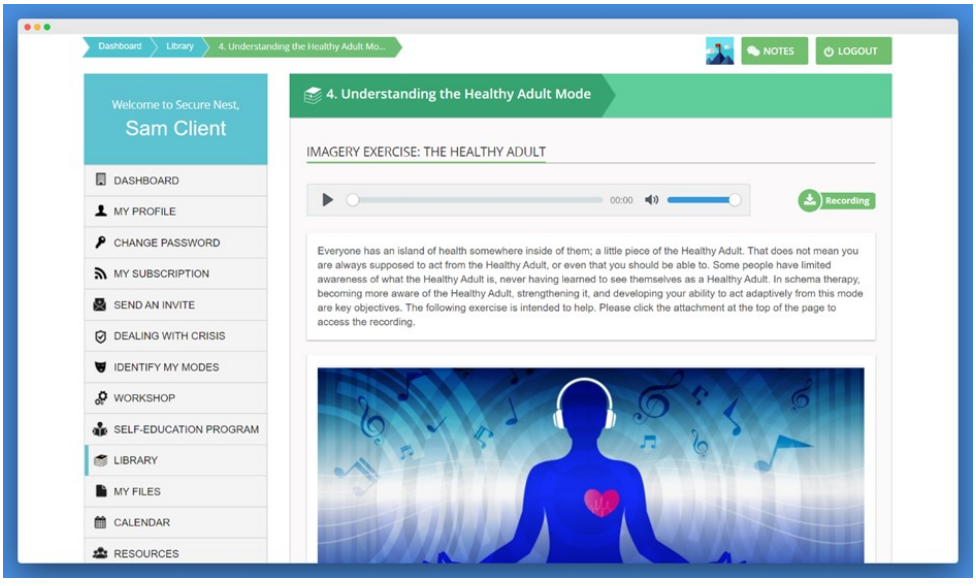
Introduction

Michiel van Vreeswijk & Sally Skewes

Schema therapy (Young, Klosko, & Weishaar, 2003) has had increased interest from therapists, researchers and patients in recent years as a treatment method for difficult to treat patients like those with personality disorders and chronic clinical syndromes (Jacob & Arntz, 2013; Masley et al., 2012; Taylor et al., 2016). Schema therapy consists of limited reparenting, multiple techniques and insights from years of clinical work and research experience across different therapies for personality disorders. Central in the work of schema therapy is the concept that when a patient's needs are not met in their childhood, a distorted view of themselves and the world around them develops, and they have problems in mentalization and healthy relationships. In schema therapy, the patient and therapist explore what is triggered in daily life. They also focus on and practice how the healthy adult part in themselves can grow to enable their vulnerable part to have their needs fulfilled in a healthy and adaptive way. In this process the therapeutic relationship is actively used as a vehicle for growth in becoming healthier. Secure Nest, an online schema therapy platform, has been developed to help both patient and therapist in creating a safe place for connecting and working on unhealthy life patterns (schemas and modes). It is a highly flexible and adaptive online schema therapy platform, written in English, for different stages of schema therapy in different formats e.g. time limited, individual or group schema therapy. It works especially well in the use of imagery exercises, imagery with rescripting, art therapy elements, cognitive behavioral techniques and for promoting the feeling of connection with the individual therapist or group therapists and group members.

Waiting list

In most countries, resources for the treatment of longstanding disorders are under pressure and waiting lists of several months or longer are common. For those patients who are interested and able there is the possibility to access a 3-week self-help program in Secure Nest which can support them to gain more insight into their unhealthy life patterns. An assessment at the beginning of the program provides an overview of the patient's schemas, needs and coping style. The patient is then guided through relevant exercises based on the assessment.



Online Therapies for PD Patients: The use of Secure Nest in (blended) schema therapy: an online tool for limited reparenting and bridging the gap between the therapist's room and the patient's daily life

The use of Secure Nest in individual schema therapy
By using Secure Nest for individual schema therapy it is possible to connect online between sessions. Patients can increase their awareness of situations which trigger their schemas and modes in daily life by filling out diaries online. Patients can also listen to recordings which support the Healthy Adult to grow in daily life (beyond the therapist's room). Sharing experiences in Secure Nest can enhance energy and engagement in therapy.

Group schema therapy and the use of Secure Nest
When using Secure Nest for blended group schema therapy it is possible to alternate sessions in the group therapy room with doing homework online and sharing experiences and reflections with each other in Secure Nest. Patients are able to see each other's homework and respond to each other. The group therapists can monitor this process and respond to the group process as a priority (instead of responding to individuals in the group).

The option of two time-limited schema therapy protocols
At this moment two time-limited schema therapy protocols are part of Secure Nest (a 10 session and 20 session protocol) which can be used for individual and group schema therapy. It is of course possible to extend the number of sessions whenever possible as the therapists can create their own material and upload it to Secure Nest depending on the needs of the patients and the possibilities of the mental health care services in that country.

Discussion
Secure Nest is an online schema therapy platform which is constantly in development based on lively feedback from users. As with all therapies not all patients can benefit from blended schema therapy. For some because of practical reasons like having no computer or Internet connection or because of problems with reading and writing. For others because of their psychological make-up; being too impulsive, easily bored, too detached or paranoid to name some of the reasons. Having said this, there might be more people who can benefit from blended schema therapy in the therapy room with the use of Secure Nest than initially thought. It is good to keep in mind that it is sometimes the therapist who is the obstacle and not the patient. Starting to learn to work with new methods and become experienced is the diligent task for a therapist. What will the future look like in ten years? Will we be more confident in giving blended schema therapy, perhaps even adding virtual reality and augmented reality to it?

See for more information:
Please visit securenest.org if you would like to create a free trial account to experience a new way of working with your clients or view this series of short videos for a tour and to learn more about the features available.

Michiel van Vreeswijk & Sally Skewes

DBT in the time of Covid

Michaela Swales

Covid-19 presents all of us with significant challenges in our personal and working lives. Those of us fortunate to benefit from good mental health may still be finding these new circumstances demanding – for our clients who struggle at the best of times, and these are not the best of times, the difficulties can be overwhelming. On the other hand, the shared sense of a community under threat, the importance of social withdrawal, the legitimacy of struggling to cope has chimed with some clients' ways of seeing the world and increased their sense of connectedness. So, as a therapist thinking about how to support our clients at this time, we are reminded of a central adage of DBT: *always assess, never assume'.*

To effectively assess how our clients are coping, we need to be able to meet with them. DBT services across the globe, along with all other mental health services, have been working to adapt to delivering during lockdown. In communities where there are good broadband services and where healthcare services have access to approved platforms, a telemedicine revolution has taken place. Many DBT programmes have transitioned to virtual delivery continuing with individual therapy and skills groups via video link. Where video has not been possible, phone, email and text delivery have been utilised.

Skills training works very well using platforms that allow therapists to share their screen with teaching content and allow all group members to see and be seen. In jurisdictions where wide access to the internet is available and healthcare services are willing to support such platforms, DBT skills training very quickly becomes almost as good as in-person training. From a learning perspective there is a distinct advantage to this type of delivery. Clients are actually learning the skills **in** the environments in which they need to practise them – this can make generalisation less of a challenge. In circumstances where these platforms are not supported, therapists, previously shy of new technology, have posted videos of themselves teaching skills on Whatsapp and learnt how to set up private YouTube channels to ensure clients receive DBT skills content. They have trawled the internet sampling the wide array of content already available for teaching skills to direct clients to useful websites and apps. Combined with follow-up phone calls to check-in with clients about their understanding and rehearsal of new skills, these methods can fulfil the function of DBT Skills classes – to acquire and strengthen new skills.

Individual therapy, like skills training, can be delivered via a number of platforms. Video is definitely preferable to voice call alone. To be maximally effective therapeutically, you need to see your clients' facial expressions and body posture, as these give you vital clues in conducting effective behavioural analyses and essential feedback about skill level when implementing new solutions. Many clients, and sometimes therapists, find exposing themselves to the camera a challenge. Therapists need to lead from the front here. Talk about which skills you have used to overcome your own anxieties about this shift in delivery and link to the clients' goals for therapy about why facing their fear, shame and discomfort will assist them to solve other issues in their lives. With both current and new clients have a separate appointment specifically to address the challenges of the technology and troubleshoot with them how to handle it. In this session it is vital to address the issue of privacy. Some clients maybe living in environments with minimal privacy. Discussing alternative options where the client feels safe to speak without being overhead is vital. Clients have joined sessions from their car (not whilst driving), whilst out walking or from garages and sheds. Therapists may need to overcome their own discomfort about delivering therapy in unconventional surroundings!

The act of getting ready and leaving your home and travelling to a separate location to receive therapy all prepares you for the act of engaging in therapy. Clients may need coaching on how to go through this process when essentially having therapy at home. Clients need to be out of bed and dressed for therapy at a minimum. You may advise clients to do a few minutes of gentle or vigorous exercise or a brief mindfulness practise ahead of the session to prepare themselves. Discussing how they can wind-down from the session and re-enter their home life is also important. Therapists too are finding this a challenge. Just as the commute to the office helps clients prepare it helps therapists too. So, think about how you can cue yourself to be in therapy mode. Set up your work space to signal DBT – even if that workspace later becomes the dining room table! Have a mindfulness

bell to hand, set out some books that remind you of the therapy. Get dressed as if you were going to work – all the way (so no dressed for work from the waist up and pyjamas from the waist down :-)). Be awake to whether working from home has changed your approach to personal disclosure (the online disinhibition effect, Suler, 2004). Reviewing the impact of this with your team will help you decide on how best to mitigate this if it is a problem.

Take time to check-in with your clients about how they are finding this new way of working. Some clients have engaged in more therapy-interfering behaviour (non-attendance of sessions by not answering phone calls or joining scheduled sessions). This is understandable. Clients may have less opportunity to be alone or to do things that benefit themselves. Maybe their family did not know about their therapy and clients do not want to discuss why they are taking video calls. Some clients (as well as therapists) are just hoping that the pandemic will stop and then they can go back to therapy as usual. In these circumstances you need to do what you would with any therapy-interfering behaviour: validate the challenges and relentlessly problem-solve them. Where solving these problems proves insurmountable, for example when the client has no access to reliable broadband and cannot afford phone calls, and where the client engages in very high-risk behaviours, appropriately risk-assessed and socially distanced face-to-face therapy may need to take place, if it is allowed in your jurisdiction.

Once you are back to 'seeing' your clients again, what are the issues facing clients that you will be having to solve. In essence they are the same as those you were dealing with before – intense emotions driving problematic escape behaviours (suicide, self-harm, drug misuse, binge-eating, vomiting…). The therapeutic difficulty may be more in identifying solutions given that some of the activities and structures that clients have used to manage are interrupted by lockdown. Essentially there are fewer distractions during the pandemic. There is an advantage here – the circumstances push therapists away from using distraction as an intervention – and require them to move into emotion regulation skills instead. So, judicious use of TIPP to regulate extreme emotions and then lean into, Cope Ahead, Check-the-facts, Opposite Action and problem-solving as solutions to clients' emotional problems.

To do any of these interventions successfully you need to continue to meet as a DBT Team. So, whatever your circumstances, prioritise meeting with you team – via phone or video –seeking consultation on treating your clients and accessing support for yourself. Even if you cannot all meet together, call your colleagues individually to ensure that you stay well to sustain this challenging work in challenging times.

Michaela Swales
Professor of Clinical Psychology, Director British Isles DBT Training team

MBT – 'new normal' or 'temporary normal' in the time of Coronavirus

Anthony Bateman

The response of most nations to Coronavirus and its associated illness of COVID-19 has been to implement measures to reduce the infection rate and to protect the immediate physical health of the population. This has fortunately reduced the lethal impact of the viral illness but there is increasing concern that it has resulted in an increase in development of mental health problems, placed a strain on society and families emotionally and economically, with reports of increasing domestic violence, substance misuse, worry about significant others or bereavements. Crucially it has led to changing patterns of social interaction, and, in individuals previously diagnosed with psychiatric conditions, may have affected their ability to harness resilience to manage their problems, not least because treatment may have been curtailed. There have been substantial challenges to the provision of mental health services and even well-organised and structured treatments have all required adaptation in technique and service delivery (Inchausti, MacBeth, Hasson-Ohayon, & Dimaggio, 2020). Some mental health service delivery and treatment changes that were already on the way have been brought forward, others have been implemented without the usual step changes and consultation, and clinicians and patients have had to be creative and embrace different ways of working overnight because face to face interaction was declared unsafe. In general, both clinicians and patients have risen to the challenge and the emergence of online therapy in individual and group format, mental health telehealth, once a niche and perhaps neglected cottage industry, has been catapulted into the frontline. This brief article is about how MBT clinicians have been meeting these challenges to implement MBT effectively and to generate personal resilience for themselves and their clients and make current adversity the source of opportunity.

MBT places mentalizing at the forefront of personality functioning and borderline personality disorder (BPD) in particular (Bateman & Fonagy, 2016) (Bateman & Fonagy, 2019). Vulnerabilities in mentalizing lead to the defining characteristics of BPD, interpersonal problems, social disruption, emotional dysregulation, and impulsivity. Mentalizing is both an implicit and explicit process by which we make sense of others and ourselves, in terms of intentional mental states. It is conceptualized as a multi-dimensional and complex social cognitive process which entails forming beliefs about the internal states of those with whom we interact. Importantly, the capacity to represent one's own actions in mental state terms is developmentally rooted in attachment. Vulnerabilities in mentalizing lead to persistent wariness and distrust in others, as exampled by rejection sensitivity – 'they want to get rid of me' - and inclusion vigilance – 'why are they being so nice to me' - and uncertainty about ones' own experiences and the motives of the world. Social cognitive processing becomes perplexing; distrust or sometimes inappropriate or excessive trust in the world around informs all interactions. In the current climate some patients with BPD feel their 'normal' internal state is now shared by others and they may legitimately have a little schadenfreude about it. Social vigilance and distrust of others are common to the whole population. Close contact is avoided. All people are potentially dangerous and a threat.

MBT focuses on increasing the resilience of the individual by enhancing mentalizing process which drives epistemic learning from the social world and facilitates personal change. While both clinicians and patient's coping strategies and resilience resources are called upon during the pandemic, patients with severe psychopathology and particularly those diagnosed with a Borderline Personality Disorder (BPD) may be especially vulnerable to symptom deterioration due to the massive environmental and social changes forced upon them along with the additional stressors of social, interpersonal, and economic uncertainty and disruption. Uncertainty in particular (Mortensen, Evensmoen, Klensmeden, & Håberg, 2016) and a subjectively experienced lack of agency and control over social and interpersonal circumstances are significant causes of distress in patients with BPD and can lead to more pronounced difficulties in emotion regulation, impulsive behaviours, and risk which, without interpersonal supportive systems in place, may become overwhelming. So it is imperative that treatment currently on offer continues throughout the pandemic and that new patients access effective treatment and are not left without their needs being met. So how can and does MBT meet this challenge?

MBT translates to online working with ease. The focus on mentalizing is concentrated by

video-based interaction which can be taken as another medium for social interaction, one that is already embraced by the young who are familiar with offline learning and comfortable with online interaction. To some extent the move to delivery of therapy online has triggered anxieties in clinicians as much as patients and arguments in psychotherapy generally that were around long ago about the potentially deleterious effects on the therapeutic relationship, for example, session to session monitoring, video of treatment, have been resurrected by some. MBT has taken an evidence-based approach right from its inception and video and outcome monitoring is built into treatment implementation; it is not defined by practice but by how principles of psychological understanding and intervention processes are applied and so it can be delivered with fidelity in a range of settings of which 'online' is one. For MBT the question is more about how can working online enhance the focus on mentalizing to increase its stability and effectiveness, drive personal resilience, and improve outcomes?

Implementation

There are a number of immediate practicalities for services not least of which is whether the service has agreed a secure platform for clinical interaction and the patient and therapist have access to the internet by phone or computer in a setting that allows confidentiality and comfort for the delivery of both individual and group MBT. Some of our patients do not have internet access and so this has to be addressed; initially sessions may be offered on the phone even though patients and therapists universally prefer video face to face. This is a particular problem in moving a current group to online work when one or two patients may not be able to join a video platform. This can be addressed by them joining by audio only, which is of course not ideal. In the future a new group may have to be designated an 'online group' with a requirement that the participants have appropriate access to the internet and the social health care system supports this financially and logistically.

Preparing for online sessions is discussed. In face to face interaction patients have to get ready, travel, prepare their minds, de-role as a patient at the end of the session and re-enter the world. How will this be done at home? A session is an important activity and the MBT clinician works out with each client how it will be given value and what value it will have; how it can become protected from all the other demands of life at home; and finally how the session will end so the patient can leave what has happened in the virtual room to be picked up later rather than taken back into the home.

Principles and Preplanning

In MBT the principle is to wrap around all discussions with a mentalizing frame and to take a not-knowing stance to generate reflection about problems and how to address them rather than to give solutions. Joining a group whilst sitting in a communal area, for example at the kitchen table of an approved hostel with other hostel residents cooking their meals in the background, breaches group and personal confidentiality. Managing such matters has to be agreed by all at the start of the group or individual work. So MBT focuses carefully on the pre-planning of the online work in terms of agreeing collaboratively the best shared environment to enhance mentalizing. In group therapy the group revisit the values of the group in the changed context. This is in itself a mentalizing process with all participants having to take into account others' circumstances and their personal reactions to them – 'if you have others coming into the room when I am on screen it makes me feel uncomfortable that people know I am having therapy. Can you be sensitive to that please' – a sensitivity that is rare in antisocial personality disorder and yet emotional empathy of others and responsiveness to it, a specific target in MBT for ASPD, can be organised as a value for the group straightaway through this discussion.

Setting up individual work online also requires preparation wrapped around with mentalizing. In particular MBT online lends itself well to enhancing the focus on self-other mentalizing. Self-awareness, self-sensitivity and the subjectivity of self-states in general is of particular importance in BPD. So in beginning therapy the MBT clinician asks the patient to reflect on their experience of being online, looking at themselves – do they want their picture in the screen so they look at themselves or do they prefer not to; can they describe who and what they

see as a technique to start building a stable and more accurate self-image? MBT is collaborative in all areas of interaction and self-disclosure by the clinician in terms of their mental states about looking at themselves and what they see facilitates contrast between the patient and clinicians' experience and the similarities and differences of their reactions to it. This can be singularly reassuring as most clinicians are equally sensitive about this but do not have to take action to manage the discomfort. Generating discussion about what it feels like for the patient when the clinician moves closer to the screen or what it feels like for the clinician when the patient is too close or too far exercises self-other mentalizing. Both need to feel comfortable about their 'position' and recognise the effects that distance changes can have in expression and reception (reminiscent of the 1 metre or 1.5 metres or 2 metres rule of social contact advised by different governments to ensure safety). The beginnings of this socialization to mentalizing online now forms part of the MBT-Introductory group (MBT-I). Some MBT clinicians have recorded the information of each session of MBT-I for patients to listen to offline before they join the online session to discuss and to personalise the learning.

Formulation and treatment

Formulation is a central part of the initial phase of MBT and online working is incorporated into personalizing this work. All interpersonal interaction, on or offline, has the potential to activate attachment strategies which, once activated engender anxiety which undermines mentalizing process. So the structured formulation which includes a mentalizing profile and attachment strategies takes the assessment of attachment processes further, defining the form that they might take in online working – avoidant strategies through technical problems, anxious-pre-occupied through increasing distress and risk towards the end of the session or need to see the clinician in person to feel real, disorganised components through interruptions of the session by having to leave the room or being unable to organise protection of the meeting with people coming in and disrupting the session – a boyfriend of one patient came in to tell the clinician that 'it was about time you did something about her' and 'you are useless - she is mad and should be locked up'. This led to a row between them in the session. Remember though that online work may allow the threshold for activation of attachment strategies to be raised. The anxious-avoidant person may feel less anxious by using distancing more easily online than when face to face. Disclosure of painful experiences, past and present, become possible without excessive anxiety that would normally stimulate rapid avoidance to manage the pain and panic. A focus on the experience of the client within the relationship with the clinician and the experience of this new found sharing and openness might usher in change – 'what is it like to talk to me at the moment about these things?' 'What is your current experience in terms of revealing this to others?' It is not as dangerous as imagined so the relationship of self-experience and other experience in attachment can be specified and become an explicit part of the interpersonal work of MBT right from the start. Relational mentalizing can be triggered by explicitly defining the 'elephant in the room' of MBT, that is an unacknowledged implicit process interfering with the interaction, which is so often an elephant of misunderstanding or distrust, perhaps consciously more acceptable limitations of online working for both patient and clinician.

Risk

The management and assessment of risk of people with severe personality disorder is of concern to clinicians who not only work with patients to assess changes in risk using clearly defined indicators, such as increase in drug use, mood changes and evidence of environmental stressors but also rely on their subjective experience and counter-responsiveness to a patients presentation. Here, clinician mentalizing and self-disclosure of personal mental states in relation to the patient's mental state is crucial. Online working requires this to be open with detailed exploration of the reciprocity of the interaction and learning from each other in a context in which some aspects of interactional process can be muted and others amplified.

What happens when a patient decompensates in a group session, threatens others in the group, is unable to talk in their individual session, behaves in ways that make the clinician anxious? The principle here in MBT is prediction and prevention rather than reaction. The formulation is used to identify predictors of risk and its presentations;

patient and therapist agree what will happen if the patient becomes overly distressed in a session online. It is possible that someone can be taken into a another 'room' during a group if there is more than one therapist or a clinician is 'on-call' and can be co-opted to support the lone group clinician. In an individual session the risk is managed and explored according to the model and the crisis planning process.

Finally

Teams continue to meet using video platforms and the welfare of clinicians and their mentalizing capacities in relation to their patients remains a priority. At some point a decision may will have to be taken to move treatment back to face to face. This perhaps can be a time for review using a not-knowing stance – what has been helpful in this telehealth delivery, what has been unhelpful, do we go back face to face or do we continue, what are the advantages of continuing in this way and what might be lost? Shall we now reformulate and take stock about where we are and what our focus needs to be? Bear in mind that anecdotally clinicians are reporting a significant decline in non-attendance at sessions, perhaps related to the lockdown and social isolation which is so painful for many, but equally perhaps related to the psychological comfort of the online telehealth delivery. Some patients have decided to return face to face for their group only and to keep individual sessions online.

The 'temporary normal' may become a 'new normal'. The time may have arrived for MBT to be delivered solely online from assessment through formulation and treatment. I can feel an RCT coming on!

Anthony W Bateman

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TFP—Working online in the transference

Stephan Doering

The Covid-19 pandemia places many burdens on our patients: The changes in their external reality, including the danger of infection and of loss of close relatives, the lockdown, the economic losses and threats. Moreover, their psychotherapies cannot be continued face-to-face, but they are "forced" to move to online (audio or video) or telephone therapy.

Since Transference-focused Psychotherapy (TFP) – as the name reveals – focuses on the transference, we need to reflect and discuss the changes that are entailed by the crisis. In how far does online or telephone treatment change the therapeutic relationship?

The most obvious facts: The embodied, nonverbal communication is dramatically truncated. The resonance of two bodies in the same room is cut off, we don´t feel the other in the same way, we can´t smell each other, and we usually see either nothing (telephone) or just the upper part of the other. Moreover, significant distortions of the sound of the voice, and timing (delay of the video signal in relation to the audio signal) might occur. One interesting aspect was mentioned by Russell (2018, p. 179): In an online setting, it is difficult to develop the fantasy to throw an object towards your therapist or to seduce your therapist, because it is impossible. As a consequence, these fantasies might not occur as they would in a face-to-face setting.

On the other hand, patients with schizoid, anxious, or avoidant traits might benefit from the online setting, because it might allow them to disclose issues that the withheld in the face-to-face setting. We have seen numerous patients, who "enjoyed" online therapy, because they felt protected from the direct confrontation with the therapist (as well as from the real threat by infection). For this reason, some of these patients did not want to return after the lockdown.

What was discussed in the psychoanalytic literature since a few years and turned out to be highly relevant for TFP during the Covid-19 crisis, is the fact that online treatment might be "used" by the patient, sometimes in collusion with the therapist, to deny separation (Gutièrrez, 2017). The threat that reality (like the lockdown) might separate patient and therapist can be overcome by moving to an online setting. This can obstruct the treatment process, if separation is an issue within the treatment process. A patient of mine, who is still in online TFP due to the lockdown, recently told me that she is going on a two-week holiday, which luckily would not be a problem, since we could continue our online meetings. She created the metaphor of a "pocket Doering", who could be always at her service.

This vignette leads me to reflect for a moment on aspects of the treatment setting of online treatments. There is a need to establish a clear concept including boundaries and a few regulations for the online therapy. There is the chance to move around the location, i.e., to call each other from different places and outside the office hours. Of course, there are business people and artists, who could not receive any treatment, if they had to stay in the same place – however, if possible, we try to restrict the sessions to clearly defined locations, i.e., the patient´s home and the therapist´s office. Moreover, we ask the patient to behave in the same way as he/she would do in a face-to-face session. This includes, clothing, sitting on a chair, abstaining from eating, drinking, and smoking, and keeping animals and other people out of the room. Another important aspect is the fact that an online video session in a way equals a mutual home visit. Patients might "accidentally" show us parts of their private homes, and vice versa, a therapist in "home office" might reveal aspects of his/her private life, too. I remember a supervisee, who conducted his sessions at home in his bedroom (due to his family situation) and was not completely able to hide the bed, so that his patient immediately engaged in a dramatic erotic transference.

In our clinical team we observed an interesting phenomenon, that at the beginning of the lockdown, patients and therapists were enthusiastic about the opportunity to use online therapy and, thus, overcome the forced separation during the lockdown. In a kind of "joint grandiosity", we felt more powerful than the virus and politically imposed restrictions. In the light of the "real threat" of the virus, we developed the tendency to engage in a more supportive way, which is not part of the general TFP technique. At the same time, we

observed a drift towards a more intellectual dialogue that in part replaced the embodied communication of the face-to-face setting. Lemma (2017, p. 107) in a similar context pointed at the relatedness of this acting out to the pretend mode as described by Fonagy and Target.

This euphoria about the online opportunity changed into a frustration about the limitations mentioned above and meanwhile reached a steady state that allows us to make the best possible use of online treatment keeping in mind its limitations and focusing them as part of the treatment where necessary.

During the last weeks we conducted an international survey on online TFP that included 479 therapists from 25 countries (Preti et al. *in preparation*) and revealed numerous highly interesting results. One key message is, that online TFP is done and seems to work, however, it imposes specific demands on the therapists regarding the maintenance of the setting and the adherence to the TFP techniques. Future prospective studies will be able to show, if online TFP is as effective as face-to-face TFP, which I assume is the case in a specific subgroup of patients, but not in others.

Taken together, our clinical experience from hundreds of cases shows that TFP can be done successfully online, but that it goes along with a certain loss of opportunities of working in the transference, which is a core technique of TFP. Other treatments that are to a higher degree organized around cognitive techniques and skills might be easier to apply online, while working in the therapeutic relationship might be more vulnerable to the loss of the physical encounter in a shared room. If possible, as a TFP therapist I would prefer face-to-face treatment over online treatment (if there is a choice), and in case of an elective face-to-face treatment I would want to meet the patient face-to-face at least once in a while.

Independent from that, there is a very long tradition of delivering TFP supervision online. The supervisee reports online to the supervisor (and a group of supervisees) about the experience of the face-to-face session and then shows a piece of the video-taped session. I assume that this works well, because the therapist can report the face-to-face experience in addition to the video-tape.

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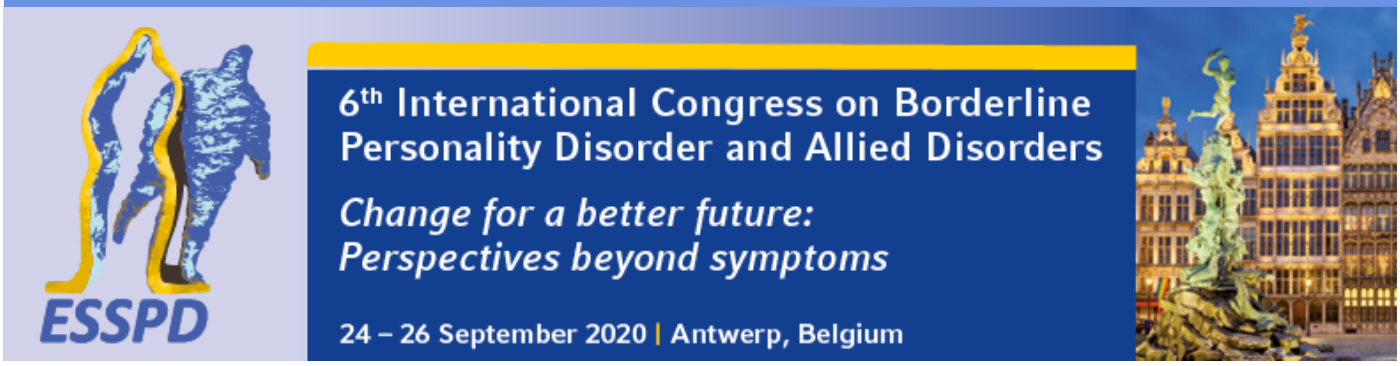
The 6th International Congress on Borderline Personality Disorder and Allied Disorders in Antwerp



It is with regret that the board of the ESSPD has decided, in light of the global pandemic, to postpone the 6th International Congress on Borderline Personality Disorder and Allied Disorders to September 2022. Paramount in our decision-making was the health and safety of our attendees and the wider community. Whilst we sincerely hope that most countries will be through the worst of the consequences of Covid-19 by September this year, we cannot be certain that will be the case and significant travel and social contact restrictions may remain in place for the well-being of all. We were very happy with our preliminary program and regret that we had to make this decision. The title of our conference "Change for a better future" will stay the same and we hope that you will be willing to contribute to our conference in 2022!

May the curve of infection rates flatten soon!

With best wishes for your health,

Babette Renneberg and Stephan Doering

Greetings from the Young Researcher Group of the ESSPD Postponement of our congress: A missing occasion or a new opportunity?

Ester di Giacomo

The recent COVID-19 outbreak was emotionally disruptive, plaguing many countries and killing thousands of people. Everybody's life changed and lockdown was necessary in several states. Health professionals in the front line experienced dramatic situations and many died. Furthermore, even if it is far from having the same relevance, social distancing influenced the possibility to join congresses and continuing education.

Our biennial international congress, *the 6th International Congress on Borderline Personality Disorder and Allied Disorders*, scheduled for September 2020 was postponed for safety reasons. The newborn Young Researcher Group of the ESSPD had identified it as the first opportunity to meet after its foundation. Founded in Sitges, during the last ESSPD International Congress, the YRG keeps in contact and shares information through social media. Our Facebook group permits sharing and granted the election of a representative.

Notwithstanding these first advancements, a face-to-face meeting would be beneficial to tighten relationship and co-operation. Despite such difficulties, an optimistic change of view should be focused on the fact that we can increase our communications enhancing discussion and exchange of views through virtual platforms.

In conclusion, I am confident we can take this distressing stop as an opportunity to work sharply and participate to the next congress as a stronger and cohesive group.

Ester di Giacomo, MD, PhD

ESSPD Research Update

This newsletter is focused upon the themes of *new evidence in frequently co-morbid conditions associated with BPD, mechanisms of change in the treatment of BPD,* and *diagnostic issues in personality disorder research.* It contains a review of the four most innovative contributions to the literature in the recent months.The corresponding scientific writer is Sophie Liljedahl, PhD.

Email: dr.s.liljedahl@gmail.com

Sophie Liljedahl

Drinking motives moderate daily-life associations between affect and alcohol use in individuals with borderline personality disorder.

Wycoff, A. M., Carpenter, R. W., Hepp, J., et al. (April 2020).
Psychology of Addictive Behaviors: Journal of the Society of Psychologists in Addictive Behaviors
DOI: 10.1037/adb0000588.

Aim: The first objective of the study was to determine whether drinking motives and overall daily affect are related through an interaction to alcohol use amongst individuals diagnosed with borderline personality disorder (BPD). A second objective was to evaluate drinking intention and drinking continuation within an episode in this population.

Background: Drinking to increase positive affect (PA) has been linked to drinking more often and at a higher volume for the purpose of managing negative affect (NA), which is in turn related to greater alcohol related risk-taking, consequences and likelihood of dependence. Individuals with BPD are vulnerable to alcohol use disorders (AUDs) due to their elevated and enduring rates of reported negative affect. In order to evaluate drinking motives, coping, and the wish to change affective states (enhancement), ecological momentary assessment (EMA: Stone & Shiffman, 1994) was utilized to test these relationships.

Method & Procedure: EMA is the process of taking repeated measures of affect in the moment alongside behaviours and the situation in which these arise, in real time via smartphone applications. The use of EMA increases research validity as it does not rely on recall. Participants were recruited from psychiatric clinics, and through ads recruiting individuals with BPD characteristics. A total of N=54 adult (M age = 26.22 years, SD = 7.21) individuals diagnosed with BPD who drank regularly (81.5% female) provided EMAs between six to ten times every day, with random prompts approximately 2.5 hours apart for 21 days. A total of 89.9% of prompts were responded to by participants. Associations that were tested for were interactions between coping motives and daily overall average NA, as well as enhancement and overall average PA in relation to further alcohol consumption. The authors tested for differing effects in initiation compared to continuation within one drinking occasion.

Results & Discussion: A total of 924 momentary drinking instances were recorded by participants across in the initiation phase (362 reports) and the continuation phase (562 reports). Momentary drinking was positively associated in an interaction between coping and overall average NA. This relationship was even more pronounced with respect to drinking continuation. That is, BPD individuals who were highly motivated to drink in order to cope had a greater likelihood of drinking when they experienced high NA over the

course of the day. This was particularly the case for the continuation phase. Enhancement motives interacted with overall-average PA. Associations were positive for initiation and negative for continuation. The overall average affect measurement facilitated separation of initiation and continuation of alcohol use within a single drinking occasion. Opportunities for treatment development may exist by teaching individuals diagnosed with BPD and vulnerable to AUD to learn to distinguish their motives and affect prior to and during occasions in which they drink alcohol.

Key Reference

Stone, A. A., & Shiffman, S. (1994). Ecological momentary assessment (EMA) in behavioral medicine. *Annals of Behavioral Medicine, 16,*199–202. http://dx.doi.org/10.1093/abm/16.3.199

Identifying specific insomnia components in borderline personality disorder and their influence on emotion dysregulation.

Fitzpatrick S, Maich KHG, Carney CE, Kuo JR. (March 2020).
Personality Disorders . DOI: 10.1037/per0000395

Aim: The focus of the study was to determine whether irregularities in bedtime, amount of time spent in bed and sleep efficiency (SE) as well as irregularities in getting out of bed worsen emotion dysregulation amongst individuals diagnosed with BPD compared to those diagnosed with GAD compared to a control group.

Background: The central clinical feature of BPD is affect dysregulation, which is worsened by regular difficulties sleeping. Insomnia is defined by longstanding challenges with going to sleep (initiating), staying asleep (maintaining) or waking too early. There is a strong relationship between insomnia and BPD, with at least one longstanding sleep challenge affecting more than half of those diagnosed with BPD (Selby, 2013). Targeting insomnia components that affect individuals diagnosed with BPD may be an important part of effective treatment for this population.

Methods & Procedure: Individuals diagnosed with BPD (n=41), GAD (n=43), as well as those with no diagnosable mental illness (n=49) were recruited from the community and matched by age and sex so that n=40 individuals per group were retained within the final sample (N=120). Participants were predominantly female adults. They completed measures of bedtime, getting out of bed, and time-in-bed behaviours as well as measures of SE and emotion dysregulation.

Results & Discussion: Data were analysed via generalized estimating equations. The control group had the best SE, particularly compared to the GAD group. The BPD group had greater delay in rising compared to the GAD group. More time in bed was predictive of increased emotion dysregulation amongst the control group, but decreased emotion dysregulation amongst the GAD group, whereas greater SE predicted greater emotion dysregulation amongst the BPD group. Taken together, these findings indicate that sleeping and disrupted sleep behaviours have differing effects on emotion dysregulation, depending upon the diagnostic status of the individual under evaluation. The authors suggest that future research investigating the role of emotion dysregulation and insomnia amongst individuals diagnosed with BPD and GAD utilize idiographic assessments to further study these relationships, ideally generating treatment recommendations.

Key Reference

Selby, E. A. (2013). Chronic sleep disturbances and borderline personality disorder symptoms. *Journal of Consulting and Clinical Psychology, 81,* 941–947. http://dx.doi.org/10.1037/a0033201

Mechanisms of change in dialectical behaviour therapy and cognitive behaviour therapy for borderline personality disorder: a critical review of the literature

Rudge, S., Feigenbaum J. D., & Fonagy, P. (2020).
Journal of Mental Health, 29:1, 92-102 DOI:10.1080/09638237.2017.1322185

Aim: The aim of the study was to review mechanisms of change in DBT and CBT for BPD, as both treatments have demonstrated efficacy and effectiveness, without broad understanding of change mechanisms.

Background: Individuals diagnosed with BPD often present to treatment settings with high risk and out-of-control behaviours that make treatment efforts difficult to maintain. Interpersonal relationships including those with care providers are also often difficult to form and sustain, which has historically led to high levels of treatment drop-out prior to specialized treatments developed for this population. There is little understanding of the key change mechanisms in therapies with consistently good outcomes. “Change process research” (Elliott, 2010) is described as a necessary accompaniment to RCT and similar research that is aimed at evaluating symptom remission in BPD treatments. Kazdin (2007) has proposed that evaluating change mechanisms in successful treatments is the future of psychotherapy research. Understanding change mechanisms could help to identify which treatments are most likely to succeed based on individual patient characteristics, as well as assisting in treatment development.

Methods & Procedure: A number of databases were searched using a combination of five search terms to evaluate studies that described change mechanisms in DBT and CBT for BPD. Inclusion criteria for studies were that studies included: 1. Individuals who met diagnostic criteria for BPD; 2. Individuals engaged in CBT or DBT; 3. Individuals completing their treatments on an outpatient basis; 4. Individuals who had their treatment summarized in state-of-the-art, peer-reviewed English language studies conducted from 1990 onwards; 4. Individuals of adult age at the time that their treatment for BPD commenced. Exclusion criteria for the review were: 1. Case studies involving one participant; 2. Outcome studies that precluded data relevant to change mechanisms. The resulting 14 studies were evaluated by comparison to a critical checklist aimed to determine the methodological quality of interventions within the provision of health services (DBC: Downs & Black, 1998).

Results & Discussion: Following screening for eligibility for the aims of the review, 52 abstracts were evaluated, with 14 papers being retained due to their determination as meeting inclusion criteria as well as having high importance. Of these, 12 pertained to DBT and two to CBT. There were three domains of change mechanisms identified. These were: 1. Affection regulation/self-management; 2. Use of skills learned in therapy, and; 3. Commitment to therapy/alliance with therapist. Study outcomes were symptoms of BPD as well as common co-occurring diagnoses such as mood and anxiety disorders. The authors recommend that future research evaluate these suggested change mechanisms in clinical therapies for BPD.

Key References

Downs SH, Black N. (1998). The feasibility of creating a checklist for the assessment of the methodological quality both of randomised and non-randomised studies of health care interventions. *Journal of Epidemiological and Community Health, 52,* 377–84.

Elliott R. (2010). Psychotherapy change process research: Realizing the promise. *Psychotherapy Research, 20,* 123–235.

Kazdin AE. (2007). Mediators and mechanisms of change in psychotherapy research. *Annual Review of Clinical Psychology, 3,* 1–27.

Intolerance of uncertainty and obsessive-compulsive personality disorder

Wheaton, M. G., & Ward, H. E. (2020)
Personality Disorders: Theory, Research, and Treatment. Advance online publication, https://doi.org/10.1037/per0000396

Aim: To evaluate intolerance of uncertainty (IU) in obsessive-compulsive personality disorder (OCPD). Specifically, to clarify IU in the formulation and treatment of OCPD.

Background: OCPD is one of the most prevalent personality disorders in community non-clinical samples, with prevalence estimates of approximately 7.8% (Grant, Mooney & Kushner 2012). There is significant distress and impairment associated with OCPD, which is a disorder that is often the primary purpose of seeking psychotherapy and primary care, resulting in high treatment costs. OCPD and OCD share symptom overlap. OCD research has evaluated the role of IU, which is a transdiagnostic factor common to many anxiety-related disorders, but IU research in relation to OCPD has been quite limited. IU was initially defined by Dugas, Freeston and Ladouceur (1997) as a pattern of detecting, understanding and behaving in problematic ways when faced with uncertain situations, historically in the context of studying anxiety disorder. Contemporary definitions of IU emphasize the role of avoidance, worry, seeking reassurance and negative emotion. IU can be defined behaviourally or in relation to personality functioning.

Methods & Procedure: A total of n=534 community-dwelling predominantly female (58.1%) adults, alongside n=76 predominantly female (50 of 76 respondents stated they were female and two did not state their gender) self-identified participants with OCPD completed measures of IU and OCPD. The community participants were recruited through a crowdsourcing marketplace, whereas the OCPD participants were recruited through on-line platforms and social media groups for individuals who self-report as having OCPD. The OCPD assessment evaluated trait dimensions as well as global severity. Other symptom and well-being measures were administered (OCD, depression, anxiety, stress and quality of life).

Results & Discussion: Compared to the community subgroup, the participants self-identifying as OCPD had the greatest IU, even when other diagnostic symptoms were controlled for. IU was further significantly associated with trait severity of OCPD, with IU effectively predicting severity of OCPD traits. This was the case even when other diagnostic symptoms were controlled for. The association between OCPD traits and diminished life quality was mediated by IU. Taken together results indicate that IU plays a significant role in OCPD as a clinical syndrome, and confirms earlier research proposing IU as a transdiagnostic factor within the anxiety disorders. Treatment development could usefully focus on IU in psychotherapies for OCPD.

Key References:

Dugas, M. J., Freeston, M. H., & Ladouceur, R. (1997). Intolerance of uncertainty and problem orientation in worry. *Cognitive Therapy and Research, 21,* 593–606. http://dx.doi.org/10.1023/A:1021890322153

Grant, J. E., Mooney, M. E., & Kushner, M. G. (2012). Prevalence, correlates, and comorbidity of DSM–IV obsessive-compulsive personality disorder: Results from the National Epidemiologic Survey on Alcohol and Related Conditions. Journal of Psychiatric Research, 46, 469–475. http://dx.doi.org/10.1016/j.jpsychires.2012.01.009

Svenja Taubner, ESSPD Newsletter Editor

ESSPD Academy Newsletter Submissions

Submissions to the *ESSPD Academy 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.

The Newsletter Editor is Svenja Taubner. Submissions should be emailed to at: **svenja.taubner@med.uni-heidelberg.de**

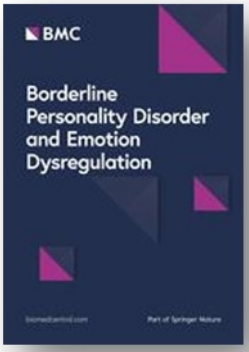
The corresponding scientific writer is Sophie Liljedahl, Ph. D.,
Email: **dr.s.liljedahl@gmail.com**

Bo Bach, ESSPD Editorial Board

Matilde Elices, ESSPD Editorial Board

Michaela Swales, ESSPD Editorial Board

The ESSPD donates three Waivers for Article Processing Charges (APC): Call for submissions from East European Members



A key mission of ESSPD is supporting research in the field of personality disorders in Eastern European countries. The European Society for the Study of Personality Disorders (ESSPD) supports publications in the Society´s online journal, *Borderline Personality Disorder and Emotion Regulation* (BPDED). This is a relatively new high-quality journal that is anticipated to receive an impact factor within the next months. The usual article processing charge (APC) is € 1,745 per article. We are pleased to announce that the ESSPD has negotiated that, in the case of three successful paper submissions, APC charges will be waived. We therefore encourage all our members from Eastern European countries to submit manuscripts to the Secretary of the ESSPD (secretary@esspd.eu) Chair of the Waiver Committee. On a first-come-first-served basis, three eligible papers will be awarded a waiver. The authors will receive waiver codes to be used during the submission via the online submission system of the journal (https://bpded.biomedcentral.com/). Please be aware that this does not replace the peer review process. Only after acceptance by the journal editors, will the papers appear in the online journal. **Please submit your manuscript before August 15, 2020 – the earlier the better.**

If you are not yet an ESSPD member, you can ask to be nominated (for details see https://www.esspd.eu/membership/how-to-become-a-member.html). If you have any questions, please contact stephan.doering@meduniwien.ac.at

The ESSPD-Board's new paper on Euthanasia in people with personality disorders

Lars Mehlum

Ester di Giacomo

Euthanasia and physician-assisted suicide (EAS) have been legalized in several countries in the last two decades giving rise to ethical debate and divided public opinion. Although EAS is still forbidden in most countries, the trend is an increase in the number of countries allowing it and in conditions for which it is permitted. Originally, EAS was legalized for people facing untreatable and unbearable suffering due to incurable illness, but the number of people who request and receive EAS for mental diseases has increased strongly. EAS in people with personality disorders has, however, received very sparse attention from clinicians and researchers. In a paper we have prepared for the official journal of the ESSPD, Borderline Personality Disorder and Emotion Dysregulation (BPDED), we examine the literature on the practice and prevalence of EAS in people with personality disorders to date and discuss the associated challenges for research and practice. Our review of the literature suggests that a large proportion of people with mental disorders who request and receive EAS are people with personality disorders. The practice of EAS in people with PD is disturbing reading. We would claim that the notion of personality disorders as "untreatable" conditions and "without prospects of improvement" are based on outdated knowledge about the state of PD treatment. Today, a range of effective psychotherapeutic interventions are available for people with personality disorders in most of the countries that have so far legalized EAS. That this has seemingly escaped the attention of both legislators and expert medical communities is deeply disturbing.

Ester di Giacomo and Lars Mehlum

Lausanne Summer School
Young Researchers : Save the date!

The Second ESSPD Summer School for young researchers will take place in Crêt-Bérard, Switzerland, between August 15 and 21, 2021. During the one-week residential program, the methodological basis for "The future of psychotherapy research for personality disorders" will be elaborated: Sabine Herpertz, Shelley McMain, Johannes Zimmermann, Lars Mehlum and Ueli Kramer have confirmed attendance. PhD students, MDs and post-doctoral fellows affiliated with a European University are welcome to apply by February 2021; special rates will be applicable for young researchers from Eastern European countries. Mark the dates in your calendars!

Ueli Kramer

For the 2021 ESSPD Summer School Work Group
Ueli Kramer, University of Lausanne (Switzerland) and Lars Mehlum

Lars Mehlum

ISSPD Conference in Oslo, October 13-15 2021

Book on BPD Parent Training

Babette Renneberg

Dysfunctional parenting is a risk factor for the development of mental disorders in children. For mothers with Borderline Personality Disorder (BPD), the upbringing of their children is especially challenging. They are often unable to recognize and/or respond (to) their children's needs, are inconsistent in their parenting styles and have difficulties in setting adequate limits. Difficulties in emotion regulation are a core feature of BPD and constitute a severe problem for parenting. Children of mothers with BPD are at high risk to develop dysfunctional behavior patterns themselves and they don't have adequate role models and orientation. The group training "Parenting Skills for Mothers with BPD" aims to support mothers with BPD in their development of positive parenting strategies and thereby to interrupt the intergenerational transmission of dysfunctional emotion regulation strategies.

"Parenting Skills for Mothers with Borderline Personality Disorder" is conceptualized as an add-on treatment to a completed or ongoing individual therapy focusing on the borderline symptomatology of the mother. The training is based on the concept of Dialectical Behavioral Therapy and consists of 12 weekly sessions. Topics include psychoeducation, mindfulness, stress and stress management, structure and flexibility, dealing with conflicts, dealing with emotions, dysfunctional assumptions about parenting.

Considering the preventive idea, the training addresses mothers of young children aged 6 months to 6 years. The group training can be applied in out- and inpatient treatment settings or assisted living facilities. Groups comprise four to eight mothers and are held by two female trainers experienced in working with patients with BPD.
The training was initially published in German language (Buck-Hortskotte, Rosenbach & Renneberg, 2015) and has now been translated into English.

The English version is available as PDF under https://refubium.fu-berlin.de/handle/fub188/26429

Rosenbach, C., Buck-Horstkotte, S., & Renneberg, B. (2020). Parenting skills for mothers with BPD - a group training. http://dx.doi.org/10.17169/refubium-26189

PDI Press Release: International Experts Launch a Standard Set of Outcomes to Measure and Improve Personality Disorders Care Globally

For immediate release:

International Experts Launch a Standard Set of Outcomes to Measure and Improve Personality Disorders Care Globally

BOSTON, Massachusetts, June 2, 2020: The International Consortium for Health Outcomes Measurement (ICHOM) announced the release of their Personality Disorders Standard Set today.

Leading mental health researchers, practitioners, and service user representatives from across Europe, North America, Asia, and Australia have joined forces to establish and launch the first international standard for measuring treatment outcomes for adults and adolescents aged 12 and above with personality disorders. This marks an important step towards promoting data quality and availability, and strengthening mental health care for this group.

This collaboration was facilitated by ICHOM and made possible by the generous contributions of NHS England and NHS Improvement; the NSW Agency for Clinical Innovation, Australia; Providence Health Care, USA; and Region Västra Götaland, Sweden.

The ICHOM Working Group
The Personality Disorders Standard Set (PDSS) was developed by a dedicated ICHOM Working Group, comprised of 17 international experts and service user representatives, from ten different countries. A full list of organizations and representatives involved in this Working Group is available on ICHOM's website.

The Personality Disorders Standard Set
The PDSS makes a set of recommendations for how treatment outcomes should be measured in clinical practice. It recommends measuring 14 health outcomes across the four broad domains of Mental Health, Behaviour, Functioning, and Recovery, as a minimum, for adults and young people seeking mental health support for personality disorders. For this purpose, it recommends a set of eight patient- and clinician-reported outcome measures. To help ensure the Standard Set is relevant across different intervention contexts, the Working Group also recommends 15 risk adjustment factors, to be collected along with the outcomes, as well as timepoints for measurement.

Measuring, reporting, and comparing these outcomes can help identify best practices in personality disorder mental health care; ultimately generating value and better outcomes for service users. The selected outcome measures being available in several languages, the Standard Set is assured to have increased adoption across countries. An open-source Reference Guide is available that outlines recommendations for administering the set, time points, and a data dictionary for organisations to begin implementation.

Lived experience working group member, Lucie Langford, shares, "Being able to contribute to something positive and meaningful for people with Personality Disorders has been a privilege. I am happy to have used my lived experience with a Personality Disorder as a strength to help others. This work is vital because patient partners were able to collaborate with the other members of the working group to capture and integrate what is important to help in our recovery. I was struck by how often our working group conversations centered around functional recovery and quality of life. In my experience, even though the inclusion of patient partners in healthcare and research has advanced, many research professionals are still hesitant to engage with persons living with such a complex psychiatric condition. I believe that our work will inspire further collaboration between these groups and I am hopeful that the outcome will produce a valuable working model that enables patients to reach the recovery goals that are important to us."

Consumer Review Period
The Working Group's recommendations were validated during an Open Review period, in a large group of external stakeholders from around the world. In this review, 96% of lived experience experts from Australia, the United Kingdom and the Unites States reported that they would be

happy for these outcome measures to be part of routine care and support. Over 80% of mental health practitioners, researchers, and policymakers surveyed across 17 countries, approved of the outcomes and measures recommended. There was over 75% agreement with risk adjustment variables recommended by the Working Group.

The Future of PDSS

From its inception, ICHOM has made Standard Sets open source. Now that this recommendation is finalised, the real work can begin, ushering in a new season for value based mental health care. It will be invaluable to learn from implementation pilots that may emerge across the globe and inform future iterations of this global set of standards.

The Chair of the Working Group, Prof. Michael Crawford of Imperial College London, says, "In recent years concerted efforts have been made to improve the quality of health care that people with personality disorder receive. But attempts to find out what works best for whom have been hampered because people working in different countries have used different methods for assessing patient outcomes. The publication of the Personality Disorder Standard Set by ICHOM provides an exciting opportunity to improve collaboration between different services within and between countries. By adopting these standards, clinicians and patients will find it easier to identify and share good practice and help shape better services for people with these complex emotional health needs."

The standard set reference guides, flyers, data dictionaries and press releases have moved to ICHOM Connect and are still available free of charge. Please log in or register to gain access to unlimited ICHOM resources at a single click of a button. Visit connect.ichom.org today to access the materials for the Personality Disorders Standard Set.

More Information on The International Consortium for Health Outcomes Measurement:

ICHOM's mission is to unlock the potential of value-based health care by defining global standard sets of outcome measures that matter most to patients and driving adoption and reporting of these measures worldwide to create better value for all stakeholders. ICHOM was founded in 2012 by Professor Michael E. Porter of Harvard Business School, the Boston Consulting Group, and Karolinska Institute.

Visit www.ichom.org or contact info@ichom.org for more details.

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)*								
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PUBLICATIONS *(list 3 most important last 5 years)*								
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HONORS, AWARDS *(list 3 most important)*								
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leadership roles *(list 3 most important current or past roles)*								
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What you believe nominee will be able to contribute to the ESSPD								
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Names of two nominators (printed letters):	Signatures of two nominators:
Place	*Date*