ESSPD | European Society for the Study of Personality Disorders

ESSPD Academy Newsletter, December 2020

Dear ESSPD members,

Babette Renneberg

First of all, I hope all of you are well at the end of this challenging year!
At our general membership meeting in October 2020, Stephan Doering stepped down as president of the ESSPD. Stephan did an excellent job in leading our society over the last years, a heartfelt thank you to Stephan for his contribution and dedication!

Let me also extend our gratitude to our colleagues who left the board during the last term: Lars Mehlum, Sebastian Simonsen, Joaquim Soler, and Paul Moran.

Information on our new board members Christian Schmahl, Chiara de Panfilis and Bo Bach can be found here. In this newsletter you will find statements of old and new members how they see their work for the society. We would also like to draw your attention to the role of social factors in personality disorders.

As the new president of ESSPD, I would like to take the opportunity to share some news with you.
It was with great regret that we had to cancel our congress in Antwerp this year because of the pandemic. We value the personal exchange and communication very highly, therefore, we are currently planning the next conference in October 2022. Our aim is to extend the limits of traditional thinking in science and clinical care by creating a platform for an innovative discussion among researchers, clinicians, members of our health care systems, as well as patients and relatives. Therefore, our motto **Change for a better future: Perspectives beyond symptoms - Helping patients to build a life worth living** as well as the venue will stay the same. Please save the new date **October 10-12, 2022** in your schedules.

For the Antwerp conference, we had planned a discussion on euthanasia and assisted suicide in people with personality disorders emerging from the article we published (more information). We will now organize this discussion as an online event on January 26, 2021. You will receive a separate invitation and will find more detailed information below. Among our activities, please note our workshops on personality disorders skills training for effective treatment with leading experts of the field. The next workshop conference will be held in beautiful Riga, Latvia in June 2021. Please also note that the ESSPD promotes and supports young researchers in the field. We all are looking forward to the second ESSPD Summer school in Crêt-Bérard, Switzerland in August 2021.

The ESSPD is expanding the communication ways with you. While we are positive that we can meet in person in Antwerp in 2022, we are preparing for alternative ways to spread news and to provide you with the state-of-the-art research and treatment developments:
Follow us on Twitter: @ESSPD
Join the discussion in closed ESSPD members' group
We will update our website https://www.esspd.eu/ regularly.

We all are facing huge challenges with the pandemic and other societal changes. At ESSPD, we count on the activities and input of our members to adapt to the changes.

It is with optimism that I am looking forward to my presidency and the tasks ahead.

For now, I wish you many moments of happiness and restful holidays,

Babette Renneberg
President of the ESSPD

Changes in the ESSPD Board

In the last general business meeting of the ESSPD three members of the board, Paul Moran (UK), Sebastian Simonsen (Denmark) and Joaquim Soler (Spain) stepped down after many years of contribution to the society. We want to thank them for their tremendous contribution to turn the ESSPD into an Academy of Excellence. When stepping down, they gave feedback how they experienced the work and here, we want to share their thoughts with the members.

Sebastian Simonsen:

It has been a great privilege to serve on the board between 2014-2020. To me the ESSPD in both structure and processes truly embodies a mentalizing organization with integration and discussion between diverse and different theoretical approaches. My work on the board has been done in support of this spirit. I would especially like to thank my fellow board members throughout the years and give a special shout-out to our Eastern European colleagues who are fighting for better recognition and treatment for people with personality disorders.

Paul Moran:

Over the past five years, it's been my pleasure to have served as a board member of ESSPD. People diagnosed with personality disorder often face serious health and social difficulties which are too often neglected or ignored by wider society. I am proud to have contributed to ESSPD's efforts in supporting scholarship, collaboration and the dissemination of research findings in the field of personality disorder and hope that ESSPD's work is helping to make a difference to the lives of people diagnosed with personality disorder.

Joaquim Soler:

During the past years I have had the privilege of participating in the ESSPD, first as a consultant, and later as a board member. My participation has now come to an end. It was a great pleasure to be part of this society and to contribute to the aims of "encouraging scholarship, education, research, and treatment for patients with personality disorders" as was pointed out in the first ESSPD publication. I feel fortunate to have had the opportunity to work closely with this active and wise group of people during these stimulating times for the study and treatment of personality disorders. I hope to have the chance to work with you again in the near future.

Three new active members for the board, Bo Bach (Denmark), Chiara De Panfilis (Italy) and Christian Schmahl (Germany) have started their work after the general business meeting that are both excellent scholars in the field of personality disorder research and excellent colleagues. Please welcome them in the board and get to know them reading their statements how they feel being part of the board and what they plan to contribute.

Bo Bach:

It is my privilege to serve on the ESSPD board. My own primary interest lies in the forthcoming implementation of WHO's ICD-11 diagnostic guidelines for personality disorders, and how we, as European practitioners and researchers, may embrace the radical change while overcoming the loss of the historically important personality disorder categories. It is my hope that we as society can be "first movers" and "kick starters" of research and clinical use of the new ICD-11 classification with respect to diagnostic operationalization, case formulation, tailored treatment, and tentative treatment guidelines – including the new borderline pattern qualifier.

Changes in the ESSPD Board (Continued)

Chiara De Panfilis:

It is for me a great honor to serve on the ESSPD board. I have been a ESSPD member since 2011, and actively participated in the ESSPD bi-annual congresses since 2014. I have always been struck by the passion and energy that the Society put in pursuing the goal of expanding the knowledge about diagnosis, etiology and effective treatment of personality disorders – often neglected by the broader field of general psychiatry. I hope to contribute to this exciting tradition with my research efforts toward clarifying how PD patients interpret and respond to social cues, and with my clinical interest in how to translate insights from evidence-based psychotherapies into generalist, community-based psychiatry services for PD and comorbid conditions.

Christian Schmahl:

I feel very honored to serve on the ESSPD board and help to shape the future of European research on personality disorders and improve clinical care for these patients. I have been involved in ESSPD since its foundation, particularly in the organization of the bi-annual Congress on Borderline Personality and Allied Disorders. My own expertise lies in the establishment of clinical programs for patients with BPD and complex PTSD as well as in the interaction between neurobiology and psychotherapy. I hope that I can fruitfully contribute my research and clinical skills for the progress of ESSPD and those afflicted by these serious and still too little considered disorders.

ESSPD Academy Newsletter Submissions

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**

From top, **Svenja Taubner, ESSPD Newsletter Editor; Bo Bach, ESSPD Editorial Board; Matilde Elices, ESSPD Editorial Board; Michaela Swales, ESSPD Editorial Board**

ESSPD Research Update

This scientific update is focused upon the themes of *measurement, mechanisms and treatment.* 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.

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Sophie Liljedahl

Boredom in borderline personality disorder: A lost criterion reconsidered

Masland, S. R., Shah, T. V., & Choi-Kain, L. W. (2020)
Psychopathology, 1–15. https://doi.org/10.1159/000511312

Aim: To rigorously evaluate how boredom pertains to borderline personality disorder (BPD) through in extensive review of the empirical and theoretical literature.

Background: Prior to the publication of DSM-IV, boredom was included as a diagnostic criterion for BPD. It was excluded from further iterations of the DSM from the 4th Ed forward due to insufficient data that were not disseminated. However, difficulties with the experience of boredom amongst those diagnosed with BPD presents an ongoing challenge in contemporary clinical practice. The authors structure their review by first evaluating the measurement of boredom and proposing a re-formulation of BPD to consider "boredom reactivity." The authors then distinguish between boredom and BPD's criterion of emptiness, which were linked in the DSM diagnostic system prior to the publication of DSM-IV. Boredom in BPD is contrasted with boredom in other personality disorders. Finally, a *Boredom Cascade Model* is generated by the authors whereby boredom reactivity, difficulties with identity and emptiness contribute to out-of-control behaviours, a hallmark feature of BPD. Treatment and research recommendations are presented.

Formulation and & Measurement: Boredom reactivity was comprised of four parts alongside their characteristics, measures, and centrality in relation to BPD. These were: 1. Sensitivity; 2. Tolerance; 3. Intensity; and 4. Duration. In relation to comprehending BPD, the authors suggest that boredom is important, particularly with respect to emptiness and related symptoms such as difficulties with identity, out-of-control behaviours and emotion dysregulation. In relation to emptiness, the authors note that there is not uniform agreement regarding how emptiness is defined. They state that if emptiness and boredom are separate, they may be expected to share important relationships. For example, the experience of disconnection common to reports of emptiness may increase the likelihood that a person also feels boredom. Further, if emptiness predisposes one to having difficulties finding meaning, then emptiness may lead to boredom as well as identity disturbance. These associations are elaborated upon in

the *Boredom Cascade Model* (described in the following section).

The authors propose that boredom is central to BPD criteria. They also note that boredom is often observed within other personality disorders, particularly psychopathy and narcissism, although standardized measurement of boredom is lacking.

Summary & Discussion: The impact of boredom in relation to BPD is summarized by the *Boredom Cascade Model* created by the authors. They explain that cascade models generate positive feedback loops, in this case with affective experience producing an outcome (behaviour) which then increases the likelihood or intensity of the first affective experience recurring (Selby, Anestis, Bender & Joiner, 2009). In the *Boredom Cascade Model*, boredom and boredom reactivity lead to out-of-control behaviours by way of possibly mediating a relationship between the experience of boredom and frustration arising from distress. Frustration may be particularly difficult to tolerate for individuals diagnosed with BPD. An unstable identity may limit development of the stable values that in turn support engagement in meaningful activities. Impulsivity is then proposed to be activated within the model, leading to a greater sense of unstable identity, which may in turn trigger a sense of emptiness that is enduring, which leads to boredom proneness. Impulsive behaviours (defined as maladaptive because they are driven by a desire to terminate boredom rather than generate meaning) further distance the individual from developing their identity, which in turn generates more boredom, frustration and more behaviours that may increase with respect to intensity, due to distress. In this way, the model explains how boredom, difficulties with identity and emptiness generate patterns of behavioural dyscontrol and distress.

The authors conclude with 11 recommendations regarding the future of boredom research in relation to BPD. Centrally, they recommend that boredom be reconsidered separately from emptiness and that the relationship between both in BPD is distinguished.

Key Reference

Selby, E. A., Anestis, M. D., Bender, T. W., & Joiner, T. E., Jr. (2009). An exploration of the emotional cascade model in borderline personality disorder. *Journal of Abnormal Psychology, 118(2)*, 375–387. https://doi-org.ludwig.lub.lu.se/10.1037/a0015711

Treatment selection in borderline personality disorder between dialectical behavior therapy and psychodynamic psychiatric management

Keefe J.R., Kim T.T., DeRubeis R.J., Streiner D.L., Links P.S., McMain, S.F. (2020).
Psychological Medicine 1–9
https://doi.org/10.1017/S0033291720000550

Aim: To evaluate the advantage of moderator-based selection between two evidence-based treatments for symptom relief amongst those diagnosed with Borderline Personality Disorder (BPD). The treatments were a year of Dialectical Behaviour Therapy (DBT) or General Psychiatric Management (GLM). Randomized clinical trial data (McMain, Guimond, Streiner, Cardish, & Links, 2012; McMain et al., 2009) were utilized for patient characteristics at baseline as well as response to both treatments at year 1 and year 2 follow-up as the source of moderator data. The overarching aim was to personalize treatments with equivalent effectiveness to increase the likelihood of enduring treatment response.

Background: Both DBT and GLM are leading treatments for BPD. They both last a year in their standardized outpatient format and they are both delivered by clinicians with specialized training. The authors note that the BPD population has a considerably broad range of presenting symptomatology, with 256 unique sets of symptom configurations possible based on meeting five of nine diagnostic criteria. Despite this there have not been clinical trials dedicated to determining the most suitable selection of evidence-based treatment based on individual symptom profile.

Method & Procedure: Data for this study were utilized from a single-blind randomized clinical trial comparing GLM to DBT including adult English-speaking patients (age 18-60) meeting diagnostic criteria for BPD with at least two incidents of self-harm within the past 5 years. The most recent self-harm incident was to have been within 3 months prior to commencing treatment within the trial. The majority of participants were female (86.1%). Participants' long-term profile of treatment response was evaluated on a number of outcomes for participants completing at least two follow-up assessments over 2 years. Of 180 possible participants randomized to treatment, 156 (86.7%) generated sufficient data for inclusion in analyses. Moderator variables were selected based on clinical presentation, which were refined through a variable selection procedure comprised of a series of analyses over two stages. A combined moderator model was created to determine which of the two treatments would best fit the individual patient.

Results & Discussion: A total of 78 of 156 individuals eligible for inclusion in the study received GPM. The only significant difference between treatment groups at baseline was childhood sexual abuse, with greater severity reported by the GPM group. No other differences existed including symptom severity over the course of the trial and 2-year follow-up. Of the initial 20 variables selected, six were retained. With respect to optimizing treatment selection, GPM was more beneficial than DBT with respect to symptom severity, and impulsivity. Treatment with DBT was more beneficial than GLM for traits of dependent personality, emotional abuse during childhood and social functioning. Individuals randomized to their best fit for treatment had significantly better treatment outcomes which persisted at follow-up. Personalizing treatment for BPD may be an important step in enhancing treatment response.

Key References

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A proposed severity classification of borderline symptoms using the borderline symptom list (BSL-23)

Kleindienst, N., Jungkunz, M. & **Bohus, M.** (2020).
Borderline Personality Disorder and Emotion Dysregulation, 7(1), 1–11.
https://bpded.biomedcentral.com/articles/10.1186/s40479-020-00126-6

Aim: The aim of the study was to create a classification system to determine the severity of symptoms rated by the Borderline symptom List (BSL-23).

Background: The (BSL-23) is a self-assessment measure that evaluates the severity of BPD symptoms. Prior to the publication of this study, the BSL-23 was lacking a system for standardizing severity ratings. Severity ratings are useful for understanding complexity of psychopathology, matching patients to therapy based on their presenting symptoms, as well as for monitoring change over time.

Methods & Procedure: A total of N=1,090 individuals' BSL-23 self-reports were included in the study. Determining the severity of symptoms was based upon data from a sample of n=241 individuals diagnosed with BPD, which was validated by data from three separate samples. The severity classification system was validated through evaluating similarity of the severity rating of the BSL-23 to the IDPE, the SCID-IV, the GSI of the SCL-90, the GAF and the BDI-II.

Results & Discussion: A total of six grades were generated within the severity system of the BSL-23 from the average score. Scores falling into the rating of "none or low" were 0-0-3; "mild" were 0.3-0.7; "moderate" were 0.7 -1.7; "high" were 1.7-2.7; "very high" were 2.7-3.5; "extremely high" were 3.5-4. These grades were repeatedly reinforced through cross-sample and cross-assessment comparisons. The authors recommend that future research continue to develop the validation of this severity system by measuring loneliness, sense of connection, self-concept and life quality.

What works for adolescents with borderline personality disorder: towards a developmentally informed understanding and structured treatment model

Bo, S., Vilmar, J. W., Jensen, S. L., Jørgensen, M. S., Kongerslev, M., Lind, M., & Fonagy, P. (2021). *Current Opinion in Psychology,* 37, 7–12. https://doi-org.ludwig.lub.lu.se/10.1016/j.copsyc.2020.06.008

Aim: To determine by selective review what works in youth BPD treatment alongside consideration of change mechanisms.

Background: Research on youth BPD treatment in relation to efficacy is scarce. This in turn limits ability to best deliver care to this population, as evidence-based guidelines are lacking. The authors review programs for youth BPD and target issues specific to the adolescent period of development that may pose difficulties to standard psychotherapy practice, as well as proposals for how to resolve those difficulties within treatment. Implications from a Danish RCT comparing mentalization-based group treatment for BPD youth with Treatment as usual (TAU) is commented upon with recommendations for future research.

Selected Review: Despite significant advancement in the field of youth BPD research including multiple RCT studies over the last 10 years, the authors state that efficacy studies are comparably quite limited. Only one RCT within their selected review (Rossouw & Fonagy, 2012) was reported to show superior findings in the treatment versus control group, and only five RCTs included assessments over a follow-up period. A systematic review and meta-analysis of youth BPD psychotherapy research reported significant reductions in BPD symptomatology including self-harm but stated that these effects were temporary to the extent that they were longer present at follow-up compared to control groups. This review was subsequently criticized from a methodological standpoint making it difficult at present to conclude whether treatments tested led to long term therapeutic change. The authors state that there is much promise in numerous psychotherapeutic treatments for youth BPD, but that there are considerable gaps in understanding what treatment is best, as well as why.

The adolescent developmental period is known for mimicking some BPD traits such as emotional lability, shifts in identity as well as impulsive behaviours, within normative limits. Some risky behaviours such as drug use and self-harm may emerge and then dissipate. It is youth for whom these traits do not dissipate, who also demonstrate greater development of the limbic system compared to the prefrontal cortex who have greater likelihood of going on to develop persistent symptoms of BPD. There are further neurological differences between youth and adults with respect to emotion processing, and different social norms whereby youth reference and involve their peers more often for emotional processing than do adults. Taken together the authors suggest that these youth-specific developmental considerations inform psychotherapy for youth BPD. They propose that youth should not be expected to have the same mentalizing capacity as adults, and so therapy should modify mentalizing demands to a reasonable expectation for youth. Communication in psychotherapy for youth was also suggested to be very clear with an emphasis on efforts to avoid misunderstandings which were said to be more likely and with greater consequence amongst emotionally sensitive young people. Monitoring group dynamics was highlighted as vital as well, given that youth more often reference and influence each other than adults.

Discussion and Future Directions: A Danish research team recently tested a group mentalization-based

treatment for youth with BPD (MGAB) compared with TAU by RCT (Beck, Bo, Gondan et al., 2016). The RCT was pilot tested in a one-year study evaluating pre-post effects, with positive results. Despite this, the RCT on MGAB showed no significant differences between MGAB and TAU on primary or secondary outcomes of the trial. These findings persisted at 3-and-12-month follow-up. The authors state that they may have had different findings if they had used the complete MBT treatment rather than solely group therapy, as well as involvement of broader social systems such as family, friends and school. The authors conclude that the full social system around the young person may be necessary to involve in effective psychotherapy for young people with BPD in order to bring about sustainable change, given that the cultivation of both mentalization and epistemic trust require social engagement.

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Social factors and Personality Disorders: Implications for etiology, maintenance and treatment: Social risk factors for PD

Chiara De Panfilis

Clinicians have long recognized a close association between environmental social adversities and personality disorders (PD). The life trajectories of individuals suffering from PD are often characterized by a long and often dramatic history of exposure to negative social experiences, such as childhood trauma, inadequate parenting, family disruptions, school and work difficulties, conflicts with peers and partners. Consistently, developmental research identified several social risk factors for the development of any PD symptoms in adulthood, including childhood adversities (i.e., parental conflict and loss, maladaptive parenting behavior, physical, sexual and verbal abuse, neglect, low family income) and adolescent difficulties (i.e., partner conflict, poor academic achievement, being suspended or expelled from school, low social competence) (Cohen et al, 2005). Genetically-informative studies also point out to a robust effect of environmental experiences across the all range of PDs (varying from an estimated total environmental influence of 59.1% for antisocial PD to 79.5% for schizotypal PD), as opposed to more modest heritability rates (20% - 41%) (Kendler et al, 2008). Finally, broader socio-cultural factors, such as the shift from "traditional" societies to "modern" ones, may also represent risks for PD. "Traditional" societies provide predictable roles for all individuals, thereby protecting the most vulnerable members from social isolation and loss of meaningful roles. Thus, the importance given to social networks and support (i.e., extended family ties, peer support, ease in developing social roles, including employment and marriage opportunities) may powerfully buffer against the familial risk factors for PD (i.e., family breakdown, ineffective parenting, early losses). By contrast, "modern" societies require individuals to find their own role within the community, and value autonomy rather than dependence on social attachments; thus, they may fail to serve a protective role for those otherwise vulnerable to PD (Paris, 1998).

Implications for PD development

Thus, clinical experience and clinical studies identified several reliable social risk factors for PD. At a community level, this could potentially help to develop familial and societal interventions to reduce people's probability to be exposed to such events, as well as early interventions for exposed individuals. However, it would be naive to interpret these clinical and empirical observations as suggesting a causal, unidirectional relationship moving from the (adverse) social environment to the individual. Accumulating evidence suggests that the exposure of an individual to environmental adversities is not random; rather, it is influenced by pre-existing, genetically rooted individual characteristics. This phenomenon, known as gene-environment correlation (rGE), is the process through which genotype is associated with environmental input, rather than independent from it: the same genetic factors that give rise to psychopathology also shape the person's environment. As such, rGE represents a powerful mechanism through which personality pathology unfolds and is maintained over time (Perlstein & Waller, 2020).

Gene-environment correlation dynamics: the interplay between individual and social factors

Three commonly recognized forms of rGE exist.

Passive rGE is the nonrandom association between a person's genotype and their environment. For example, childhood maltreatment may be a reflection of personality disorders and other psychopathology in parents, who may also transmit their genetic liability to their child. Thus, the child's phenotype occurs in an environment correlated with the genotype shared between the parent and child. In this way, the observed correlations between early parental adversities and PD may be "passively" accounted for the genotype shared by parents and offspring.

In *Evocative* rGE, an individual's phenotype inadvertently evokes a reaction from the environment that is correlated with their genotype. For example, individuals with marked temperamental affective instability and interpersonal hypersensitivity, such as those vulnerable to Borderline PD, might negatively overreact to perceived rejection from others, and in turn this increases the likelihood of experiencing further rejection, interpersonal conflict, and ultimately poor social support. In this way, genetically mediated personality traits elicit and perpetuate certain social experiences.

Finally, through *Active* rGE processes the individual select environments that are consistent with their genotype, again creating a nonrandom environmental exposure. For example, adolescents with a liability to aggression might affiliate with aggressive and deviant peers rather than attending school or normative activities, which in turn could increase their risk for conduct problems and later Antisocial PD. In the same vein, persons with avoidant PD

actively avoid new social encounters, which in turn predisposes them to increasing feelings of shame and fear of rejection when exposed to novel situations, thus maintaining their feelings of inadequacy and perpetuating avoidance behaviors.

Overall, these different rGE processes explain why many risk factors for psychopathology that are traditionally considered "environmental" in nature, such as social support, parenting behavior, family cohesion, quality of peer interaction and stressful life events, appear to be to some extent inheritable (Kendler & Baker, 2007). They also indicate that a sole focus on a direct association between social adversities and PD might be confounding. Rather, patients suffering from PD seem to create the environment they respond to, and this leads to repetitive maladaptive patterns of inner experiences and behaviors that, tragically, keep the environment around them stable and problematic, and their pathology resistant to change (Livesley, 2001).

Patients' perspective on the research on social problems in PD

Clinical psychology usual refers to the rGE personality dynamics as to "self-fulfilling prophecies" (Mischel & Shoda, 2008). Indeed, we might be tempted to use this metaphor when describing PD patients' complex interactions with their social environment. On a personal and self-disclosing note, I precisely did that when writing a research paper on trusting behavior in Borderline PD. I was very fortunate to ask the founder of The Research Loop (www.theresearchloop.com) to comment on an early draft of the manuscript. The Research Loop website was launched in 2017 by BPD patients and advocates with the goal to include patients and caregivers in the research process. Specifically, patients and caregivers are offered the opportunity to provide their personal feed-back to researchers regarding their studies and findings, with the idea to help them designing further research in the field. With my big embarrassment – and shame – I was gently told that yes, it is true that patients with borderline PD are captured by a vicious circle by which their tendency to perceive others as untrustworthy makes them to behave in an untrustworthy way toward them. And yes, when reflecting upon this, they are accurately and painfully aware of that, and of how this prevents them to appreciate novel, positive social exchanges. But no, from the patients' perspective this is by no means a *self*-fulfilling prophecy: rather, they personally struggle every day to find a solution for their interpersonal problems and to overcome their many -and reiterating- traumatic experiences. Did I realize that? It was a lot of work…So, my phrasing was inaccurate, and thoughtless: what about the hope that this painful and seemingly endlessness cascade of interpersonal and social difficulties can end? what about patients' decision-making capacity that is preserved in BPD and can be recruited to accomplish that goal? (Needless to say, that wording disappeared from my paper, and I keep relying with gratitude on my "advisors' " comments in my research work).

Implications for treatment and recovery

Not surprisingly, all effective treatments for PD focus, in their own way, on interrupting the maladaptive interactions between the individual and their social environment. While recognizing the important impact of earlier social adversities, interventions should promote patients' ability, in the here and now, to stop the ongoing cascade of further social difficulties. As d'Abrera and Paris (2018) elegantly wrote, "effective treatments…are those that promote accountability and steer the person away from the siren song of victimhood" by helping the individual to create "virtuous cycles of interpersonal effectiveness". Probably what matter most is a solid optimistic stance toward treatment and treatment outcome: in spite of the many social adversities they faced over time, and of their functional limitations, patients maintain the ability to change their behavior, or to learn to do that. Neither genes nor previous social adversities "code", in any direct way, for specific social environments in the present. Rather, what PD patients ask us is to help them to stop perceiving and reacting to actual, novel social events *as if* they were traumatic, invalidating and hostile as those they encountered in the past – in other words, to overcome their transference dispositions. If so, their social environment will change, and their level of functioning, interpersonal competence and satisfaction with life will improve.

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Social factors in Avoidant Personality Disorder

Theresa Wilberg

As Chiara de Panfilis outlines the developmental pathways to personality disorder and functional impairment is characterized by complex interactions between temperament and environmental factors. Avoidant Personality Disorder (AvPD) fits well into this picture. It's a disorder characterized by extensive avoidance of social interaction driven by fears of rejection and feelings of personal inadequacy, leading to impairments in social or work functioning.

Even though patients with AvPD are temperamentally heterogeneous, behavioral inhibition, introversion, neuroticism and rejection sensitivity are the best documented temperamental risk factors. Such temperamental dispositions may influence parenting in various ways. Parents are faced with the task to balance the inhibited and fearful child's need for safety with the child's need to be encouraged or pushed towards adequate social challenges. For those parents who share these temperamental traits and easily can identify with their child's fearfulness, there may be an extra challenge to balance between protection and overprotection of the child. Overprotection and a controlling parental style are known risk factors for later internalizing problems in shy and inhibited children. But the interaction between children's temperament and their environments are complex. Shy and inhibited children may be particularly vulnerable to critical, rejecting or punishing parenting styles. Quiet, introverted and inhibited children may also have difficulties communicating their distress or emotions to their care givers and risk being overlooked. For many patients with AvPD, various degrees of emotional neglect are part of their history. They may also be left alone emotionally in environments of family discord. Sometimes more severe maltreatment adds to their insecure attachment with a harsh negative self-view, relational cautiousness and social withdrawal proneness.

Belonging to social groups and interaction with peers are important arenas for learning and practicing social skills. Many adult patients with AvPD lack confidence in their own social skills or are not aware of how their behaviors influence other people's reactions towards them. Social withdrawal during early years may therefore have negative consequences with increased risk of peer exclusion or bullying.

Yet, the majority of inhibited and shy children do not develop internalizing problems as adults. Even if research indicates that there may be some delay regarding establishment of a first romantic relationship or full time work, it looks like on average they catch up without major consequences for education or satisfaction with social relations as adults. However, temperament is subject to change and modification during childhood and adolescence, with different trajectories of development. Those with the strongest initial temperamental dispositions or those who experience an increase in shyness or inhibition over time are particularly at risk for later mental distress. It's noteworthy that for children who despite their fearfulness, do not withdraw socially or have one or more close friends, their inhibition has little negative consequences for their mental wellbeing later on, while those who withdraw are more at risk. It is therefore an important task to pay attention to children and adolescence with increased risk and develop suitable social and family interventions to prevent a negative development.

Patients with AvPD have often experienced peer exclusion or bullying in childhood and adolescence. Many have painful school experiences with intense anxiety in classroom settings impacting their educational career. Factors like being in the center of attention, fear of ridicule, humiliation and criticism are disturbing their learning potentials in addition to comorbid disorders like anxiety, mood, eating and substance abuse disorders. Some drop out from school in spite of good intellectual resources, while some pursue further education with significant difficulties, mainly in the social domain, like attending classes, joining social arrangements or dating. Some are in need of special social support or various kinds of social welfare arrangements to utilize their resources, manage education and continue in ordinary work.

In modern western societies people are left more to themselves to find their social roles, networks and identities. In this respect the relational cautiousness of patients with AvPD is a clear disadvantage. Moreover, work is an important source of social identity in our culture, which is of course also the case for patients with AvPD. To improve education and work functioning is therefore an important issue. Yet, there are both internal and external barriers to join the workplaces regarding AvPD. Among the internal barriers is the patients' self-uncertainty, fear of novelty, sometimes poor agency, sensitivity to rejection, and often rigid beliefs that other people share their self-critical stance, which make a positive self-presentation and communication and collaboration with colleagues challenging.

External barriers refer to aspects of society or work-places. Unfortunately, children and adolescence with externalizing problem and acting-out behaviors have received far more attention than quiet, introverted children with internalizing problems. This holds for preschool institutions, educational systems, health care, and society at large, hindering early interventions to help young people overcome their avoidance. Hopefully this is about to change. However, businesses and work-places tend to signal a preference for outgoing extroverted employees. Interestingly, research shows that introverted leaders on average achieve at least as good results as extroverted leaders. Moreover, despite indications that work teams comprising a diversity of personalities can be more innovative and productive, the idea of diversity in businesses and other sectors of society, have so far mainly focused on gender and ethnicity and not on personality diversity.

Working environments may represent good opportunities for corrective experiences important for the identity of patients with AvPD. From a societal perspective, efforts to increase work and social functioning is probably cost-effective, as has been demonstrated for other mental disorders. To achieve this goal there is a need for collaboration between the health care systems, external agencies with competence in work rehabilitation and work-places in different sector of society. This is not a task for the health care systems alone. However, attention to work and social functioning should be part of the treatment for patients with AvPD.

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Training Clinicians Working with BPD Clients in Psychosocial Settings: A Necessity

Lyne Desrosiers

People with borderline personality disorder (BPD) are high users of services (Cailhol et al., 2012; Comtois et al., 2016). In addition to mental health consultations, they receive services for a multitude of other problems and, as such, are seen by professionals in different psychosocial and healthcare settings. Adolescents with BPD may receive services from professionals in school or in child protection. Pediatricians, social workers, and primary care clinicians may have to intervene with parents with BPD who seek out services for their child.
Helping people with BPD is known to be a challenge, even for experienced clinicians in specialized care settings. Emotional activation and compassion fatigue are common with this clientele and can increase counterproductive interventions. Yet, the majority of clinicians in the field of child and family social services have not been trained to offer interventions adapted to clients with BPD (Laporte et al., 2014). Moreover, only 18% report using evidence-based practices (Chagnon et al., 2010). At best, they are trained on diagnostic criteria, prevalence, etiologic factors but little guidance is offered about clinical know-how as well as self-management skills and attitudes which are essential in the work with this clientele. Some studies have shown that education programs alleviate stigma and negative attitudes toward people with BPD. However, most of them were geared to the needs of mental health professionals working with adults excluding front-line workers where adolescents and adults with BPD are receiving services. Furthermore, they did not target clinicians' self-management skills and clinical know-how by means of a pedagogical approach based on experiential learning.

To address this gap, we developed two different training programs aimed at child protection caseworkers and primary care clinicians. TANGO, through experiential learning, teaches participants to use DBT skills to regulate themselves during difficult interventions with BPD clients with the goal of reducing mood-dependent intervention. It covers how to: be mindful of emotions in the context of difficult intervention, decrease mood-dependent interventions, validate for non-judgmental interventions, think dialectically for wise mind interventions, change emotional response in the context of difficult intervention, engage effectively without power struggle, and treat therapy interfering behaviours. This 22-hour training includes role-playing, homework, and team consultation. The second one, My Child & Me (MC&M) also based on DBT, is part of a program developed for parents with BPD and for their referring clinicians. It teaches intervention strategies (seeking the noble intention and validation, engaging the parent towards change) and propose a different way of perceiving parents with BPD (9-hour training and 8 videos demonstrating how to intervene in an emotionally demanding context https://youtu.be/D2VDPpMuvqs).

The effects of these two programs are currently being evaluated. Self-report measures assess differences in capabilities to intervene and motivation to help from pre- to post-training. Capabilities are evaluated through ease of working with people with BPD, a sub-scale of the EA-TPL (Imbeau et al., 2013), and emotional regulation during difficult intervention (DERS). Motivation to help is assessed with ProQOL (compassion satisfaction, burnout, compassion fatigue) (Stamm, 2005), perception and attitudes towards people with BPD (EA-TPL) and self-esteem as a clinician when working with this clientele (Corbière et al., 2011). Participants are asked to answer each question based on their most difficult client. Pre- and post-training interviews are conducted in order to assess the effects that are more difficult to quantify and allow a more in-depth interpretation of the quantitative results. Professionals from child protection, schools, child and adolescent mental health services in primary care and adult substance abuse clinics (n = 92 TANGO, 84 MC&M) received training and were compared with 88 controls (n = 62 TANGO, 26 MC&M).

There was no difference in the experimental group and the control group at pretest. Worthy of note, however, is that there was a significant difference between the different groups of clinicians before the training. Caseworkers from child protection services reported significantly fewer difficulties with emotional regulation, less burnout and higher self-esteem than primary care clinicians. Also, clinicians working with parents reported significantly more

difficulties on all measures of capabilities and motivation to help. Both training programs demonstrated significant improvement on awareness of emotion, ease of working with people with BPD, perceptions and attitudes, with a larger effect size for TANGO. MC&M showed more effect on compassion satisfaction, burnout and self-esteem while TANGO demonstrated more impact on emotional regulation; especially with awareness, clarity, acceptance of emotions and access to emotional strategies. Though nonsignificant differences, youth protection caseworkers reported higher difficulties with impulse control, access to emotional strategies and higher compassion fatigue after training.

Since child protection workers reported high scores prior to training, it left little margin for changes, and no significant differences were found on most outcomes at post-test. This result could be understood as better insight and mindfulness to report more accurately on one's emotions, attitudes, perceptions and their impact on interventions. Thus, lower scores at post-test could, paradoxically, be an indication of a positive effect of the training. This narrative seems to support this hypothesis: *"The training helped us to become aware that some of our interventions are determined by our emotions… "*

Our results also indicate that participants working with parents with BPD report significantly lower capabilities and more distress than those intervening with adolescents with this diagnosis. As their mandate is not to treat the parent but to obtain their cooperation in implementing measures aimed at the child's well-being, they may face additional challenges. In this respect, the most important impact of the training received in MC&M is greater ease and increased compassion for these parents and better self-esteem as clinicians with this clientele, suggesting that they feel better equipped after the training. This could reflect the importance of teaching know-how strategies in this training. On the other hand, teaching self-management skills through experiential learning, as used in TANGO, appears to be more effective in helping clinicians use strategies to improve their emotional disposition in difficult intervention contexts.

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The 17th World Congress of the ISSPD in Oslo, October, 13-15, 2021

The ISSPD board has decided on Oslo as the next venue for the ISSPD international congress in 2021. Among the many reasons for such a choice is the great local interest in PD research and treatment development in Oslo, Norway and Scandinavia. Personally, I have fond memories as a then young researcher when the ISSPD World Congress last time took place in Oslo, now 30 years ago in 1991. Since then, field has expanded considerably in Norway and developed into a large and vibrant community of researchers dedicated to PD. To plan for large international conferences during the Covid-19 pandemic may seem like a risky business. However, the organizers have prepared well for all eventualities and state of the art digital solutions are already in place should they be needed. The theme of "Kaleidoscope Perspectives" has been chosen to reflect the ISSPD's celebration of diverging perspectives in our field, and to capture the sentiment that change is constant and that the most resilient personalities are those that can adapt. An impressive line-up of outstanding keynote speakers has agreed to contribute, such as Pim Cuijpers (intervention science), Martin Bohus (DBT for Complex PTSD), Dan McAdams (personality development), Dusica Lecic-Tosevski (ICD-11) and Theresa Wilberg (avoidant personality disorder), master clinicians such as Michaela Swales (DBT), Dawn Bales (MBT) and Irene Sarno (TFP). Eighteen special symposia with leading researchers as chairs have been invited and ample space has been set aside for additional symposia submissions and free communications. More detailed information will be placed on the conference website (https://www.isspd2021.com) in the days and weeks to come.

An exciting social program including cultural performances, a reception in the Oslo City Hall – the venue for the annual Nobel Prize ceremony, and a gala dinner in the Munch Museum who has recently opened its ultramodern new waterfront gallery, will hopefully offer additional facets and colours in the kaleidoscope of this conference. Deadline for abstract submissions is 1 March 2021 and early bird registration ends 9 April 2021. We hope to see you there!

Lars Mehlum
Organizing Committee

Second ESSPD Summer School 2021

The future of psychotherapy research for personality disorders

August 15 - 21, 2021

Crêt-Bérard, VD, Switzerland

The European Society for the Study of Personality Disorders (ESSPD) is proud to announce the second ESSPD Summer School for young researchers organized in collaboration with the University of Lausanne, Department of Psychiatry, Institute of Psychotherapy and General Psychiatry Service, with the financial support of the Swiss National Science Foundation (SNSF).

The aim of the summer school is to increase the methodological competencies in conducting high quality psychotherapy research on the treatment of personality disorders. Topics include: research designs (efficacy and effectiveness, naturalistic), neurobiological aspects of psychotherapeutic change, approaches to mechanisms of change, dimensional approaches, mixed methods studies and case formulation in psychotherapy research.

We will adopt a theory-integrative, disorder-oriented and evidence-based approach. Throughout the one-week program, the focus will be on the plurality of methods, their productive use for specific research questions and their creative combinations in order to deepen the understanding of change in psychotherapy for patients with personality disorders.

Teaching methodologies include interactive presentations, workshop exercises on actual research material, plenary and small group discussions, individual work, speed-talk presentations, playfully structured question-and-answer sessions.

Faculty:

Sabine Herpertz
MD, University of Heidelberg (Germany)

Shelley McMain
PhD, CAMH and University of Toronto, (Canada)

Lars Mehlum
MD PhD, University of Oslo (Norway)

Ueli Kramer
PhD, University of Lausanne (Switzerland)

Johannes Zimmermann
PhD, University of Kassel (Germany)

Where? The summer school takes place in a relaxing and inspiring atmosphere at the picturesque retreat center Crêt-Bérard, calmly perching over Lac Léman in Switzerland, one of the largest lakes in Western Europe. Activities as part of a social program will be organized.

When? Sunday, August 15th, 2021 (arrival day) – Saturday, August 21th, 2021 (departure day; 5 full days residential).

For whom? PhD students, MDs, or early post-doctoral fellows affiliated with a European university.

Deadline: Applications by February 1st, 2021 per e-mail to summerschool@esspd.eu. All applications must contain a letter of motivation, a curriculum vitae and a 1-page summary of the relevant research project (in one PDF file). Applications from Eastern European countries are explicitly encouraged.

Full fee EUR 750 (includes registration to all scientific activities, six overnight stays at Crêt-Bérard, all meals/coffee breaks, and organized social activities).

Reduced fee EUR 300 for participants from Eastern European countries (includes registration to all scientific activities, six overnight stays at Crêt-Bérard, all meals and organized social activities).

Important: ESSPD, with funding from SNSF, fully supports financially up to five participants from Eastern European countries (will be paid for: reduced fee and travel expenses). Please attach one letter of support (e.g. from your supervisor) if you are interested to apply for this funding.

2021 ESSPD Summer School Work Group
Babette Renneberg, Ueli Kramer, Lars Mehlum, Joost Hutsebaut

The ESSPD Summer School has received kind support from the Swiss National Science Foundation, the University of Lausanne and the University of Oslo.

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CHUV 2020 | 51663
FNSNF Swiss National Science Foundation
UiO : University of Oslo

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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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*