ESSPD NEWSLETTER

ESSPD | European Society for the Study of Personality Disorders

ESSPD Newsletter
A publication of the European Society for the Study of Personality Disorders

Editor
Theresa Wilberg, ESSPD

Editorial Assistant
Nicola Harding

Volume 4, Issue 1
January 2015

Message from the President

January 2015

Martin Bohus

Dear members of the ESSPD and colleagues

I took over the presidency of the ESSPD after being elected at the membership meeting in Rome, Sept. 2014. First of all, I wish to thank Anthony Bateman for his dedicated leadership of the ESSPD during its first four years, following on from Thomas Rinne, and for his courage in getting our new society fully launched. I highly appreciate the confidence the members of the ESSPD have placed in me and Lars Mehlum (as president elect) and I warmly welcome our new members of the ESSPD board, Paul Moran and Sebastian Simonsen.

For the next two years we have several important tasks to be done: the first major issue involves the publicity and discussion of the planned revisions of the personality disorder section in the ICD 11. The current planned changes will have far reaching consequences in the field of personality disorders, particularly in relation to science and treatment, and these changes will influence insurance companies and health care systems worldwide. The far reaching consequences have to be considered carefully by a broader group of researchers and clinicians than is currently the case.

As a second aim, the ESSPD intends to strengthen the dissemination of evidence based treatments of personality disorders in Europe. To this end we will provide workshop congresses mainly in Eastern Europe, and will support the dissemination of national treatment guidelines to a broader field of European colleagues. Of course we will carry forward the successful career of our International Congress on Borderline Personality Disorders, which has grown out of small beginnings to an important, highly frequented trans-scholar platform of international scientists and clinicians. We wish to thank Stephan Doering for offering Vienna as the next venue in 2016. In order to strengthen the influence of our foundation on both science and mental health care in Europe, we will invite selected European scientists and recommended clinicians to join us to enlarge our scope.

Of course, this can only be a segment of to work to be done by the ESSPD within the next two years. I am happy to serve as president during this period.

Martin Bohus
President, ESSPD

Welcome to the two new members of the ESSPD Board : Paul Moran and Sebastian Simonsen

Paul Moran

Paul Moran: Paul Moran is a Reader and Honorary Consultant Psychiatrist, at King's College London. After qualifying in Medicine from St Bartholomew's Hospital Medical College in London (1991), he trained in Psychiatry at the Maudsley Hospital, before going on to study a Masters in Epidemiology at the London School of Hygiene & Tropical Medicine (obtained with Distinction in 1999). He first developed an interest in the needs of people with severe personality difficulties, whilst working as a junior doctor on the Cawley Centre at the Maudsley Hospital. His doctoral thesis described the first rigorous examination of the prevalence and impact of personality disorder in a primary care sample. He has subsequently published widely on the public health impact and treatment of personality disorders and also on the epidemiology of self-harming behaviour. His research has directly impacted on policy and clinical practice, having been cited in national guidelines and also in UK parliamentary discussion. Paul's current portfolio of externally-funded projects includes a series of studies examining the mortality and health status of people with personality disorder, the national evaluation of the UK's Offender Personality Disorder Pathway, and the development of an eHealth package for young people who self-harm. As a senior clinician at the Maudsley Hospital, he runs a national outpatient service for people who recurrently self-harm. He also acts as the Consultant Psychiatrist to London South Bank University. He has previously advised UK government, NHS organizations and the Royal College of Psychiatrists and is currently an expert member of NICE's Quality Standards Advisory Committee (QSAC) on Personality Disorders.

Sebastian Simonsen

Sebastian Simonsen: I am a Danish psychologist employed at Psychotherapy Centre Stolpegaard located on the outskirts of Copenhagen. My time is divided equally between research and psychotherapy. The topic of my doctoral thesis was assessment of personality pathology and prediction of change following group therapy. I firmly believe that doing research makes me a better therapist and vice versa. For the last ten years, I have been deeply fascinated by the area of personality and personality disorders. Throughout this period, I have been privileged enough to attend several of the ESSPD and ISSPD Congresses and felt the enormous impact of listening to some of the greatest minds in our field and sharing ideas with kindred spirits. I see it as an honor to now contribute to the sustainment and development of the established community which revolves around the European society. As the youngest member of the board, there is obviously still a lot of learning on my part in the period to come, but with that said, I also believe that I can bring something important to the table. Generally, I come with a good sense of the needs of both researchers and clinicians and especially how the two can enrich each other. More specifically, I am active on several boards, networks and working groups in Denmark. For many years I was part of the board of The Institute for the Study of Personality Theory and Psychopathology that played a leading role in planning the very successful jubilee ISSPD congress in Copenhagen last year. As a member of the scientific committee I therefore have some experience of this part of the work. I am currently Vice-president of the Danish National Network for the Study of Psychotherapy which regularly hosts national research psychotherapy seminars; I am also part of the Danish work group responsible for National Clinical Guidelines for borderline personality disorder. This work done by several national groups could be coordinated and reach more people through the ESSPD and benefit more patients. In the end, that is what it is all about.

Michael Kaess, the winner of the Young Researcher Award, Rome 2014
by Theresa Wilberg

Michael Kaess

We congratulate Michael Kaess with the Young Research Award. The newsletter was lucky to have an interview with Michael Kaess just before he held his plenary talk in Rome. Michael Kaess is a consultant for child and adolescent psychiatry at the University Hospital of Heidelberg and also holds the position as managing consultant.

What does it mean for you to win the Young Researcher Award?
I'm very excited actually, because it's just a very nice acknowledgement of the last couple of year's research that I've done. It actually means a lot.

So what will be your main research topics in the next years?
So far I've basically done research in two areas. There's one area, mainly on developmental pathways to BPD. Coming from child and adolescent psychiatry I spend much time investigating precursors of BPD such as self harm, impulsive aggression, and temperament, and I've also spent time on investigating neurobiological pathways and vulnerabilities in BPD. And then, as a clinician I have another research field which is treatment. I founded an early intervention centre one and a half year ago where we're building up a large cohort of young adolescents engaging in multiple forms of risk taking and self harm behaviour, and we are rigorously diagnosing them, also with BPD. We're having a staging approach, first targeting self harm and risk taking behaviour with a short CBT intervention, but then if they do not respond they get more intervention according the their personality pathology, like family intervention, trauma intervention, or DBT. I think this is something that we will need to do in the future, somatic medicine already does a lot of personalized medicine. So I'm very interested in finding predictors, what's the differences between the adolescents who have a normative remission of self harming behaviours and those who enter the pathway to chronic BPD. Once we have the predictors we can adapt our treatment. There may be some adolescents who only need a little bit of support, and there are other adolescents who need a lot more. But at the moment we have just started to talk about BPD in adolescence so we're very far away from knowing predictors of the course and even further away from knowing how we individually tailor treatments. These are the areas that I'm hoping to contribute in the next couple of years.

That sounds very important. What are your hopes regarding BDP research in the years to come?
Well, there are a few big hopes. I hope we will be able to improve treatment. I don't say that we don't have good treatment for BPD, but I think that still there are unsolved issues about improving functioning and the long life time course in terms of, you know, socio-economic status and maintaining healthy relationships. And of course, as a medical person I'm dreaming of a biomarker that really gives us a reliable and valid hint so that we can just say, ok, you are going to develop BPD and you are not, even if that may be more complex than for somatic deceases.

What do you think are important factors for a young researcher like you to be able to do a research carrier?
First of all you need to have people who support you. I couldn't have done that without my mentors. I've been very lucky to have the opportunity to work with two well known research groups on adolescent borderline pathology in Heidelberg and Melbourne and to work with people like Romuald Brunner, Franz Resch and Andrew Chanen. And then it's important for young researchers to have time for both research and clinical work. I think that research informs clinical work and clinical work highly informs research. So what we need is clinician researchers who are able to connect both areas and to ask the right questions.

Michael Kaess with Andrew Chanen and Romauld Brunner

Tallin Conference, Estonia
4th-6th June 2015 by Andres Kaera (Local Chair)

Andres Kaera

One of the aims of the ESSPD is to address the specific needs of the European personality disorder field. This includes adding diversity into the field in areas where it is one-sided and working with areas where the personality disorders have a less prominent status in the mental health policy and community. The ESSPD biannual conferences on personality disorders have hopefully become a traditional meeting place for the international scientific community of personality disorder specialists with three events behind and fourth announced.

Now the ESSPD has planned to promote education and knowledge in the field of personality disorders among clinicians, giving them up to date recommendations based on latest research data for assessing and treating personality disorders. As the clinicians don't often have the time, interest or opportunity to visit scientific conferences, a special event has been tailored to their needs.

The first ESSPD Workshops on Personality Disorders will take place on June 4–6 2015 in Tallinn, the capital of Estonia. The event is directed to the clinicians from the Baltics - Estonia, Latvia, Lithuania, and other countries in Eastern and Northern Europe. With some notable exceptions the research and consequently practice in the field of personality disorders, for different historical and cultural reasons, seems to be scarce in those areas. This is reflected in ESSPD members' list and low number of attendants at ESSPD conferences from those countries.

In Estonia, there is a small but locally productive group of researchers-therapists working mainly with assessment of personality disorders. The group comprises mostly of former students of University of Tartu Institute of Psychology, led by clinical psychologist and lecturer Maie Kreegipuu. There are not many publications to show, as research emphasis of the University lie elsewhere. The work is mostly available as masters' thesis, with ten of them successfully defended, and the number is growing constantly. The members of the group have worked on Armand W. Loranger's International Personality Disorder Examination (IPDE), adaptation of Lee Anna Clark's The Schedule for Nonadaptive and Adaptive Personality (SNAP), and recently on adapting and validating Semi-structured Interview for Personality functioning DSM-5 (STiP-5) authored by Han Berghuis, Joost Hutsebaut, Ad Kaasenbrood, Hilde de Saeger & Theo Ingenhoven. Although evidence-based treatments, mostly DBT, are used in larger psychiatric hospitals, there is clear need for wider dissemination of skills and techniques.

ESSPD is collaborating with Tallinn University Institute of Psychology, Estonian Association for Cognitive Behavioural Therapy and Union of Estonian Psychologists, and the local interest in upcoming event is noticeable. Of course participants from other countries are invited to refresh their knowledge and skills and also learn new ones. Hopefully there's also an opportunity to make new contacts and welcome new members to the ESSPD family. Here is a short overview of the workshops offered; more details can be found on ESSPD the website.

Arnoud Arntz has prepared a workshop about schema therapy for personality disorders in general. He will offer participants an introduction into the clinical application of Schema Therapy for personality disorders in general, so that participants have a feel how to apply Schema Therapy to Cluster B, Cluster C, and Paranoid Personality Disorder. Anthony Bateman's workshop deals with applying Mentalization Based Treatment to Antisocial personality disorder. The workshop will teach participants to identify mentalizing difficulties specific to ASPD, help develop a mentalizing therapeutic stance and use some basic techniques in everyday clinical work. Martin Bohus provides an introduction to DBT-based structured multicomponent program tailored for Borderline patients with PTSD related to Childhood Sexual Abuse. The participants will learn the basic principles and rules for this mode of therapy and get an overview of treatment modules, among other things. Giancarlo Dimaggio introduces attendants to Metacognitive Interpersonal Therapy for Avoidant personality disorder. The workshop goes through step-by-step description of therapy procedures from case formulation to expanding the patient's relationship networks. A focus will be put on therapeutic relationship and metacommunication. Ad Kaasenbrood presents a wider approach to personality disorders, emphasizing the crucial role of crisis intervention, vocational therapy and other services forming a comprehensive system of services and therapies. Finally, Babette Renneberg gives a workshop about treatment strategies for the treatment of patients with extreme social anxiety and Avoidant personality disorder. The workshop will focus on cognitive and behavioural techniques to help patients overcome their anxiety and to get a more positive self-image. All the workshops will use video examples, role play, discussions, or other means of active learning to help the participants get the most out of the workshops.

In addition to exceptional programme, the city of Tallinn is worth visiting. It is an amazing melting pot of old and new, tradition and innovation - well illustrated by having access to fast free WiFi while strolling the cobblestone streets of the medieval old town. On behalf of the local organizing committee I hope to meet many of you in Tallinn!

Email: andres.kaera@gmail.com

Scientific News: Mentalization-Based Treatment for Self-Harm in Adolescents: A Randomised Control Trial by Trudie Rossouw

Trudie Rossouw

Introduction:

Self-harm can be defined as any act of deliberate self-harm, regardless of whether it is accompanied by suicidal thoughts.[1] It is common in community samples[2] and the incidence of self-harm is increasing.[3] Self-harm in clinical groups is associated with negative outcomes.[1] Self-harm is common amongst young people with treatment-resistant depression and is a significant predictor of future suicide.[4] In a population-based US sample, the prevalence of self-harm in youths was 17%.[5] Thirty percent of young people with self-harm continue to harm themselves into adulthood[6]. When adolescents present with self-harm and depression, the close association of self-harm with suicide is of particular clinical concern.[1,4] Apart from the RCT presented here, conducted by me and my colleague Peter Fonagy[7], there is lack of any evidence of an effective treatment intervention for this group.[8]

Study design and results: We[7] developed mentalization based treatment for adolescents (MBT-A), an adapted version of adult MBT treatment developed by Bateman & Fonagy[8] for the treatment of borderline personality (BPD). We then conducted an RCT (n=80) comparing MBT-A against treatment as usual (TAU) for adolescents presenting with self-harm[7]. The MBT-A program consisted of once a week individual MBT-A therapy and once a month MBT-F (MBT family therapy). Treatment duration was 1 year. The MBT-A program was significantly more effective than TAU with regard to reduction in self-harm. At the end of the study 68% of participants in the TAU group were rated as definitely self-harming by the blind assessor, compared with only 43% of the MBT-A group (Fisher's exact test, $p<.05$). The level of self-rated depression decreased for participants in both groups following both quadratic and linear paths. The linear rate of decrease was somewhat greater for the MBT-A group ($p<.04$) and the model yielded a significant difference at 12 months. By 12 months, 58% (18/31) of the TAU group but only 33% (10/30) of MBT-A participants met criteria for BPD diagnosis (Fisher's exact test, $p<.05$). Attachment avoidance and improvement in mentalization emerged as the mediating factors in the reduction of self-harm.

What is mentalization and how does it work?

Mentalization is the capacity to understand one's own state of mind, your impact on someone else's state of mind as well as the ability to be curious and try and understand the mind of the other. It is the ability to understand actions in terms of thoughts and feelings. The capacity to mentalize is sensitive to emotional arousal and under the influence of arousal can cease to function. Adolescents in particular, are prone to relapses in their ability to mentalize in the face of even mild interpersonal stress. During these moments they experience an increasing sense that people do not make sense. They misrepresent the motives of others and can perceive of them as judging or attacking or humiliating them. This often leads to acting out behaviour in an attempt to control the other or to get away from the mental state. Strengthening the capacity to mentalize in families and young people, particularly under stress, lead to an improved sense of agency and self-control and protect against affect dysregulation and impulse control problems[9]. Enhanced mentalization in families helps to turn around passivity and helplessness into agency and lack of reciprocity into compassion for one another and connectedness[10].

Adolescence is a time of particular vulnerability in one's capacity to mentalize. The origin of this vulnerability is in part due to the adolescent phase of development and the increasing demand for social relatedness and belonging, the push for independence from parents and the quest to establish an identity, and additionally it is a period of massive brain reorganisation, all of which leaves young people prone to collapses in their ability to mentalize.

Working with adolescents requires sensitivity and understanding of their particular vulnerability. The MBT-A therapist is an active participant in the session, and his or her keen interest and curiosity in the patient should be evident throughout. The therapist prioritizes learning about the patient's feelings, rather than focusing on behaviour. The therapist sees herself as a participant in the dynamic interaction between her and the patient and takes responsibility for the fact that what she says or does can have an emotional impact on the patient. Similarly, misunderstandings on her part can evoke painful experiences in the patient, for which she will need to take responsibility[11].

Building a strong therapeutic alliance, making authentic emotional contact, and interacting in a supportive capacity are central characteristics in this work. These are of particular importance in working with adolescents, as they often present profound feelings of inadequacy associated with great difficulty in regulating their self experience and thus forming a positive and

coherent self esteem. Hence they are acutely sensitive to any experience that may exacerbate their sense of inadequacy or threaten their self esteem. Minor misunderstandings or comments from the therapist which makes them feel judged or exposed, can easily lead to acting out and self-harming behaviour in an attempt to restore their vulnerable self esteem and sense of control.

The focus of the therapeutic work is in the here and now and detailed attention is paid to the affective state of the patient. In the face of a mentalizing failure, the therapist will try and rewind to what happened before the failure and then try to establish the affect as well as the interpersonal context in which the failure occurred. Clarifying the details of the interpersonal event, allows the assumptions that triggered the affective storm to become clearer. Once clearer they can be understood, challenged or questioned.

The main aim of the work is to help young people become more able to mentalize in the context of strong emotional states. This will enhance the stability of their interpersonal relationships as well as improve their sense of compassion to themselves. It will turn the experience of helplessness and passivity around into a sense of hope and mastery and it often helps these youngsters back onto the developmental tract.

Trudie Rossouw **is a consultant child and adolescent psychiatrist, North East London NHS Foundation Trust, London, UK and Associate Medical Director for Children's Services, North East London NHS Foundation Trust, London, UK**
Email: trudie.rossouw@nelft.nhs.uk

References:

1. Wilkinson P, Kelvin R, Roberts C, Dubicka B, Goodyer I. (2011) Clinical and psychosocial predictors of suicide attempts and nonsuicidal self-injury in the Adolescent Depression Antidepressants and Psychotherapy Trial (ADAPT). *Am J Psychiatry,* 168 (5):495-501.

2. Madge N, Hewitt A, Hawton K, et al. (2008) Deliberate self-harm within an international community sample of young people: comparative findings from the Child & Adolescent Self-harm in Europe (CASE) Study. *J Child Psychol Psychiatry,* 49(6):667-677.

3. Jacobson CM, Gould M. (2007) The epidemiology and phenomenology of non-suicidal self-injurious behavior among adolescents: A critical review of the literature. *Arch Suicide Res,* 11(2):129-147.

4. Asarnow JR, Porta G, Spirito A, et al. (2011) Suicide attempts and nonsuicidal self-injury in the treatment of resistant depression in adolescents: findings from the TORDIA study. *J Am Acad Child Adolesc Psychiatry,* 50(8):772-781.

5. Nixon MK, Cloutier P, Jansson SM. (2008) Nonsuicidal self-harm in youth: a population-based survey. *CMAJ,* 178(3):306-312.

6. Harrington R, Pickles A, Aglan A, Harrington V, Burroughs H, Kerfoot M. (2006) Early adult outcomes of adolescents who deliberately poisoned themselves. *J Am Acad Child Adolesc Psychiatr,* 45(3):337-345.

7. Rossouw TI & Fonagy P. (2012) Mentalization-based treatment for self-harm in adolescents: a randomized controlled trial. *J Am Acad Child Adolesc Psychiatry,* 51(12):1304-1313.

8. Ougrin D, Tranah T, Leigh E, Taylor L, Asarnow JR. (2012) Practitioner review: Self-harm in adolescents. *J Child Psychol Psychiatry,* 53(4):337-350.

9. Fonagy P. (1998) An attachment theory approach to treatment of the difficult patient. *Bulletin of The Menninger Clinic*, 62:147-169.

10. Bleiberg E, Rossouw T, & Fonagy P. (2012) Adolescent breakdown and emerging borderline personality disorder. In (Eds) Bateman AW & Fonagy P: *Handbook of mentalizing in mental health practice*. American Psychiatric Publishing, Washington, London, 463-511.

11. Bateman AW & Fonagy P. (2004) *Psychotherapy for borderline personality disorder: Mentalization based treatment*. Oxford: Oxford University.

Scientific News: Dialectical Behavior Therapy adapted for Self-Harming and Suicidal Adolescents—A Randomised Trial by Lars Mehlum

Lars Mehlum

Introduction

Non-suicidal self-harm and suicide attempts are important public health problems in all age groups, but have particularly high prevalence in young people (Jacobson & Gould, 2007). In a substantial subgroup of self-harming adolescents this is a repetitive pattern that is linked to an increased sensitivity to environmental stress, strong emotional reactivity and problems of emotion regulation. Although many clinicians are reluctant to diagnose Borderline Personality Disorder (BPD) in adolescents, the disorder is indeed diagnosable in adolescence and it is highly predictive of adult pathology. Repetitive self-harm is not only associated with a strongly reduced quality of life, but it is also a powerful predictor of completed suicide. There is thus a strong need to develop effective interventions accessible and acceptable to adolescents and their families and feasible to deliver by clinicians in community mental health settings.

Dialectical behaviour therapy (DBT) is a partially manual-based multi-modal outpatient treatment developed by Linehan (1993), University of Washington, to respond to core problems experienced by adults with BPD: emotional, cognitive, behavioural and interpersonal dysregulation. This dysregulation is thought to result from transactional influences between an individual's biological disposition and an invalidating environment. In altogether 18 randomized control trials (RCT) at independent sites DBT has been found to be superior to comparison treatments in reducing suicidal and non-suicidal self-harm, emergency department visits and hospitalizations, improving outpatient treatment completion, global and social adjustment and personality functioning. DBT has since been adapted for outpatient treatment of self-harming adolescents (DBT-A) with borderline personality traits by Miller and colleagues (2007) through shortening the treatment length from 12 to 3-5 months, including parents or other care-givers in weekly skills training groups and family therapy sessions, and adding a new skills module to address common skills deficits among teens with emotion regulation problems. Several small pilot studies have shown that DBT-A is a treatment that is feasible to deliver to self-harming adolescents and their families, and treatment outcomes have been promising. Based on these favourable results we conducted a randomized controlled trial (Mehlum et al., 2014) to study whether DBT-A would be superior to usual care in reducing self-harm behaviour, suicidal ideation and depressive symptoms in self-harming adolescents with BPD features.

Study methodology and results

The study was conducted by a research group at the National Centre for Suicide Research and Prevention at the University of Oslo. Altogether 77 adolescents with recent and repetitive self-harm were randomly allocated to receive 19 weeks of either DBT-A or enhanced usual care (EUC); both treatment conditions at community child and adolescent psychiatric outpatient clinics. Assessments of self-harm, suicidal ideation, depression, hopelessness, and symptoms of borderline personality disorder were made at baseline and after 9, 15, and 19 weeks, and frequency of hospitalizations and emergency department visits over the trial period were recorded. Evaluations were made both through self-report and by researcher ratings conducted blind to treatment condition. Although some patients (27%) dropped out of treatment (no between-group differences), all patients were followed from baseline to trial completion with no dropouts from the research. The average drop on logarithmic scale in self-harm frequency in the DBT-A group (slope = 1.28, 95% CI= -1.77 to -0.80, $p < .001$) was highly significant, whereas the drop in the EUC group was not. The between-group difference was statistically significant (Δ slope= -0.92, 95% CI = -1.69 to -0.15, $p = .021$). DBT-A was also found to be superior to EUC in reducing suicidal ideation and depressive symptoms. These differences remained when analyses were conducted with only treatment completing patients. Effect sizes were large for treatment outcomes in patients who received DBT, whereas effect sizes were small for outcomes in patients receiving EUC.

Some characteristics of DBT for adolescents

A basic assumption in DBT is that people with BPD lack skills to effectively regulate emotions, behaviour and interpersonal relations and skills to tolerate emotional distress. Personal and environmental factors may, furthermore, prevent individuals with BPD from using the skills they have. In DBT-A both the adolescents and their parents receive skills training in weekly seminar style group meetings with their therapists (usually two therapists per group) and other families (4-5 families per group). Parents receive the same skills training as their teenagers and are expected to do the same amount of homework between group meetings. Skills training involves learning core mindfulness, distress tolerance, emotion regulation, and interpersonal effectiveness skills as in standard DBT, in addition to so-called 'Walking the middle path'-skills addressing important problems and dilemma in adolescents' lives. Most adolescents and families experience both the contents of the training and the format as very helpful and relevant. Newcomers are admitted into the group at regular intervals and participants who have been on the group for some time frequently help these newcomers quickly orient themselves to the rather unusual and sometimes demanding situation.

An equally important mode of the DBT-A treatment is the weekly individual therapy. Therapists adopt both change oriented strategies, based on CBT principles and learning theory, and acceptance oriented strategies based on Zen philosophy and mindfulness practice and a very active use of validation. To be able to balance change and acceptance strategies in all contact with the patient throughout the course of the treatment is regarded as essential to help the patient tolerate the challenging treatment and avoid dropping out. This also helps the patient – and therapist – to foster a dialectical world view where contradictions may exist, where apparent opposites may sometimes both have truth and where the goal is to find a wise balance between changing what can be changed, and accepting what cannot be changed.

As in the original version of DBT, the treatment programme adapted for adolescents encourage the patients to contact their individual therapists between sessions when in situation where they need coaching to effectively use skills in stead of attempting suicide or engage in problem behaviour such as self-harm. Our experiences with adolescents suggest that telephone coaching is an important and effective way for the patient to generalize skills use to her daily life outside of the therapy context.

Future development

Our research suggests that DBT-A is equally efficacious for self-harming adolescents with borderline traits as it is for adult patients with BPD. Questions left to be addressed are what the active ingredients in DBT-A are, and whether focusing on specific symptom domains (such as self-harm and suicidal ideation) rather than an entire range of behaviours in the lives of multi-problem adolescents would be more effective. To study the long-term effects of the treatment we will follow the cohort of adolescents in our study with assessments one and two years after the trial completion and then well into adulthood with a final follow-up after 10 years.

Lars Mehlum M.D. Ph.D. is professor of psychiatry and suicidology and head of the National Centre for Suicide Research and Prevention at the University of Oslo, Norway
Email: lars.mehlum@medisin.uio.no

References

Jacobson, C. M., & Gould, M. (2007). The epidemiology and phenomenology of non-suicidal self-injurious behavior among adolescents: a critical review of the literature. *Arch Suicide Res, 11*(2), 129-147. doi: 10.1080/13811110701247602

Linehan, Marsha M. (1993). *Cognitive-behavioral treatment of borderline personality disorder*. New York: Guilford Press.

Mehlum, L., Tormoen, A. J., Ramberg, M., Haga, E., Diep, L. M., Laberg, S., . . . Groholt, B. (2014). Dialectical behavior therapy for adolescents with repeated suicidal and self-harming behavior: a randomized trial. *J Am Acad Child Adolesc Psychiatry, 53* (10), 1082-1091. doi: 10.1016/j.jaac.2014.07.003

Miller, A. L., Rathus, J. H., & Linehan, M. M. (2007). *Dialectical Behavior Therapy with Suicidal Adolescents*. New York: Guilford.

ESSPD Rome Congress: Poster Prizewinners: 1st Prize

Rejection Sensitivity and Self-Esteem in Patients with Borderline Personality Disorder

Authors: **Melanie Bungert, Lisa Liebke, Lisa Liebke, Janine Thome, Georgia Koppe, Christian Schmahl, Martin Bohus, Stefanie Lis**

Background:

Borderline Personality Disorder (BPD) is characterized by interpersonal dysfunction described in the DSM-V as an 'anxious preoccupation with real or imagined abandonment'. This symptom description is strongly related to the concept of rejection sensitivity. People high in rejection sensitivity report a greater tendency to expect and perceive rejection in social situations and to react more strongly to those experiences. First studies also support enhanced rejection sensitivity in BPD. The aim of the present study was to investigate rejection sensitivity and its relation to BPD symptom severity, childhood maltreatment and self-esteem in acute and remitted BPD patients.

Melanie Bungert

Methods:

167 female subjects (77 acute BPD, 15 remitted BPD, 75 age and educationally matched healthy controls) participated in the study. Rejection sensitivity was assessed with a German version of the Adult Rejection Sensitivity Questionnaire. Additionally, all subjects completed the Childhood Trauma Questionnaire to measure the frequency of childhood maltreatment, the Rosenberg Self-Esteem Scale to measure self-esteem, and the short version of the BSL measure BPD symptom severity. Mediational analyses were conducted using multiple regressions.

Results:

Acute and remitted BPD patients reported enhanced rejection sensitivity compared to healthy controls. Rejection Sensitivity was linked to self-esteem and borderline symptom severity, but these variables did not correlate with childhood maltreatment. Self-esteem mediated the relation between rejection sensitivity and borderline symptom severity.

Discussion:

Our findings strongly support the relevance of rejection sensitivity not only in acute but also in remitted BPD patients. Despite the importance of childhood maltreatment in the development of rejection sensitivity and BPD, our data did not support direct associations between these variables. Instead, the amount of self-esteem accounted for the relation between rejection sensitivity and BPD symptom severity

Melanie Bungert, Dipl.Psych., Research Unit 'Experimental Psychology', Central Institute of Mental Health, Dept. of Psychosomatic Medicine and Psychotherapy, Medical Faculty Mannheim, University of Heidelberg, J5, D-68159 Mannheim, Germany
Email: melanie.bungert@zi-mannheim.de

ESSPD Rome Congress: Poster Prizewinners: 2nd Prize

Social Feedback and Emotion Regulation in Borderline Personality Disorder: A fMRI Study

Charlotte C. Van Schie

Authors: **Charlotte C. Van Schie, Chui-De Chiu, Bert van Klaveren, Bianca G. Van Den Bulk, Serge A.R.B. Rombouts, Willem J. Heiser, Bernet M. Elzinger**

Objectives: It is thought that Borderline Personality Disorder (BPD) patients are more reactive to negative social feedback, due to lower and more variable self-esteem and additional difficulties with emotion dysregulation, which may in turn impair social interactions[1,2]. The current study investigates the affective and neural responses in BPD patients to negative, neutral and positive interpersonal feedback.

Methods: Nineteen participants with BPD and 35 healthy controls (HC) receive feedback that in their belief is given by another participant. The feedback is shown to the participant while lying in a (3T) functional magnetic imaging (fMRI) scanner. The feedback is presented in the form of 15 positive, 15 neutral and 15 negative adjectives. The same 45 feedback words are shown to each participant in a semi-random order. Self-report ratings of trait self-esteem before the task, anger, tension and state self-esteem before and after the task, and affect ratings after each feedback word are collected.

Results: Recruitment is still ongoing, but preliminary results of the BPD group (N=19) and the HC group (N=35) indicate that BPD patients rate their trait and state self-esteem lower than healthy controls. Participants with BPD show a decline in state self-esteem after receiving feedback, whereas HC's are not affected by the task with respect to their self-esteem. Furthermore, BPD patients report an increase in anger after receiving feedback whereas HC's levels of anger remain stable. Regardless of group, reported affect is more positive after positive words compared to neutral words and negative feedback words and reported affect is more positive for neutral words compared to negative words. Remarkably, affective ratings after each feedback word specifically seem to differ for neutral and positive words, with BPD patients reporting more negative ratings than HC's to positive and neutral words, but not negative words. FMRI data shows that negative affective ratings to the words are associated with increased activation in the right medial frontal gyrus, the left superior frontal gyrus, the right insula and the left lingual gyrus in both groups.

Conclusions: Preliminary results show that, compared to HC's, BPD patients report a more negative mood after neutral and positive feedback, but not after negative feedback, suggesting that BPD patients particularly have difficulties to benefit from positive feedback.

BPD patients report specifically decreased self-esteem and increased anger after the social feedback, whereas healthy controls remain stable in their ratings, illustrating BPD patients' sensitivity for and negative reactions to social feedback, which also may play a role in their social interactions in daily life.

Preliminary fMRI results indicate that the insula, lingual gyrus, superior and medial frontal gyrus become more active as affect ratings decrease after social feedback in both groups.

More BPD patients and a second control group with low trait self-esteem, but no BPD, are being recruited. Furthermore, we will investigate the mediating role of trait self-esteem and emotion (dys)-regulation in reaction to the social feedback.

References:

1. Gunderson, J G. (2007). Disturbed relationships as a phenotype for borderline personality disorder. *American Journal of Psychiatry, 164*, 1637-1640.
2. Lieb, K., Zanarini, M. C., Schmahl, C., Linehan, M. M., & Bohus, M. (2004). Borderline personality disorder. *Lancet, 364*, 453–461.

Charlotte C. Van Schie is a PhD Candidate at Leiden University, Leiden, The Netherlands
Email: c.c.van.schie@fsw.leidenuniv.nl

ESSPD Rome Congress: Poster Prizewinners: 3rd Prize

Functional abnormalities of moral judgement in Borderline Personality Disorder: A BOLD fMRI Study

Authors: **Chiara Bulgarelli, Daniele Radaelli, Bendetta Vai, Sara Poletti, Andrea Fossati, Cesare Maffei, Cristina Colombo, Francesco Bendetti**

Chiara Bulgarelli

Background: Moral judgment is an important aspect of every day-life and it relies on the functional integration of multiple cognitive, emotional and social processes. Alterations in several social cognition domains, emotional dysregulation and impaired cognitive functions are some of the core features of Borderline Personality Disorder (BPD)[1]. Moreover, several neuroimaging studies highlighted that the brain structures involved in moral judgment, such as amydala, cingulate cortex, insula and frontal lobe[2], present structural and functional abnormalities in BPD. Notwithstanding these data, no previous study investigated the neural correlates of moral judgment in BPD and healthy controls (HC). This study is aimed at exploring the neurobiological underpinning of BPD, in terms of abnormal brain response during moral processing, by using BOLD fMRI.

Method: A 3.0 Tesla fMRI acquisition was used to study 10 BPD and 10 HC, matched for gender and age. The fMRI task includes moral and non-moral (use for subtractive contrast) dilemmas[3]. Subjects were asked for judge whether the choice presented in each dilemma was appropriated or not. As second level analyses we performed an ANOVA test to compare BOLD responses. We also compared, with student t-test, the reaction times to moral and non-moral dilemmas between groups.

Results: Imaging analysis showed an hyperactivation of the insula in BPD compared to HC. BPD had also a higher reaction time in responses to moral dilemmas compared to HC. No differences has been found related to non-moral condition.

Conclusions: Results highlighted longer reaction times and an hyperactivation of insula in BPD in response to moral dilemmas. A "dual-process" is engaged by subjects in answering to the moral dilemmas, which involve both emotional and cognitive processes. These data may prompt a difficulty of BPD to manage this “dual process” in the face of an emotional dysregulation[4]. To our knowledge, this is the first study which evaluate the neural correlates of moral judgment in BPD. Future research may help us to define a new neurobiological correlate of the disorder.

References:

1. Mier, D., Lis, S., Esslinger, C., Sauer, C., Hagenhoff, M., Ulferts, J., Gallhofer, B., Kirsch, P. Neuronal correlates of social cognition in borderline personality disorder. Soc Cogn Affect Neurosci. 2013; 8(5):531-7.

2. Greene, J., Sommerville, R., Nystrom, LE, Darley, JM., Cohen, JD. (2001). An fMRI investigation of emotional engagement in moral judgment. Science, 293, 2105-2018.

3. Greene, J., Nystrom, LE., Engell, AD., Darley, JM., Cohen, JD. (2004). The neural bases of cognitive conflict and control in moral judgment. Neuron, 44, 389–400.

4. Frick, C., Lang, S., Kotchoubey, B., et al. (2012). Hypersensitivity in borderline personality disorder during mindreading. PLoS One, 7 (8) :e41650

Chiara Bulgarelli, Dept of Clinical Neurosciences, Scientific Institute and University Vita-Salute San Raffaele and CERMAC (Centro di Eccellenza Risonanza Magnetica ad Alto Campo),
Milan, Italy
Email: bulgarelli.chiara@libero.it

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 both 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 at uxthwi@ous-hf.no