GiT-PD
Guideline-Informed Treatment for Personality Disorders

Kenniscentrum Persoonlijkheidsstoornissen

Guideline-Informed Treatment for Personality Disorders

Simple principles for Common factors in PD treatment

Joost Hutsebaut
Riga, June 2025

ESSPD Clinical Workshops: Dealing with alliance ruptures

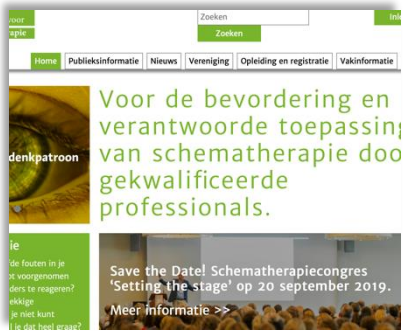
BACKGROUND OF GIT-PD

Background

- 2008: first publication of official guidelines for PDs in the Netherlands

- These guidelines were in favor of 'evidence-based' psychotherapy (DBT, MBT, ST, TFP)


TFPNederland
zoeken
TFP Nederland
Home
Problemen in de persoonlijkheid /TFP
TFP behandelingen in Nederland
Agenda
Ledenpagina
Literatuur en publicaties
Recensies
Lid worden?
NIEUWS


Zoeken
Zoeken
Home
Publieksinformatie
Nieuws
Vereniging
Opleiding en registratie
Vakinformatie
denkpatroon
Voor de bevordering en
verantwoorde toepassing
van schematherapie doo
gekwalificeerde
professionals.
Save the Date! Schematherapiecongres
'Setting the stage' op 20 september 2019.
Meer informatie >>


Dialexis
Het trainingsinstituut voor Dialectische Gedragstherapie (DGT) in Nederl
geaffilieerd aan Behavioural Tech
Symposium 'Behandelen als praten moeilijk is'


mbt nederland
MBT Nederland
MBT Congres
Trainingen
Professionals
Expertisecentrum MBT Nederland
Expertisecentrum MBT Nederland is partner in het wereldwijde netwerk
van het Anna Freud Centre (AFC). Anthony Bateman en Peter Fonagy,
grondleggers van de Mentalization-Based Treatment (MBT) zijn
hieraan verbonden. MBT Nederland verbetert de kwaliteit van
behandelingen voor patiënten met een borderline

BIG 4-HYPE

Scalability of Evidence-based treatment

Treatment of Borderline Personality Disorder: Is Supply Adequate to Meet Public Health Needs?

Evan A. Iliakis, B.A., Anne K. I. Sonley, M.D., J.D., Gabrielle S. Ilagan, B.A., Lois W. Choi-Kain, M.D., M.Ed.

Objectives: This study aimed to assess the supply of and demand for treatment of borderline personality disorder (BPD) to inform current standards of care and training in the context of available resources worldwide.

Methods: The total supply of mental health professionals and mental health professionals certified in specialist evidence-based treatments for BPD was estimated for 22 countries by using data from publicly available sources and training programs. BPD prevalence and treatment-seeking rates were drawn from large-scale national epidemiological studies. Ratios of treatment-seeking patients to available providers were computed to assess whether current systems are able to meet demand. Training and certification requirements were summarized.

to 192:1 in Singapore. The ratio of treatment-seeking patients to clinicians certified in providing evidence-based care ranged from 49:1 in Norway to 148,215:1 in Mexico. Certification requirements differed by treatment and by country.

Conclusions: Shortages of both providers available to treat BPD and providers certified in specialist treatments of BPD exist in most of the 22 countries studied. In well-resourced countries, training clinicians to provide generalist or abbreviated treatments for BPD, in addition to specialist treatments, could help address the current implementation gap. More resource-efficient alternatives must be considered in countries with insufficient staff to implement even generalist treatments. Consideration of realistic allocation of care may shape future guidelines and standards

TABLE 1. Ratio between prevalence of treatment seeking for borderline personality disorder (BPD) and supply of mental health care providers, by country

	Supply of mental health care providers					Ratio between treatment-seeking BPD prevalence and providers		Generalist treatments caseload requirements	
Country	Total providers	Total EBT-certified providers	Total population	BPD prevalence	Treatment-seeking BPD prevalence	Total providers	EBT-certified providers	Proportion of weekly caseload (%)[a]	Hours per week
Australia	29,766	39	24,451,000	660,177	112,230	3.8:1	2,878:1	10–11	4
Netherlands	18,627	127	17,036,000	459,972	78,195	4.2:1	616:1	11–12	4–5
Norway	5,623	498	5,305,000	143,235	24,350	4.3:1	49:1	11–13	4–5
United States	328,695	251	324,459,000	8,760,393	1,489,267	4.5:1	5,933:1	12–13	5
Austria	8,353	22	8,735,000	235,845	40,094	4.8:1	1,822:1	12–14	5–6
Switzerland	6,243	52	8,476,000	228,852	38,905	6.2:1	748:1	16–18	6–7
Germany	56,387	342	82,114,000	2,217,078	376,903	6.7:1	1,102:1	17–20	7–8
Canada	20,053	18	36,624,000	988,848	168,104	8.4:1	9,339:1	21–25	9–10
Belgium	5,413	19	11,429,000	308,583	52,459	9.7:1	2,761:1	25–29	10–11
Poland	17,341	9	38,171,000	1,030,617	175,205	10.1:1	19,467:1	26–30	10–12
Lithuania	1,099	2	2,890,000	78,030	13,265	12.1:1	6,633:1	31–36	12–14
Sweden	3,665	37	9,911,000	267,597	45,491	12.4:1	1,230:1	32–37	13–15
United Kingdom	18,698	378	66,182,000	1,786,914	303,775	16.3:1	804:1	42–48	17–19
Denmark	1,580	18	5,734,000	154,818	26,319	16.7:1	1,462:1	43–49	17–20
Russia	25,900	13	143,990,000	3,887,730	660,914	25.5:1	50,840:1	65–75	26–30
Italy	10,562	32	59,360,000	1,602,720	272,462	25.8:1	8,514:1	66–76	26–30
South Korea	8,176	2	50,986,000	1,376,622	234,026	28.6:1	117,013:1	73–84	29–34
Spain	7,234	30	46,354,000	1,251,558	212,765	29.4:1	7,092:1	75–86	30–35
Ireland	640	20	4,762,000	128,574	21,858	34.2:1	1,093:1	88–101	35–40
Turkey	4,798	9	80,745,000	2,180,115	370,620	77.2:1	41,180:1	198–227	79–91
Mexico	4,922	4	129,163,000	3,487,401	592,858	120:1	148,215:1	309–354	124–142
Singapore	136	2	5,709,000	154,143	26,204	192:1	13,102:1	494–567	198–227

[a] Assuming a caseload of 34–39 patients per week relative to the ratio of treatment-seeking BPD prevalence to total mental health care providers. In the Netherlands, for example, 4.2 patients would account for 11%–12% of a 34–39 patient weekly caseload.

Barriers to Implementing the Clinical Guideline on Borderline Personality Disorder in the Netherlands

Marleen L. M. Hermens, Ph.D.
Peter T. van Splunteren, M.Sc.
Annemiek van den Bosch, M.Sc.
Roel Verheul, Ph.D.

Objective: **This study determined the gap between actual care and optimal care (recommended in the clinical guideline) for patients with borderline personality disorder in the Netherlands. Factors that affected guideline implementation were identified.** ***Methods:*** **Ten specialized mental health organizations participated in this cross-sectional study. The number and proportion of pa-**

Conclusions: **Most patients with borderline personality disorder did not receive the recommended first-step treatment (psychotherapy). Care pathways may help improve efficiency and quality of care. (*Psychiatric Services* 62: 1381–1383, 2011)**

Borderline personality disorder is a severe mental disorder associated with a high burden of disease (1) determined by the specific theoretical orientation. One of the most important determinants of the efficacy is a clear and coherent therapy framework, which should be applied consistently. Dialectical behavior therapy, schema-focused therapy, mentalization-based treatment, and transference-focused psychotherapy are examples of empirically supported psychodynamic and cognitive-behavioral psychotherapeutic treatments that

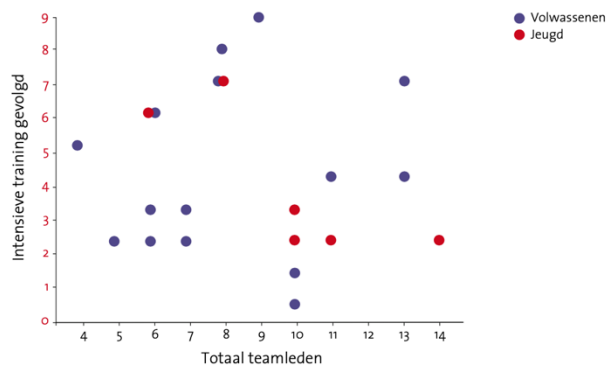
And still… low availability

- 23 % of referred BPD patients receives psychotherapy (and if so, in lower dosages)

Due to:

- Capacity problems (lack of trained staff)
- Organizational barriers

FIGUUR 1 **Aantal teamleden met intensieve training in verhouding tot de grootte van het DGT-team (DGT = dialectische gedragstherapie)**



Van den Bosch & Sinnaeve, 2015

Also…cumbersome implementation

- Differences between institutions
- Most teams are poorly trained in these methods

Journal of Personality Disorders, 37(2), 233–262, 2023

A SYSTEMATIC REVIEW OF THE HETEROGENEITY OF SCHEMA THERAPY

Silvia D. M. van Dijk, PhD, Martine S. Veenstra, MSc, Rob H. S. van den Brink, PhD, Sebastiaan P. J. van Alphen, PhD, and Richard C. Oude Voshaar, MD, PhD

We aimed to explore the heterogeneity of schema therapy regarding (a) patient characteristics, (b) content, and (c) way of delivering schema therapy. A search was conducted of the electronic databases EMBASE, PsycINFO, Web of Science, MEDLINE, and COCHRANE up to June 15, 2022. Treatment studies were eligible if they (a) used schema therapy as (component of) the intervention examined, and (b) reported an outcome measure quantitatively. A total of 101 studies met the inclusion criteria, including randomized controlled trials (n = 30), non-randomized controlled trials (n = 8), pre-post designs (n = 22), cases series (n = 13), and case reports (n = 28), including 4006 patients. Good feasibility was consistently reported irrespective of format (group versus individual), setting (outpatient, day-treatment, inpatient), intensity of treatment, and the specific therapeutic components included. Schema therapy was applied to various (psychiatric) disorders. All studies presented promising results. Effectiveness of the different models of schema therapy as well as application beyond personality disorders should be examined more rigorously.

6 sessions… or 4 years

Bi-weekly … or full inpatient

Provided by nurses … or fully licensed psychotherapists

Poor sustainability

King et al. BMC Psychiatry (2018) 18:302
https://doi.org/10.1186/s12888-018-1876-7

BMC Psychiatry

RESEARCH ARTICLE Open Access

The survivability of dialectical behaviour therapy programmes: a mixed methods analysis of barriers and facilitators to implementation within UK healthcare settings

Joanne C. King*, Richard Hibbs, Christopher W. N. Saville and Michaela A. Swales

Abstract

Background: Dialectical Behaviour Therapy (DBT) is an evidence-based intervention that has been included in the National Institute of Health and Care Excellence guidelines as a recommended treatment for Borderline Personality Disorder in the UK. However, implementing and sustaining evidence-based treatments in routine practice can be difficult to achieve. This study compared the survival of early and late adopters of DBT as well as teams trained via different training modes (on-site versus off-site), and explored factors that aided or hindered implementation of DBT into routine healthcare settings.

Methods: A mixed-method approach was used. Kaplan-Meier survival analyses were conducted to quantify and compare survivability as a measure of sustainability between early and late implementers and those trained on- and off-site. An online questionnaire based on the Consolidated Framework for Implementation Research was used to explore barriers and facilitators in implementation. A quantitative content analysis of survey responses was carried out.

Results: Early implementers were significantly less likely to survive than late implementers, although, the effect size was small. DBT teams trained off-site were significantly more likely to survive. The effect size for this difference was large. An unequal amount of censored data between groups in both analyses means that findings should be considered tentative. Practitioner turnover and financing were the most frequently cited barriers to implementation. Individual characteristics of practitioners and quality of the evidence base were the most commonly reported facilitators to implementation.

Conclusions: A number of common barriers and facilitators to successful implementation of DBT were found among DBT programmes. Location of DBT training may mediate programme survival.

Keywords: Implementation, DBT, CFIR, Kaplan-Meier, Sustainability

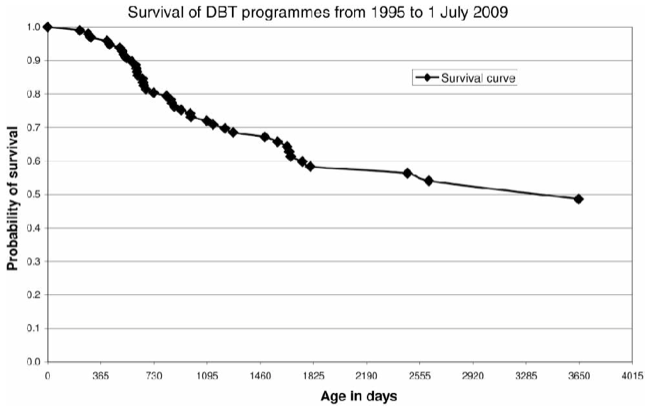


Figure 1. Survival curve.

About half of (DBT) programs stop within the first 5-8 years

Personality and Mental Health

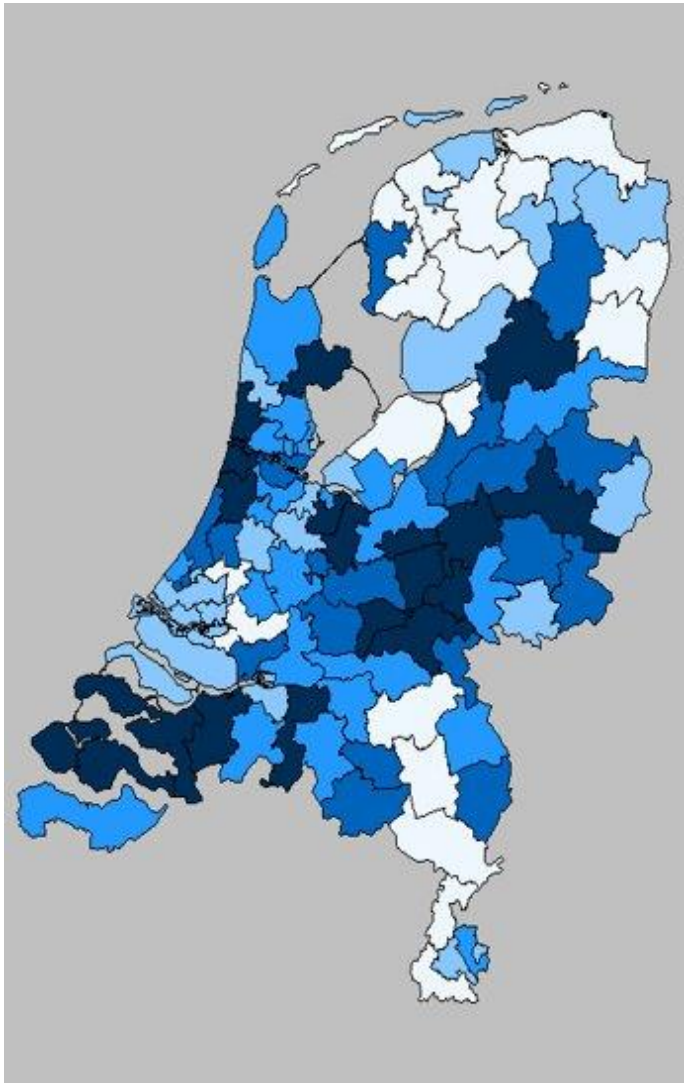
Personality and Mental Health
11: 118–131 (2017)
Published online in Wiley Online Library
(wileyonlinelibrary.com) DOI 10.1002/pmh.1368

Barriers and facilitators to the implementation of mentalization-based treatment (MBT) for borderline personality disorder

DAWN L. BALES, ROEL VERHEUL AND JOOST HUTSEBAUT, Viersprong Institute for Studies on Personality Disorders (VISPD), MBT Netherlands, The Netherlands

ABSTRACT

There are several evidence-based treatments for borderline personality disorder, but very little is known about the success or failure of implementation in daily practice. This study aims to investigate the success or failure of newly started mentalization-based treatment programs, and to explore the barriers and facilitators. The implementation trajectories of seven different mentalization-based treatment programs in six mental health clinics in the Netherlands were included in a multiple case study combining a qualitative and quantitative design. Semi-structured interview data were collected from several stakeholders of each program. Narrative reconstructions of each interview were assessed by 12 independent experts. Results showed that several programs struggled to



The outcome: huge differences across the Netherlands

- Strong local differences
  - Average treatment duration varies from 24 to 128 days
  - Cost price varies from € 3.500 to 13.000 / patient
  - % inpatient treatment varies from 8 to 24%

- No standard of care re: PD treatment in mental health care across the Netherlands
- Strong pressure from health insurance companies to better define 'standard of care'

Challenge

How can we improve the general level of care for PDs in this diverse landscape?

How can we make good-enough treatment really accessible?

Center of Expertise on PDs

Our first solution: centrally organized training, implementation, consultation, supervision of evidence-based treatment programs (e.g. DBT and MBT)

- No interest ☹

Our second solution: improving 'treatment as usual' by providing general principles, training, etc

What's the evidence on effective treatment for PDs?

The evidence on effective treatment

There is most likely on average equivalence in efficacy between different specialist treatment methods and all of them are better than TAU

JAMA Psychiatry | Original Investigation | META-ANALYSIS

Efficacy of Psychotherapies for Borderline Personality Disorder
A Systematic Review and Meta-analysis

Ioana A. Cristea, PhD; Claudio Gentili, MD, PhD; Carmen D. Cotet, PhD; Daniela Palomba, MD; Corrado Barbui, MD; Pim Cuijpers, PhD

IMPORTANCE Borderline personality disorder (BPD) is a debilitating condition, but several psychotherapies are considered effective.

OBJECTIVE To conduct an updated systematic review and meta-analysis of randomized clinical trials to assess the efficacy of psychotherapies for BPD populations.

DATA SOURCES Search terms were combined for borderline personality and randomized trials in PubMed, PsycINFO, EMBASE, and the Cochrane Central Register of Controlled Trials (from database inception to November 2015), as well as the reference lists of earlier meta-analyses.

STUDY SELECTION Included were randomized clinical trials of adults with diagnosed BPD randomized to psychotherapy exclusively or to a control intervention. Study selection differentiated stand-alone designs (in which an independent psychotherapy was compared with control interventions) from add-on designs (in which an experimental intervention added to usual treatment was compared with usual treatment alone).

DATA EXTRACTION AND SYNTHESIS Data extraction coded characteristics of trials, participants, and interventions and assessed risk of bias using 6 domains of the Cochrane Collaboration Risk of Bias tool (independent extraction by 2 assessors). Outcomes were pooled using a random-effects model. Subgroup and meta-regression analyses were conducted.

MAIN OUTCOMES AND MEASURES Standardized mean differences (Hedges g) were calculated using all outcomes reported in the trials for borderline symptoms, self-harm, suicide, health service use, and general psychopathology at posttest and follow-up. Differential treatment retention at posttest was analyzed, reporting odds ratios.

RESULTS Thirty-three trials (2256 participants) were included. For borderline-relevant outcomes combined (symptoms, self-harm, and suicide) at posttest, the investigated psychotherapies were moderately more effective than control interventions in stand-alone designs (g = 0.32; 95% CI, 0.14-0.50 and add-on designs (g = 0.40; 95% CI, 0.15-0.65). Results were similar for other outcomes, including stand-alone designs: self-harm (g = 0.32; 95% CI, 0.09-0.54), suicide (g = 0.44; 95% CI, 0.15-0.74), health service use (g = 0.40; 95% CI, 0.22-0.58), and general psychopathology (g=0.32; 95% CI, 0.09-0.55), with no differences between design types. There were no significant differences in the odds ratios for treatment retention (1.32; 95% CI, 0.87-2.00 for stand-alone designs and 1.01; 95% CI, 0.55-1.87 for add-on designs). Thirteen trials reported borderline-relevant outcomes at follow-up (g = 0.45; 95% CI, 0.15-0.75). Dialectical behavior therapy (g=0.34; 95% CI, 0.15-0.53) and psychodynamic approaches (g=0.41; 95% CI, 0.12-0.69) were the only types of psychotherapies more effective than control interventions. Risk of bias was a significant moderator in subgroup and meta-regression analyses (slope β = −0.16; 95% CI, −0.29 to −0.03; P = .02). Publication bias was persistent, particularly for follow-up.

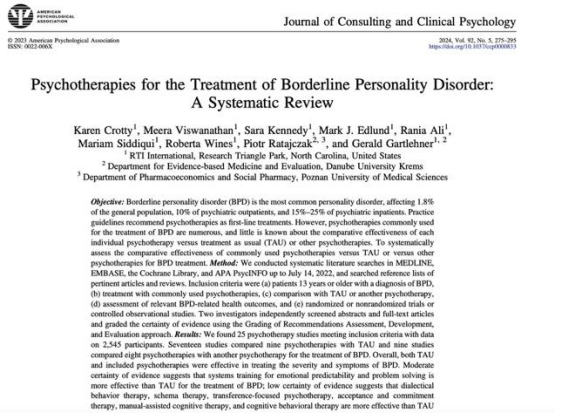
CONCLUSIONS AND RELEVANCE Psychotherapies, most notably dialectical behavior therapy and psychodynamic approaches, are effective for borderline symptoms and related problems. Nonetheless, effects are small, inflated by risk of bias and publication bias, and particularly unstable at follow-up.

JAMA Psychiatry. doi:10.1001/jamapsychiatry.2016.4267
Published online March 1, 2017.

Editorial
Supplemental content

Author Affiliations: Department of Clinical Psychology and Psychotherapy, Babeş-Bolyai University, Cluj-Napoca, Romania (Cristea, Cotet); Department of General Psychology, University of Padova, Padova, Italy (Cristea, Gentili, Palomba); Meta-Research Innovation Center at Stanford, Stanford University, Stanford, California (Cristea); Section of Psychiatry, Department of Neuroscience, Biomedicine and Movement Sciences, University of Verona, Verona, Italy (Barbui); Department of Clinical Psychology, Vrije Universiteit Amsterdam, Public Health Research Institute, Vrije Universiteit, Amsterdam, the Netherlands (Cuijpers).

Corresponding Author: Ioana A. Cristea, PhD, Department of Clinical Psychology and Psychotherapy, Babeş-Bolyai University, 37 Republicii St, 400015, Cluj-Napoca, Romania (ioana.cristea@ubbcluj.ro).



Journal of Consulting and Clinical Psychology

© 2023 American Psychological Association
ISSN: 0022-006X

2024, Vol. 92, No. 5, 275–295
https://doi.org/10.1037/ccp0000815

Psychotherapies for the Treatment of Borderline Personality Disorder: A Systematic Review

Karen Crotty[1], Meera Viswanathan[1], Sara Kennedy[1], Mark J. Edlund[1], Rania Ali[1], Mariam Siddiqui[1], Roberta Wines[1], Piotr Ratajczak[2, 3], and Gerald Gartlehner[1, 2]

[1] RTI International, Research Triangle Park, North Carolina, United States
[2] Department for Evidence-based Medicine and Evaluation, Danube University Krems
[3] Department of Pharmacoeconomics and Social Pharmacy, Poznan University of Medical Sciences

Objective: Borderline personality disorder (BPD) is the most common personality disorder, affecting 1.8% of the general population, 10% of psychiatric outpatients, and 15%–25% of psychiatric inpatients. Practice guidelines recommend psychotherapies as first-line treatments. However, psychotherapies commonly used for the treatment of BPD are numerous, and little is known about the comparative effectiveness of each individual psychotherapy versus treatment as usual (TAU) or other psychotherapies. To systematically assess the comparative effectiveness of commonly used psychotherapies versus TAU or versus other psychotherapies for BPD treatment. *Method:* We conducted systematic literature searches in MEDLINE, EMBASE, the Cochrane Library, and APA PsycINFO up to July 14, 2022, and searched reference lists of pertinent articles and reviews. Inclusion criteria were (a) patients 13 years or older with a diagnosis of BPD, (b) treatment with commonly used psychotherapies, (c) comparison with TAU or another psychotherapy, (d) assessment of relevant BPD-related health outcomes, and (e) randomized or nonrandomized trials or controlled observational studies. Two investigators independently screened abstracts and full-text articles and graded the certainty of evidence using the Grading of Recommendations Assessment, Development, and Evaluation approach. *Results:* We found 25 psychotherapy studies meeting inclusion criteria with data on 2,545 participants. Seventeen studies compared nine psychotherapies with TAU and nine studies compared eight psychotherapies with another psychotherapy for the treatment of BPD. Overall, both TAU and included psychotherapies were effective in treating the severity and symptoms of BPD. Moderate certainty of evidence suggests that systems training for emotional predictability and problem solving is more effective than TAU for the treatment of BPD; low certainty of evidence suggests that dialectical behavior therapy, schema therapy, transference-focused psychotherapy, acceptance and commitment therapy, manual-assisted cognitive therapy, and cognitive behavioral therapy are more effective than TAU

Which psychotherapy is most effective and acceptable in the treatment of adults with a (sub)clinical borderline personality disorder? A systematic review and network meta-analysis

Kim Setkowski[1,3], Christina Palantza[2], Wouter van Ballegooijen[2,3], Renske Gilissen[1], Matthijs Oud[4], Ioana A. Cristea[5,6], Hisashi Noma[7], Toshi A. Furukawa[8], Arnoud Arntz[9,10], Anton J. L. M. van Balkom[3] and Pim Cuijpers[2]

[1]Research Department, 113 Suicide Prevention, Amsterdam, the Netherlands; [2]Department of Clinical, Neuro and Developmental Psychology, Vrije Universiteit, Amsterdam, the Netherlands; [3]Department of Psychiatry, Amsterdam UMC, VU University, Amsterdam Public Health research institute, and GGZinGeest Specialized Mental Health Care, Amsterdam, the Netherlands; [4]Department of Treatment, Care and Reintegration, Trimbos Institute, Utrecht, the Netherlands; [5]Department of Brain and Behavioral Sciences, University of Pavia, Pavia, Italy; [6]IRCCS Mondino Foundation, Pavia, Italy; [7]Department of Data Science, The Institute of Statistical Mathematics, Tokyo, Japan; [8]Department of Health Promotion and Human Behavior, Kyoto University Graduate School of Medicine/ School of Public Health, Kyoto, Japan; [9]Department of Clinical Psychological Science, Maastricht University, Maastricht, the Netherlands and [10]Department of Clinical Psychology, University of Amsterdam, Amsterdam, the Netherlands

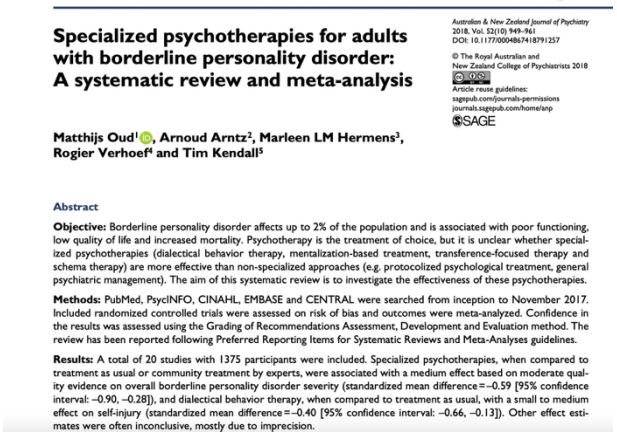
Abstract

A broad range of psychotherapies have been proposed and evaluated in the treatment of borderline personality disorder (BPD), but the question which specific type of psychotherapy is most effective remains unanswered. In this study, two network meta-analyses (NMAs) were conducted investigating the comparative effectiveness of psychotherapies on (1) BPD severity and (2) suicidal behaviour (combined rate). Study drop-out was included as a secondary outcome. Six databases were searched until 21 January 2022, including RCTs on the efficacy of any psychotherapy in adults (≥18 years) with a diagnosis of (sub)clinical BPD. Data were extracted using a predefined table format. PROSPERO ID:CRD42020175411. In our study, a total of 43 studies ($N = 3273$) were included. We found significant differences between several active comparisons in the treatment of (sub)clinical BPD, however, these findings were based on very few trials and should therefore be interpreted with caution. Some therapies were more efficacious compared to GT or TAU. Furthermore, some treatments more than halved the risk of attempted suicide and committed suicide (combined rate), reporting RRs around 0.5 or lower, however, these RRs were not statistically significantly better compared to other therapies or to TAU. Study drop-out significantly differed between some treatments. In conclusion, no single treatment seems to be the best choice to treat people with BPD compared to other treatments. Nevertheless, psychotherapies for BPD are perceived as first-line treatments, and should therefore be investigated further on their long-term effectiveness, preferably in head-to-head trials. DBT was the best connected treatment, providing solid evidence of its effectiveness.

Conclusions and Relevance Psychotherapies, most notably dialectical behavior therapy and psychodynamic approaches, are effective for borderline symptoms and related problems. Nonetheless, effects are small, inflated by risk of bias and publication bias, and particularly unstable at follow-up.

The evidence on effective treatment

There is most likely on average non-inferiority of generalist treatment methods compared to specialist treatment methods and superiority of both structured approaches compared to TAU



Review

ANZJP

Specialized psychotherapies for adults with borderline personality disorder: A systematic review and meta-analysis

Australian & New Zealand Journal of Psychiatry
2018, Vol. 52(10) 949–961
DOI: 10.1177/0004867418791257

SAGE

Matthijs Oud[1], Arnoud Arntz[2], Marleen LM Hermens[3], Rogier Verhoef[4] and Tim Kendall[5]

Abstract

Objective: Borderline personality disorder affects up to 2% of the population and is associated with poor functioning, low quality of life and increased mortality. Psychotherapy is the treatment of choice, but it is unclear whether specialized psychotherapies (dialectical behavior therapy, mentalization-based treatment, transference-focused therapy and schema therapy) are more effective than non-specialized approaches (e.g. protocolized psychological treatment, general psychiatric management). The aim of this systematic review is to investigate the effectiveness of these psychotherapies.

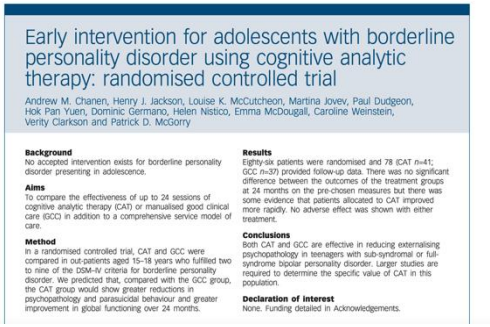
Methods: PubMed, PsycINFO, CINAHL, EMBASE and CENTRAL were searched from inception to November 2017. Included randomized controlled trials were assessed on risk of bias and outcomes were meta-analyzed. Confidence in the results was assessed using the Grading of Recommendations Assessment, Development and Evaluation method. The review has been reported following Preferred Reporting Items for Systematic Reviews and Meta-Analyses guidelines.

Results: A total of 20 studies with 1375 participants were included. Specialized psychotherapies, when compared to treatment as usual or community treatment by experts, were associated with a medium effect based on moderate quality evidence on overall borderline personality disorder severity (standardized mean difference = –0.59 [95% confidence interval: –0.90, –0.28]), and dialectical behavior therapy, when compared to treatment as usual, with a small to medium effect on self-injury (standardized mean difference = –0.40 [95% confidence interval: –0.66, –0.13]). Other effect estimates were often inconclusive, mostly due to imprecision.

Outcome	Sub-analysis	Trials (reference)	N	Effect size	[95% CI]	Heterogeneity (I^2)	Intervention length (weeks)	Quality (GRADE)
SMD below zero or a RR below 1 means the treatment (condition) was more effective than the comparator (condition)								
1. Specialized psychotherapy versus treatment as usual (TAU)								
Overall BPD severity	Total	4	151	SMD = –0.75	[–1.30, –0.19]	58%	20–52	Low[b,d]
	DBT	(Priebe et al., 2012; Koons et al., 2001)	90	SMD = –0.36	[–0.78, 0.05]	0%	26–52	
	DBT-PTSD	(Steil et al., 2011)	33	SMD = –0.85	[–1.57, –0.13]	N/A	20	
	SFT-Group	(Farrell et al., 2009)	28	SMD = –1.66	[–2.54, –0.78]	N/A	35	
Self-injury	Total	7	314	SMD = –0.33	[–0.57, –0.09]	0%	26–78	Moderate[d]
	DBT	(Feigenbaum et al., 2012; Koons et al., 2001; Linehan et al., 1991; Priebe et al., 2012; Van Den Bosch et al., 2005)	225	SMD = –0.40	[–0.66, –0.13]	0%	26–52	Moderate[d]
		(Carter et al., 2010)	51	RR = 1.11	[0.78, 1.57]	N/A	26	
	MBT-PH	(Bateman and Fonagy, 1999a)	38	RR = 0.44	[0.24, 0.81]	N/A	78	
Dropout	Total	10	486	RR = 1.54	[0.70, 3.38]	76%	20–78	Low[b,d]
2. Specialized psychotherapy versus community treatment by experts (CTBE)								
Overall BPD severity	Total	2	170	SMD = –0.47	[–0.78, –0.16]	0%	52–104	Moderate[d]
	MBT	(Jorgensen et al., 2013)	66	SMD = –0.33	[–0.84, 0.17]	N/A	104	
	TFP	(Doering et al., 2010)	104	SMD = –0.55	[–0.95, –0.16]	N/A	52	
Self-injury	TFP	(Doering et al., 2010)	104	RR = 1.09	[0.84, 1.40]	N/A	52	Low[d]
Dropout	Total	3	316	RR = 0.62	[0.39, 0.99]	73%	52–104	Low[b,d]
3. Specialized psychotherapy versus protocolized psychological treatment								
Overall BPD severity	DBT vs GPM	(McMain et al., 2009)	180	SMD = –0.04	[–0.33, 0.25]	N/A	52	Low[d]
Self-injury	Total	2	122	RR = 0.80	[0.42, 1.55]	80%	52–78	Very low[b,c,d]
	DBT vs GPM	(McMain et al., 2009)	177	RR = 1.09	[0.79, 1.50]	N/A	52	Low[d]
	MBT-PH or out vs SCM	(Bateman and Fonagy, 1999b)	134	RR = 0.56	[0.34, 0.92]	N/A	78	Moderate[d]
Self-injury	DBT vs CCT	(Turner, 2000)	24	SMD = –1.28	[–2.17, –0.38]	N/A	52	Low[d]
Dropout	Total	4	265	RR = 1.06	[0.81, 1.40]	0%	52–78	Low[c,d]

Effective generalist treatments

Relational Clinical Care



Early intervention for adolescents with borderline personality disorder using cognitive analytic therapy: randomised controlled trial

Andrew M. Chanen, Henry J. Jackson, Louise K. McCutcheon, Martina Jovev, Paul Dudgeon, Hok Pan Yuen, Dominic Germano, Helen Nistico, Emma McDougall, Caroline Weinstein, Verity Clarkson and Patrick D. McGorry

Background
No accepted intervention exists for borderline personality disorder presenting in adolescence.

Aims
To compare the effectiveness of up to 24 sessions of cognitive analytic therapy (CAT) or manualised good clinical care (GCC) in addition to a comprehensive service model of care.

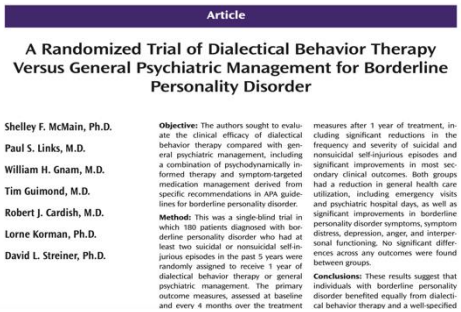
Method
In a randomised controlled trial, CAT and GCC were compared in out-patients aged 15–18 years who fulfilled two to nine of the DSM-IV criteria for borderline personality disorder. We predicted that, compared with the GCC group, the CAT group would show greater reductions in psychopathology and parasuicidal behaviour and greater improvement in global functioning over 24 months.

Results
Eighty-six patients were randomised and 78 (CAT *n*=41; GCC *n*=37) provided follow-up data. There was no significant difference between the outcomes of the treatment groups at 24 months on the pre-chosen measures but there was some evidence that patients allocated to CAT improved more rapidly. No adverse effect was shown with either treatment.

Conclusions
Both CAT and GCC are effective in reducing externalising psychopathology in teenagers with sub-syndromal or full-syndrome bipolar personality disorder. Larger studies are required to determine the specific value of CAT in this population.

Declaration of interest
None. Funding detailed in Acknowledgements.

Good Psychiatric Management



Article

A Randomized Trial of Dialectical Behavior Therapy Versus General Psychiatric Management for Borderline Personality Disorder

Shelley F. McMain, Ph.D.
Paul S. Links, M.D.
William H. Gnam, M.D.
Tim Guimond, M.D.
Robert J. Cardish, M.D.
Lorne Korman, Ph.D.
David L. Streiner, Ph.D.

Objective: The authors sought to evaluate the clinical efficacy of dialectical behavior therapy compared with general psychiatric management, including a combination of psychodynamically informed therapy and symptom-targeted medication management derived from specific recommendations in APA guidelines for borderline personality disorder.

Method: This was a single-blind trial in which 180 patients diagnosed with borderline personality disorder who had at least two suicidal or nonsuicidal self-injurious episodes in the past 5 years were randomly assigned to receive 1 year of dialectical behavior therapy or general psychiatric management. The primary outcome measures, assessed at baseline and every 4 months over the treatment measures after 1 year of treatment, including significant reductions in the frequency and severity of suicidal and nonsuicidal self-injurious episodes and significant improvements in most secondary clinical outcomes. Both groups had a reduction in general health care utilization, including emergency visits and psychiatric hospital days, as well as significant improvements in borderline personality disorder symptoms, symptom distress, depression, anger, and interpersonal functioning. No significant differences across any outcomes were found between groups.

Conclusions: These results suggest that individuals with borderline personality disorder benefited equally from dialectical behavior therapy and a well-specified

Structured Clinical Management

Article

Randomized Controlled Trial of Outpatient Mentalization-Based Treatment Versus Structured Clinical Management for Borderline Personality Disorder

Anthony Bateman, M.A., F.R.C.Psych.
Peter Fonagy, Ph.D., F.B.A.

Objective: This randomized controlled trial tested the effectiveness of an 18-month mentalization-based treatment (MBT) approach in an outpatient context against a structured clinical management (SCM) outpatient approach for treatment of borderline personality disorder.

Method: Patients (N=134) consecutively referred to a specialist personality disorder treatment center and meeting selection criteria were randomly allocated to MBT or SCM. Eleven mental health professionals equal in years of experience and training served as therapists. Independent evaluators blind to treatment allocation conducted assessments every intervals, were analyzed using mixed effects logistic regressions for binary data, Poisson regression models for count data, and mixed effects linear growth curve models for self-report variables.

Results: Substantial improvements were observed in both conditions across all outcome variables. Patients randomly assigned to MBT showed a steeper decline of both self-reported and clinically significant problems, including suicide attempts and hospitalization.

Conclusions: Structured treatments improve outcomes for individuals with borderline personality disorder. A focus on specific psychological processes brings

The evidence on effective treatment

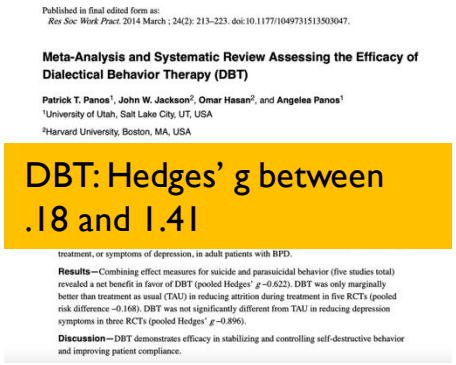
RESEARCH REPORT

Absolute and relative outcomes of psychotherapies for eight mental disorders: a systematic review and meta-analysis

Pim Cuijpers[1,2], Clara Miguel[1], Marketa Ciharova[1], Mathias Harrer[3], Djordje Basic[1], Ioana A. Cristea[4], Nino de Ponti[1], Ellen Driessen[5,6], Jessica Hamblen[7,8], Sadie E. Larsen[7,8], Minoo Matbouriahi[1], Davide Papola[9,10], Darin Pauley[1], Constantin Y. Plessen[1,11], Rory A. Pfund[1,2], Kim Sestowski[12,13], Paula P. Schnurr[7,8], Wouter van Ballegooijen[1,14], Yingying Wang[1], Heleen Riper[1,14], Annemieke van Straten[1], Marit Sijbrandij[1], Toshi A. Furukawa[15], Eirini Karyotaki[1]

[1]Department of Clinical, Neuro and Developmental Psychology, Amsterdam Public Health Research Institute, Vrije Universiteit, Amsterdam, The Netherlands; [2]International Institute for Psychotherapy, Babeș-Bolyai University, Cluj-Napoca, Romania; [3]Psychology & Digital Mental Health Care, Technical University of Munich, Munich, Germany; [4]Department of General Psychology, University of Padua, Padua, Italy; [5]Department of Clinical Psychology, Behavioural Science Institute, Radboud University, Nijmegen, The Netherlands; [6]Depression Expertise Center, Pro Persona Mental Health Care, Nijmegen, The Netherlands; [7]National Center for PTSD, White River Junction, VT, USA; [8]Department of Psychiatry, Geisel School of Medicine at Dartmouth, Hanover, NH, USA; [9]Department of Psychiatry and Behavioral Medicine, Medical College of Wisconsin, Milwaukee, WI, USA; [10]Department of Neuroscience, Biomedicine and Movement Sciences, Section of Psychiatry, University of Verona, Verona, Italy; [11]Department of Global Health and Social Medicine, Harvard Medical School, Boston, MA, USA; [12]Department of Psychosomatic Medicine, Charité Universitätsmedizin Berlin; Freie Universität Berlin and Humboldt-Universität zu; Berlin, Berlin, Germany; [13]Tennessee Institute for Gambling Education & Research, Department of Psychology, University of Memphis, Memphis, TN, USA; [14]Research Department, 113 Suicide Prevention, Amsterdam, The Netherlands; [15]Department of Pedagogical and Educational Sciences, Faculty of Behavioural and Social Sciences, University of Groningen, Groningen, The Netherlands; [16]Department of Psychiatry, Amsterdam University Medical Center, Amsterdam, The Netherlands; [17]Department of Health Promotion and Human Behavior, Kyoto University Graduate School of Medicine and School of Public Health, Kyoto, Japan

Psychotherapies are first-line treatments for most mental disorders, but their absolute outcomes (i.e., response and remission rates) are not well studied, despite the relevance of such information for health care users, providers and policy makers. We aimed to examine absolute and relative outcomes of psychotherapies across eight mental disorders: major depressive disorder (MDD), social anxiety disorder, panic disorder, generalized anxiety disorder (GAD), specific phobia, post-traumatic stress disorder (PTSD), obsessive-compulsive disorder (OCD), and borderline personality disorder (BPD). We used a series of living systematic reviews included in the Metapsy initiative (www.metapsy.org), with a common strategy for literature search, inclusion of studies and extraction of data, and a common format for the analyses. Literature search was conducted in major bibliographical databases (PubMed, PsycINFO, Embase, and the Cochrane Register of Controlled Trials) up to January 1, 2023. We included randomized controlled trials comparing psychotherapies for any of the eight mental disorders, established by a diagnostic interview, with a control group (waitlist, care-as-usual, or pill placebo). We conducted random-effects model pairwise meta-analyses. The main outcome was the absolute rate of response (at least 50% symptom reduction between baseline and post-test) in the treatment and control conditions. Secondary outcomes included the relative risk (RR) of response, and the number needed to treat (NNT). Random-effects meta-analyses of the included 441 trials (33,881 patients) indicated modest response rates for psychotherapies: 0.42 (95% CI: 0.39-0.45) for MDD; 0.38 (95% CI: 0.33-0.43) for PTSD; 0.38 (95% CI: 0.30-0.47) for OCD; 0.38 (95% CI: 0.33-0.43) for panic disorder; 0.36 (95% CI: 0.30-0.42) for GAD; 0.33 (90% CI: 0.29-0.37) for social anxiety disorder; 0.33 (90% CI: 0.29-0.37) for specific phobia; and 0.34 (90% CI: 0.15-0.56) for BPD. Most sensitive



Published in final edited form as:
Res Soc Work Pract. 2014 March ; 24(2): 213–223. doi:10.1177/1049731513503047.

Meta-Analysis and Systematic Review Assessing the Efficacy of Dialectical Behavior Therapy (DBT)

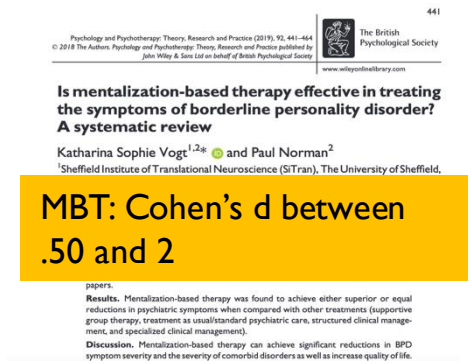
Patrick T. Panos[1], **John W. Jackson**[2], **Omar Hasan**[2], and **Angelea Panos**[1]
[1]University of Utah, Salt Lake City, UT, USA
[2]Harvard University, Boston, MA, USA

treatment, or symptoms of depression, in adult patients with BPD.

Results—Combining effect measures for suicide and parasuicidal behavior (five studies total) revealed a net benefit in favor of DBT (pooled Hedges' *g* −0.622). DBT was only marginally better than treatment as usual (TAU) in reducing attrition during treatment in five RCTs (pooled risk difference −0.168). DBT was not significantly different from TAU in reducing depression symptoms in three RCTs (pooled Hedges' *g* −0.896).

Discussion—DBT demonstrates efficacy in stabilizing and controlling self-destructive behavior and improving patient compliance.

DBT: Hedges' g between .18 and 1.41



Psychology and Psychotherapy: Theory, Research and Practice (2019), 92, 441–464
© 2018 The Authors. Psychology and Psychotherapy: Theory, Research and Practice published by John Wiley & Sons Ltd on behalf of British Psychological Society
The British Psychological Society
www.wileyonlinelibrary.com

Is mentalization-based therapy effective in treating the symptoms of borderline personality disorder? A systematic review

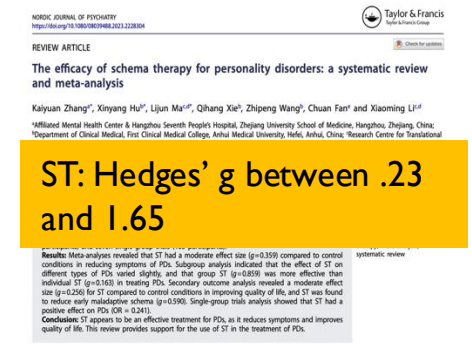
Katharina Sophie Vogt[1,2]* and Paul Norman[2]
[1]Sheffield Institute of Translational Neuroscience (SiTran), The University of Sheffield,

papers.

Results. Mentalization-based therapy was found to achieve either superior or equal reductions in psychiatric symptoms when compared with other treatments (supportive group therapy, treatment as usual/standard psychiatric care, structured clinical management, and specialized clinical management).

Discussion. Mentalization-based therapy can achieve significant reductions in BPD symptom severity and the severity of comorbid disorders as well as increase quality of life.

MBT: Cohen's d between .50 and 2



NORDIC JOURNAL OF PSYCHIATRY
https://doi.org/10.1080/08039488.2023.2228304
Taylor & Francis
Taylor & Francis Group

REVIEW ARTICLE

The efficacy of schema therapy for personality disorders: a systematic review and meta-analysis

Kaiyuan Zhang[a,e], Xinyang Hu[b,e], Lijun Ma[c,d*], Qihang Xie[a], Zhipeng Wang[a], Chuan Fan[a] and Xiaoming Li[b,d]

[a]Affiliated Mental Health Center & Hangzhou Seventh People's Hospital, Zhejiang University School of Medicine, Hangzhou, Zhejiang, China; [b]Department of Clinical Medical, First Clinical Medical College, Anhui Medical University, Hefei, Anhui, China; [c]Research Centre for Translational

Results: Meta-analyses revealed that ST had a moderate effect size (*g* = 0.359) compared to control conditions in reducing symptoms of PDs. Subgroup analysis indicated that the effect of ST on different types of PDs varied slightly, and that group ST (*g* = 0.859) was more effective than individual ST (*g* = 0.163) in treating PDs. Secondary outcome analysis revealed a moderate effect size (*g* = 0.256) for ST compared to control conditions in improving quality of life, and ST was found to reduce early maladaptive schema (*g* = 0.590). Single-group trials analysis showed that ST had a positive effect on PDs (OR = 0.241).

Conclusion: ST appears to be an effective treatment for PDs, as it reduces symptoms and improves quality of life. This review provides support for the use of ST in the treatment of PDs.

ST: Hedges' g between .23 and 1.65

Differences in treatment effectiveness do exist, but most likely depend on a range of contextual factors and not on type of treatment method

Personality and Mental Health
Personality and Mental Health
(2017)
Published online in Wiley Online Library
(wileyonlinelibrary.com) DOI 10.1002/pmh.1381

Implementation of evidence-based treatments for borderline personality disorder: The impact of organizational changes on treatment outcome of mentalization-based treatment

DAWN L. BALES[1], REINIER TIMMAN[1,2], PATRICK LUYTEN[1], JAN BUSSCHBACH[1,2], ROEL VERHEUL[1] AND JOOST HUTSEBAUT[1], [1]Viersprong Institute for Studies on Personality Disorders (VISPD), Halsteren, the Netherlands; [2]Erasmus Medical Center Rotterdam, Section of Medical Psychology and Psychotherapy, Rotterdam, the Netherlands

ABSTRACT

The quality of implementation of evidence-based treatment programs for borderline personality disorder (BPD) in routine clinical care is a neglected issue. The first aim of this mixed-method naturalistic study was to explore the impact of organizational changes on treatment effectiveness of a day-hospital programme of mentalization-based treatment. Consecutively referred BPD patients were divided into a pre-reorganization cohort (PRE-REORG) and a cohort during reorganization (REORG). Psychiatric symptoms (Brief Symptom Inventory) and personality functioning (Severity Indices of Personality Problems-118) before treatment and at 18- and 36-month follow-up were compared using multilevel modelling. Effect sizes in the PRE-REORG cohort were approximately twice as large at 18 months (PRE-REORG: range 0.81–1.22; REORG: range 0.03–0.71) and three times as large at 36 months (PRE-REORG: range 0.81–1.80; REORG: range 0.27–0.81). The quantitative results of this study suggest that even when mentalization-based treatment is successfully implemented and the structure of the programme remains intact, major organizational changes may have a considerable impact on its effectiveness. Second, we aimed to explore the impact of the reorganization on adherence at organizational, team and therapist level. The qualitative results of this study indicate that the organizational changes were negatively related to adherence to the treatment model at organizational, team and therapist level, which in turn was associated with a decrease in treatment effectiveness. The implications of these findings for the implementation of effective treatments for BPD in routine clinical practice are discussed.

Personality and Mental Health
Personality and Mental Health
11: 118–131 (2017)
Published online in Wiley Online Library
(wileyonlinelibrary.com) DOI 10.1002/pmh.1368

Barriers and facilitators to the implementation of mentalization-based treatment (MBT) for borderline personality disorder

DAWN L. BALES, ROEL VERHEUL AND JOOST HUTSEBAUT, Viersprong Institute for Studies on Personality Disorders (VISPD), MBT Netherlands, The Netherlands

ABSTRACT

There are several evidence-based treatments for borderline personality disorder, but very little is known about the success or failure of implementation in daily practice. This study aims to investigate the success or failure of newly started mentalization-based treatment programs, and to explore the barriers and facilitators. The implementation trajectories of seven different mentalization-based treatment programs in six mental health clinics in the Netherlands were included in a multiple case study combining a qualitative and quantitative design. Semi-structured interview data were collected from several stakeholders of each program. Narrative reconstructions of each interview were assessed by 12 independent experts. Results showed that several programs struggled to implement their program successfully, leading to discontinuation in three programs. According to the experts, particularly elements at the organizational level (i.e. organizational support) and team level (i.e. leadership) contributed to implementation outcome. These findings have important implications for the translation of guidelines and research findings in daily practice.

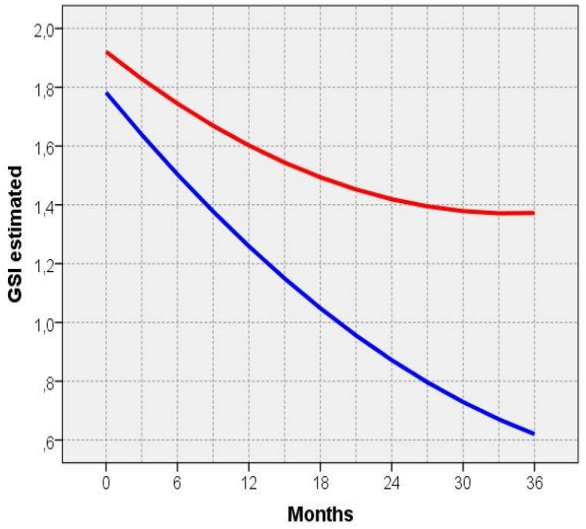


Table 2: Success and/or failure of implementation: (relative) contribution of organizational, team and therapist factors as judged by experts on a 0–5 Likert rating scale (average score and range)

	Case A	Case B	Case C	Case D	Case E	Case F	Case G	Average
Success or failure (phase 1)	Failure	Success	Failure	Failure	Mixed	Mixed	Success	
Success of implementation depends on a combination of factors at organization, team and therapist level	4.8 (4–5)	4.4 (4–5)	4.8 (4–5)	4.6 (3–5)	4.2 (3–5)	4.4 (3–5)	4.1 (3–5)	4.49
Organizational factors have contributed to success/failure	4.8 (4–5)	3.8 (3–5)	4.1 (3–5)	4.1 (3–5)	3.9 (3–5)	4.4 (3–5)	3.6 (2–5)	4.1
Team factors have contributed to success/failure	3.9 (3–5)	4.5 (4–5)	4.4 (3–5)	3.8 (3–5)	4.9 (4–5)	4.0 (3–5)	3.8 (3–5)	4.2
Therapist factors have contributed to success/failure	2.4 (1–4)	3.8 (3–4)	3.3 (3–4)	3.1 (2–4)	3.8 (3–4)	3.9 (3–4)	3.8 (3–4)	3.4

1: Strongly disagree; 2: Disagree; 3: Neither agree nor disagree; 4: Agree; 5: Strongly agree.

It’s the dough, not the apples or pears

It's the dough, not the apples or pears

JAMA Psychiatry | Original Investigation | META-ANALYSIS

Efficacy of Psychotherapies for Borderline Personality Disorder

A Systematic Review and Meta-analysis

Subgroup analysis[d]					
Dialectical behavior therapy	9	0.34 (0.15 to 0.53)	19 (0 to 62)	5.26	.87
Psychodynamic approaches	7	0.41 (0.12 to 0.69)	42 (0 to 74)	4.39	
Cognitive behavior therapy	5	0.24 (−0.01 to 0.49)	15 (0 to 69)	7.46	
Other interventions	6	0.38 (−0.15 to 0.92)	79 (41 to 89)	4.72	
Control group					
Treatment as usual	18	0.40 (0.25 to 0.56)	22 (0 to 57)	4.50	.49
Supportive therapy	3	0.37 (−0.36 to 1.09)	62 (0 to 87)	4.85	
Ad hoc control group	6	0.17 (−0.17 to 0.52)	73 (13 to 86)	10.42	
Control group manualized					
No	19	0.39 (0.25 to 0.53)	17 (0 to 52)	4.59	.27
Yes	7	0.16 (−0.22 to 0.55)	73 (26 to 86)	11.11	
Study team treating the control group					
No	17	0.42 (0.28 to 0.56)	6 (0 to 48)	4.27	.14
Yes	10	0.18 (−0.11 to 0.46)	67 (21 to 81)	9.80	
Treatment developer a trial author					
No	12	0.31 (0.16 to 0.46)	5 (0 to 52)	5.75	.79
Yes	15	0.35 (0.10 to 0.59)	63 (26 to 78)	5.10	
Therapist supervision					
Treatment developer	11	0.37 (0.13 to 0.62)	52 (0 to 74)	4.85	.49
Other	8	0.26 (0.08 to 0.45)	9 (0 to 60)	6.85	
Low risk of bias criteria					
0-2	18	0.48 (0.33 to 0.64)	15 (0 to 52)	3.76	.01
3-4	9	0.11 (−0.12 to 0.35)	57 (0 to 78)	16.13	

The dough:

Leadership
Expertise
Structured pathway of care
…

The evidence on effective treatment

Specialist treatment methods have become more complex throughout the years, whereas most clinicians do better when using simple methods

Day hospital versus intensive out-patient mentalisation-based treatment for borderline personality disorder: multicentre randomised clinical trial

Maaike L. Smits, Dine J. Feenstra, Hester V. Eeren, Dawn L. Bales, Elisabeth M. P. Laurenssen, Matthijs Blankers, Mirjam B. J. Soons, Jack J. M. Dekker, Zwaan Lucas, Roel Verheul and Patrick Luyten

Background

Two types of mentalisation-based treatment (MBT) have been developed and empirically evaluated for borderline personality disorder (BPD): day hospital MBT (MBT-DH) and intensive out-patient MBT (MBT-IOP). No trial has yet compared their efficacy.

Aims

To compare the efficacy of MBT-DH and MBT-IOP 18 months after start of treatment. MBT-DH was hypothesised to be superior to MBT-IOP because of its higher treatment intensity.

Method

In a multicentre randomised controlled trial (Nederlands Trial Register: NTR2292) conducted at three sites in the Netherlands, patients with BPD were randomly assigned to MBT-DH (*n* = 70) or MBT-IOP (*n* = 44). The primary outcome was symptom severity (Brief Symptom Inventory). Secondary outcome measures included borderline symptomatology, personality functioning, interpersonal functioning, quality of life and self-harm. Patients were assessed every 6 months from baseline to 18 months after start of treatment. Data were analysed using multilevel modelling

was not superior to MBT-IOP on the primary outcome measure, but MBT-DH showed a clear tendency towards superiority on secondary outcomes.

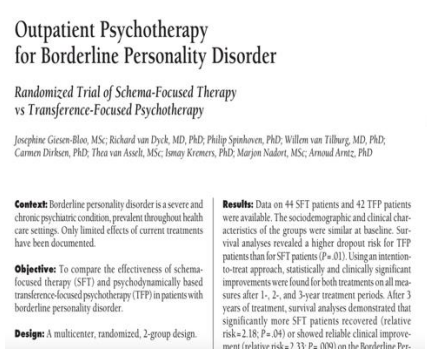
Conclusions

Although MBT-DH was not superior to MBT-IOP on the primary outcome measure despite its greater treatment intensity, MBT-DH showed a tendency to be more effective on secondary outcomes, particularly in terms of relational functioning. Patients receiving MBT-DH and MBT-IOP, thus, seem to follow different trajectories of change, which may have important implications for clinical decision-making. Longer-term follow-up and cost-effectiveness considerations may ultimately determine the optimal intensity of specialised treatments such as MBT for patients with BPD.

Declaration of interest

P.L. and D.L.B. have been involved in the training and dissemination of MBT.

Keywords



Outpatient Psychotherapy for Borderline Personality Disorder

Randomized Trial of Schema-Focused Therapy vs Transference-Focused Psychotherapy

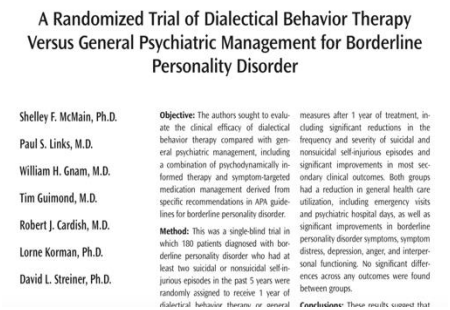
Josephine Giesen-Bloo, MSc; Richard van Dyck, MD, PhD; Philip Spinhoven, PhD; Willem van Tilburg, MD, PhD; Carmen Dirksen, PhD; Thea van Asselt, MSc; Ismay Kremers, PhD; Marjon Nadort, MSc; Arnoud Arntz, PhD

Context: Borderline personality disorder is a severe and chronic psychiatric condition, prevalent throughout health care settings. Only limited effects of current treatments have been documented.

Objective: To compare the effectiveness of schema-focused therapy (SFT) and psychodynamically based transference-focused psychotherapy (TFP) in patients with borderline personality disorder.

Design: A multicenter, randomized, 2-group design.

Results: Data on 44 SFT patients and 42 TFP patients were available. The sociodemographic and clinical characteristics of the groups were similar at baseline. Survival analyses revealed a higher dropout risk for TFP patients than for SFT patients ($P = .01$). Using an intention-to-treat approach, statistically and clinically significant improvements were found for both treatments on all measures after 1-, 2-, and 3-year treatment periods. After 3 years of treatment, survival analyses demonstrated that significantly more SFT patients recovered (relative risk = 2.18; $P = .04$) or showed reliable clinical improvement (relative risk = 2.33; $P = .009$) on the Borderline Per-



A Randomized Trial of Dialectical Behavior Therapy Versus General Psychiatric Management for Borderline Personality Disorder

Shelley F. McMain, Ph.D.
Paul S. Links, M.D.
William H. Gnam, M.D.
Tim Guimond, M.D.
Robert J. Cardish, M.D.
Lorne Korman, Ph.D.
David L. Streiner, Ph.D.

Objective: The authors sought to evaluate the clinical efficacy of dialectical behavior therapy compared with general psychiatric management, including a combination of psychodynamically informed therapy and symptom-targeted medication management derived from specific recommendations in APA guidelines for borderline personality disorder.

Method: This was a single-blind trial in which 180 patients diagnosed with borderline personality disorder who had at least two suicidal or nonsuicidal self-injurious episodes in the past 5 years were randomly assigned to receive 1 year of

measures after 1 year of treatment, including significant reductions in the frequency and severity of suicidal and nonsuicidal self-injurious episodes and significant improvements in most secondary clinical outcomes. Both groups had a reduction in general health care utilization, including emergency visits and psychiatric hospital days, as well as significant improvements in borderline personality disorder symptoms, symptom distress, depression, anger, and interpersonal functioning. No significant differences across any outcomes were found between groups.

REVIEWS AND OVERVIEWS

Scorn Not Its Simplicity: Examining the Effectiveness of Simple Generalist Treatment for Personality Disorders

Joost Hutsebaut, Ph.D.

Treatment guidelines for personality disorders have typically recommended specialized psychotherapeutic interventions. In this review, the author suggests that an intervention's effectiveness may be determined less by the specific method than by therapist competence, team culture, clinical process structure, and institutional context. The author argues that these elements determine variance in effectiveness between and within methods. Whereas initial studies of a specialized treatment may reflect the exceptional competencies of the treatment's developers and early adopters, in daily clinical practice, therapists with an average level of skill may struggle with the theoretical and methodological complexities of these treatments, which can hinder genuine connection with patients. This interference may particularly affect treatment outcomes when therapists encounter the intense emotions and interpersonal hypersensitivity experienced by patients with personality disorders. Most therapists would benefit from a set of simple generalist principles that determine the context for their work and offer a framework for dealing with clinical challenges while enabling them to be true to themselves and use their previously learned competencies. The Guideline-Informed Treatment for Personality Disorders is an enhanced common-factors approach that summarizes the core principles of effective treatment and can be feasibly implemented by most therapists.

Am J Psychother in Advance
(doi: 10.1176/appi.psychotherapy.20230042)

Common factor	Meaning	Effect size
Alliance / Therapeutic relationship	Quality of cooperation and of personal, emotional bond	d=.58
Real relationship	Personal relationship between therapist and client, characterized by the extent to which each is sincere with the other and experiences and perceives the other as he or she is	d=.80
Positive approach	Warm acceptance and positive approach to all facets of the client's inner world of experiences; approaching the client as an equal	g=.28
Agreement on goals and tasks/ Cooperation	Process of reaching agreement on what the goals of treatment are and what is needed to achieve them (tasks)	d=.49 (agreement); d=.61 (collaboration)
Repairing ruptures	Using strategies to restore a good therapeutic relationship after a temporary deterioration (consensus on tasks and goals and an affectively good bond)	d=.62
Expressing emotions	Helping clients express emotions (rather than avoiding them)	d=.85
Expression of emotions by the therapist	Openness about the therapist's own feelings, for example in relation to the effect the client has on the therapist	d=.56
Empathy	Feeling, understanding and putting into words what the client might be feeling	d=.63

Psychotherapy, 2018 (Special Issue)

The evidence on effective treatment

Common factors account for the largest share in treatment effectiveness

The evidence summarized

Differences in efficacy are determined not so much by differences in treatment methods, but by differences in context, practitioners, teams, training, implementation….

All treatments become more effective when a few common factors are secured at the institutional, clinical process, team and practitioner levels

Capacity for effective PD treatment can be scaled up most efficiently when regular treatment is improved following a simple set of principles at the level of therapists, teams, clinical process and institution

The recipe for effective PD treatment

- Provide a well-structured program
- Establish a genuine contact
- Provide strategies to work on motivation to change, emotions and relational issues
- Create a supportive (holding, containing) context for clinicians

A method may be 'only' a strategy to secure this recipe

If the method becomes too demanding, it may interfere with this recipe

GIT-PD: A PRINCIPLE-DRIVEN COMMON FACTORS APPROACH

GIT-PD

- What's the minimal framework needed to deliver 'good enough' treatment as usual? How simple can we go?

- How can we translate, train and implement these common principles of effective treatments in institutions, teams and therapists to improve the local 'treatment as usual'?

Hutsebaut et al. Borderline Personality Disorder and Emotion Dysregulation
(2020) 7:16
https://doi.org/10.1186/s40479-020-00133-7

Borderline Personality Disorder and Emotion Dysregulation

REVIEW Open Access

Improving access to and effectiveness of mental health care for personality disorders: the guideline-informed treatment for personality disorders (GIT-PD) initiative in the Netherlands

Joost Hutsebaut[1,2*], Ellen Willemsen[2,3], Nathan Bachrach[4,5,6] and Rien Van[7]

Abstract

Evidence-based treatment for patients suffering from personality disorders (PDs) is only available to a limited extend in the Netherlands. Consequently, most patients receive non-manualized, unspecialized care.
This manuscript describes the background, rationale and design of the Guideline-Informed Treatment for Personality Disorders (GIT-PD) initiative. GIT-PD aims to provide a simple, principle-driven, 'common-factors' framework for the treatment of PDs. The GIT-PD framework integrates scientific knowledge, professional expertise and patient experience to design a good-enough practice, based on common factors. It offers a basic framework including general principles, a structured clinical pathway, a basic professional stance, interventions focused on common factors, and team and organizational strategies, based on common features of evidence-based treatments and generic competences of professionals.
The GIT-PD initiative has had a large impact on the organization of treatment for PDs in the Netherlands. For countries with an interest in improving their health care system for PDs, it could serve as a template that requires only limited resources.

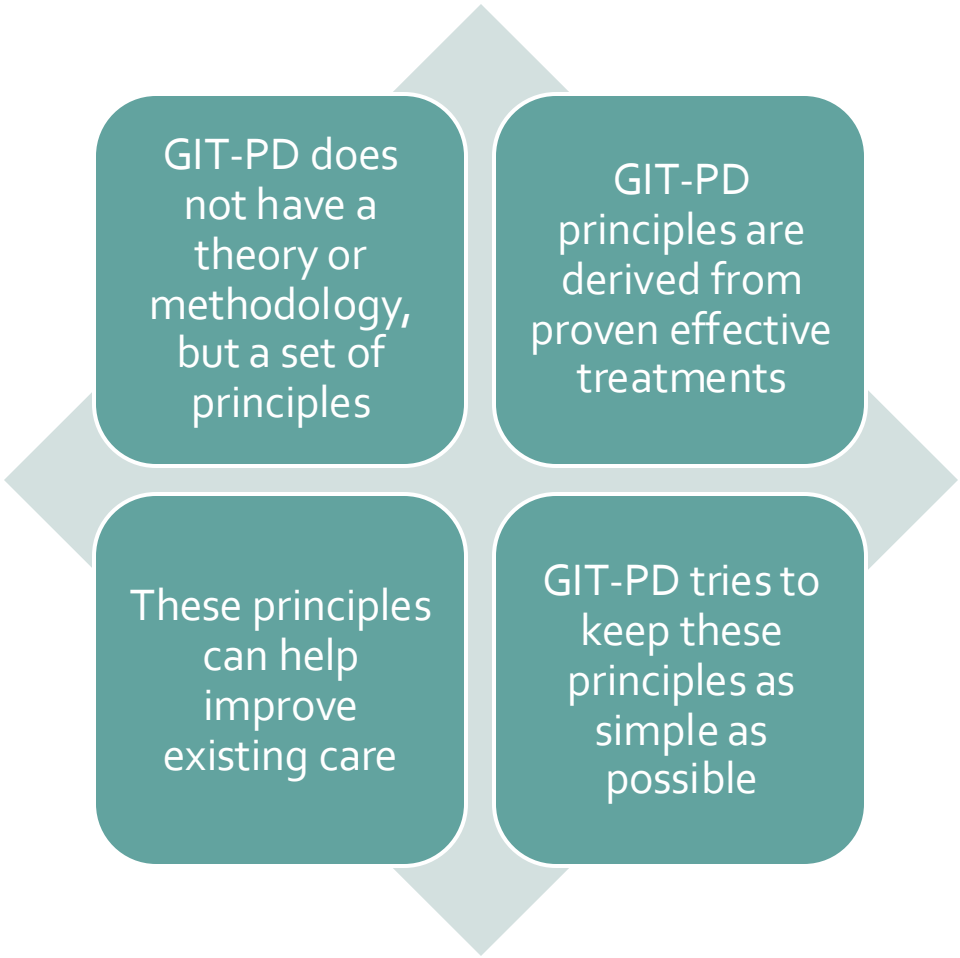
Keywords: Personality disorders, Generalist treatment, Implementation, Dissemination, Common factors

Background

Personality disorders (PDs) are a highly prevalent mental condition world-wide, associated with lifelong social and professional disability [1, 2], reduced life expectancy [3], and high societal and health care costs [4]. Following a range of studies showing effectiveness of psychotherapy for PD patients [5], there now is a rather optimistic view of the treatability of PDs. Several national guidelines recommend one of the evidence-based psychotherapy programs, such as Dialectical Behavior Therapy, Schema Therapy and Mentalization-Based Treatment [6–8]. However, implementation of these guidelines in clinical practice is cumbersome and most PD patients do not receive psychotherapy [9]. This is mainly due to capacity problems: delivering specialist psychotherapy is expensive and there is a lack of sufficiently trained professionals due to long training trajectories [10, 11]. Various studies also indicate that the sustainability of highly specialized evidence-based psychotherapy programs both for PD and for other complex disorders in the mental health services is often not guaranteed [12–14]. As a consequence, even in a country like the Netherlands, with relatively accessible mental health care services, only 23% of Borderline PD (BPD) patients received some sort of psychotherapy, not necessarily evidence-based,

* Correspondence: Joost.Hutsebaut@deviersprong.nl
[1]Viersprong Institute for Studies on Personality Disorders, Halsteren, The Netherlands
[2]Centre of Expertise on Personality Disorders, Utrecht, The Netherlands
Full list of author information is available at the end of the article

GIT-PD


GIT-PD does not have a theory or methodology, but a set of principles
GIT-PD principles are derived from proven effective treatments
These principles can help improve existing care
GIT-PD tries to keep these principles as simple as possible

GIT-PD Treatment Program

There is no single GIT-PD treatment program

Local expertise, traditions etc can lead to differences in implementation

GIT-PD does impose criteria on the content and form of treatment programs

GIT-PD Treatment Program: contents

- Content of a program should meet the target group's problem areas

- Learning to regulate negative emotions
- Better control of impulses
- Improving negative self-image
- Better conflict resolution in a relationship
- …..

GIT-PD Treatment Program: contents

- Make sure you have treatment modules or interventions in your program that address these problem areas

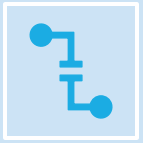
- Exactly how you design those modules may vary depending on the expertise/competencies of your team members

- Skills group
- Psychomotor therapy
- Relaxation skills
- Art therapy
- Insightful individual therapy
- Case management
- Family counseling

GIT-PD Treatment Program: form

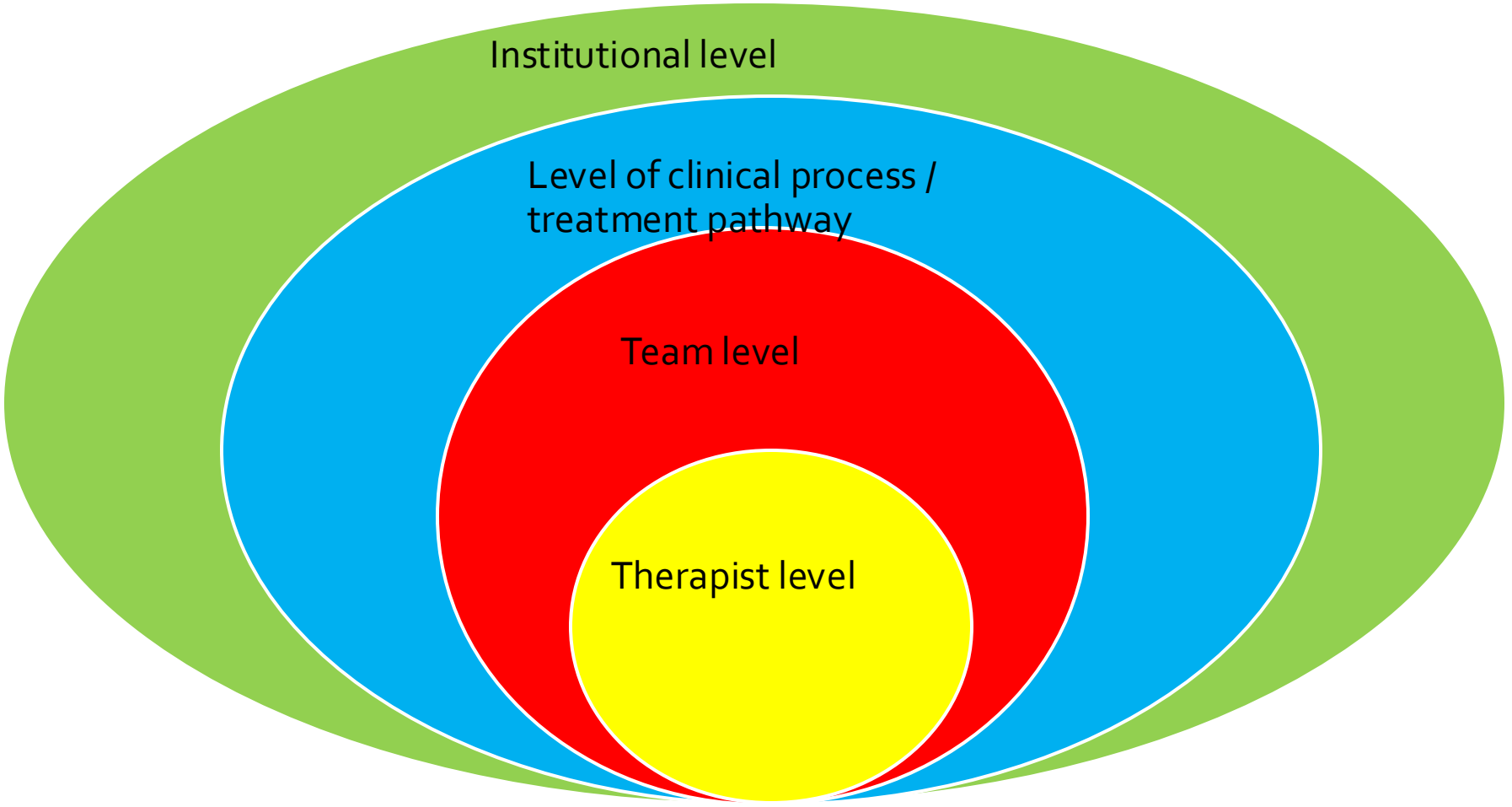
What makes GIT-PD GIT-PD is that all practitioners are constantly monitoring common factors throughout all program components

What makes GIT-PD GIT-PD is that both the organization, the clinical process and the team help the practitioners to do this

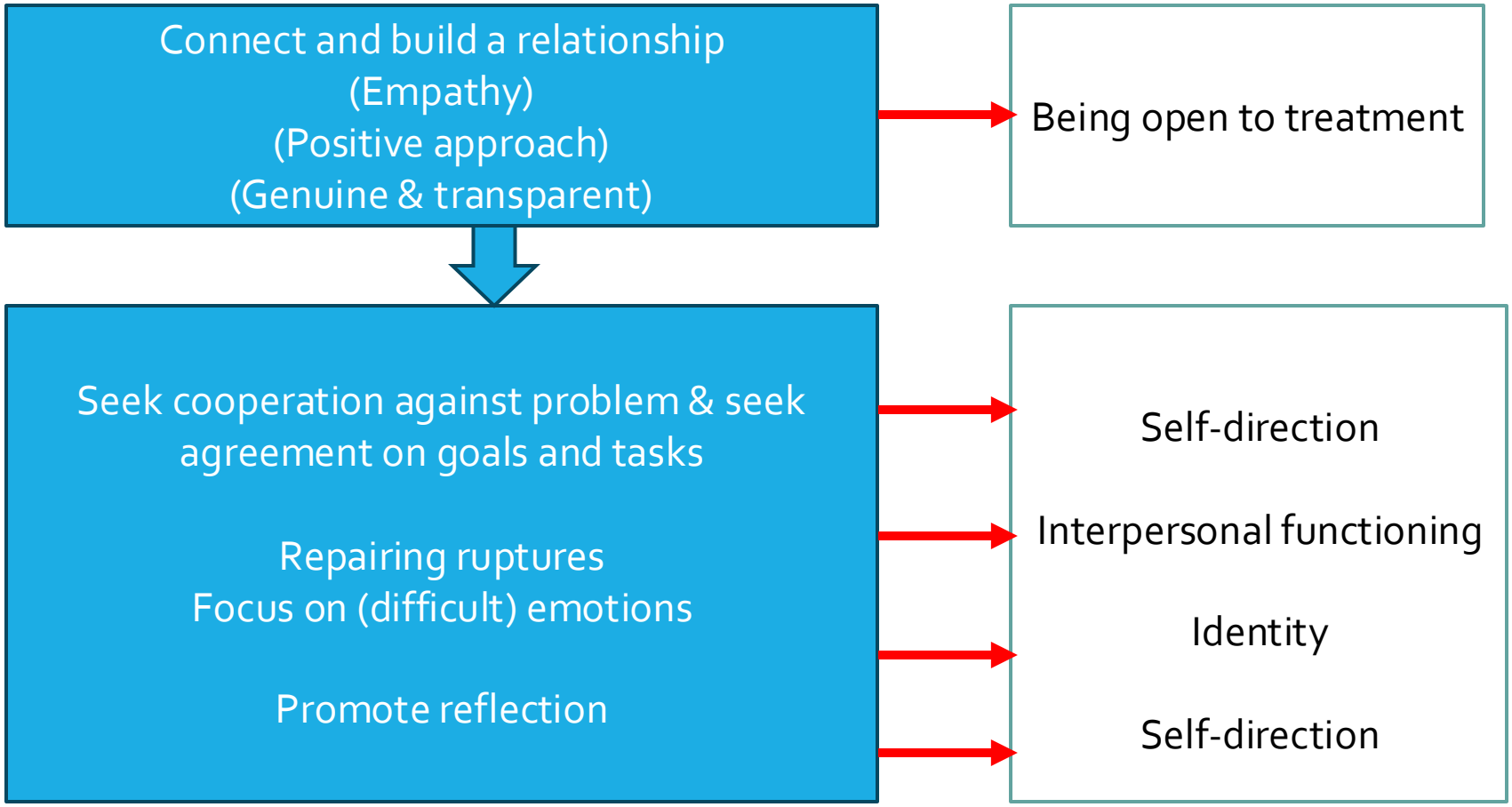


Within GIT-PD, the constant securing of the common factors is the backbone of treatment

GIT-PD Principles (enhanced common factors approach)



GIT-PD principles at the practitioner level



GIT-PD principles at the Team level

Principle	Meaning
Help each other in a team	Help your colleague stay focused on the common factors by asking the following questions: • Are you being honest with this client (genuine)? • Do you still like him/her (positive approach)? • Does he/she agree with the goals and tasks in treatment? (consensus on goals/tasks) • Are there any fractures/frictions? (repairing fractures) • Are you avoiding something (emotions)? • Are you acting too quickly or too slowly (self-reflection)?
Leverage Differences	Ensure that in a team different opinions and views are brought to the table, explored and brought together
Make policy reasoned	Be aware when certain decisions regarding policy are going too fast or too slow
Practice what you preach	Apply the same principles (common factors) in mutual team relationships as well

GIT-PD principles at the level of clinical process

Principle	Meaning
Manual	Treatment is described in a manual • Who do we treat and what are common problem areas? • What modules do we have for these problem areas?
Structure	Treatment has structure • Assessment-treatment phase-booster/aftercare • Episodic treatment
Dosage	Treatment has sufficient but also clearly limited dose (intensity/duration)
Goal-focused	Treatment is goal-oriented and goals are evaluated (treatment plan)
Personal/Flexible	Treatment is personally tailored (modular)
Context	Treatment focuses on generalization and empowerment of the client and his context

GIT-PD principles at the institutional level

Principle	Meaning
Support	The team experiences support and trust from management and feels facilitated (training, consultation time, learning on the job,…)
Buffer	The institution shields the team from internal or external disruptive influences
Cross-fertilization / context of expertise	The institution joins the GIT-PD network
Team size/composition	A team has a medium size (4-8) and balanced composition (with sufficient experience and expertise)
embedding	A team has regular treatment plan meetings, supervisions and intervisions
Quality Monitoring	A team regularly monitors operation (audit, team supervision) and treatment outcomes

GIT-PD dissemination

- 35 institutions for mental health care in the Netherlands and Belgium
- 1000s of practitioners have been trained directly by the CoE of through the TdT principle
- E-learning to support independency from trainers and CoE
- Recognition by Health Care Standards and by Guidelines for PDs in the Netherlands

Emerging evidence

ONDERZOEKSARTIKEL

Een ROM-studie van de *Guideline-Informed Treatment for Personality Disorders* in vier behandelcentra

J. Hutsebaut, K.C.M. Kindt, L.J.H. van Dam, N. Bachrach

Achtergrond De *Guideline-Informed Treatment for Personality Disorders* (GIT-PD) wordt breed toegepast in Nederland en België in de zorg voor mensen met een persoonlijkheidsstoornis. Tot op heden bestond er geen evidentie voor de mogelijke werkzaamheid van dit behandelkader.

Methode Een observationele cohortstudie in vier instellingen op basis van routine outcome monitoring(ROM)-data gekeken naar verbeteringen op gebied van symptoomlast (BSI/OQ-45) en persoonlijkheidsfunctioneren (SIPP-SF) bij 470 patiënten.

Resultaten In elk van de instellingen werden zowel voor symptoomlast als persoonlijkheidsfunctioneren significante verbeteringen geobserveerd. De effectgroottes voor een verbetering van algemene symptoomlast varieerden (d = 0,55 tot d = 1,05).

Conclusie De behandelresultaten voor GIT-PD liggen in de lijn van behandelresultaten die ook voor specialistische behandelvormen voor persoonlijkheidsstoornissen worden gezien in vergelijkbare praktijkstudies. Mogelijke verschillen tussen de instellingen zouden te maken kunnen hebben met de intensiteit, structuur en coherentie van het betreffende GIT-PD-programma.

Instelling	Meting	M	SD	t	df	p	Cohens d
Altrecht	BSI-s	1,53	0,76	5,0	82	< 0,001	0,55
	BSI-e	1,18	0,81				
de Viersprong	BSI-s	1,74	0,64	8,82	85	< 0,001	1,05
	BSI-e	1,06	0,66				
GGZ Oost Brabant	OQ-45-s	91,3	21,3	4,26	108	< 0,001	0,61
	OQ-45-e	77,5	25,8				
NPI	OQ-25-s	51,2	16,0	8,45	118	< 0,001	0,69
	OQ-25-e	39,7	17,3				

-s = startmeting; -e = eindmeting

REPAIRING RUPTURES

Therapist level

Exercise

- Did you ever experience a clear rupture in one of your sessions? E.g. that a patient was clearly upset by something you said or did?
  - What was the experience of the patient? How did he/she feel by what you had been doing or saying? (Your effect)
  - What was your intention? Why did you say or do what you said or did? (Your intention)

Exercise 2

- Take one of your 'difficult' patients in mind
  - What's going on in the room making him/her 'difficult'?
  - What 'emotions' of 'thoughts' come to your mind when thinking about this patient?
  - If you could freely 'ventilate' to a friend or colleague about this patient, what would you be telling them?

Exercise

- Take one of your 'difficult' patients in mind
  - What's going on in the room making him/her 'difficult'?
  - What 'emotions' of 'thoughts' come to your mind when thinking about this patient?
  - If you could freely 'ventilate' to a friend or colleague about this patient, what would you be telling them?
- How much of these thoughts and feelings are 'on the table' in your sessions?

Ruptures

- We have an (unintended) impact upon patients, leading to disruptions in the alliance
  - Usually: patients feel as if the effect they experience **IS** also our intention
- Patients have an (unintended) impact upon us, leading to disruptions in the alliance
  - Usually: we feel an unpleasant effect that we believe will result in ruptures if we would act upon it

Ruptures according to GIT-PD: Why?

- Interpersonal problems
  - PD patients generate interpersonal reactions they fear the most and do not generate the reactions they need the most
- Good working relationship is emotionally close, which can simultaneously evoke fear and insecurity
- Confrontational versus withdrawing ruptures
- Repairing ruptures adds to treatment effectiveness

Ruptures according to GIT-PD: objectives

- Establishing an emotionally close and involved therapeutic relationship while continually monitoring for potential ruptures
- Helping clients to manage frictions or ambivalent emotions in close relationships
- Helping clients understand why their relationships 'outside' are so difficult *and* motivating them to practice doing something different in these relationships

GIT-PD principles for repairing ruptures

Principle	What?	Stance	Common factor
Do not avoid ruptures	The practitioner remains transparent and authentic, including with regard to the effects the client has on him/her	I want to be honest with you, even if it means discussing something painful	**ALLIANCE**
Always monitor the therapist relationship	The practitioner alternates between content' work and 'relational' work	I also always keep an eye on whether we are still on the same page in contact	
Actively address ruprtures	The practitioner actively discusses possible ruptures	I want to discuss with you what is going on between us	**REPAIRING RUPTURES**

Do not avoid ruptures: how?

STEP 1:

Ask yourself if you are being "honest" ("authenticity") : is there something I'm thinking or noticing that is not being talked about?

Constantly monitor if you notice anything in yourself while being in contact

STEP 2:

If you notice that you are avoiding something or that something is going on in the contact, actively discuss it (see repairing ruptures)

Always monitor the therapist relationship: how?

STEP 1:

Constantly monitor if you notice anything in the patient while being in contact

E.g. more withdrawn, less open, annoyed, somewhat suspicious, agitated, sighing,…

STEP 2:

If you notice something is going on in the contact, actively discuss it (see repairing ruptures)

Repairing ruptures: how?

STEP 1:

Bring up something you notice; seek cooperation against the pattern/occurrence between the client and you; express your absolute willingness to have this solved

Let the negative emotional experience exist; give recognition

STEP 2:

Look for the trigger for this experience; possibly take your share for the effect on the client

Repairing ruptures: how?

STEP 3:

Explore whether you can disconnect the effect (the negative experience) from the intention behind your behavior (why you did or said something) so that the interpretation underlying the rupture is challenged

Optional: STEP 4:

Zoom out: how did we get into this? How come I did what I did?

(get a better understanding of how interactions develop throughout time and if this could be of relevance for interactions outside the therapy room)

Repairing ruptures: how (simple version)?

- STEP 1: Listen (Let ventilate)
- STEP 2: Validate (own your part in the rupture)
- Step 3: Change interpretation
- Step 4: Understand in context

Relationship & repairing ruptures: pitfalls

Dare to discuss what may be going on; avoidance does not help

Take enough time to thoroughly understand what exactly the (negative) emotional experience was that led to the breakup and what exactly the triggers were

Take in only what feels authentic and genuine

Be honest about your intentions (why you did something), even when it stemmed from something negative; in that case, explore what led to that negative as well

Video Demonstration

- Part of e-learning

REPAIRING RUPTURES

Team level

Example

- Have you ever had the experience that you were struggling with a patient, felt a bit bad about it, discussed it with colleagues in a team or intervision group,… and felt even worse afterwards?

- What happened? Why?

Background

- Treatment is more effective when the common factors are secured
- Therefore: if treatment isn't effective, the reason is usually that common factors are not secured well enough
- Common factors aren't secured well enough because therapists get caught in an **interpersonal trap**
- Clinicians can sometimes get so "sucked in" (relationally) that they are not the most effective versions of themselves in contact with people with personality disorders. As a result, common factors are compromised.
- A team can help the practitioner zoom out and regain focus on what is working

Objective Team

- Helping colleagues stay focused on what works in treatment
- Helping colleagues understand what is going on interpersonally that compromises common factors

Case discussion according to GIT-PD principles

- Is there progress/stagnation/backward progress toward the goals?

- If there is no progress:

  - Motivation/collaboration: are you on the same page in terms of goals? Is there agreement on what this requires of everyone?
  - Emotions/identity: are you avoiding something? Is there an elephant in the room?
  - Breaks/relationships: is there something going on in the contact? Is it clicking? Are you being honest? Do you like seeing him/her (still)?

- What should you include in treatment to get the process "flowing" again?

Helping colleagues

Common factor	Questions colleagues can ask in a team meeting
Empathy	Are you still in touch with how it must feel for this client?
Positive approach	Do you still like him/her?
Genuineness, transparency, expressing emotions by practitioner	Are you being honest with him/her? Is what you are discussing here on the table?
Working together against problem	Are you working together or against/against each other? What is the problem that the client wants to do something about or that puts pressure on treatment?
Agreement on goals and tasks	Does he/she agree with the goals? Is there enough burden to change anything? Is he/she doing what can help achieve the goal? Who works hardest in treatment?
Expressing emotions	Are you avoiding something (elephant in the room)?
Repair ruptures	Are you still on the same page? Do you think the client feels the same way?

Case discussion in case of stagnation

Starting point: what is the bottleneck/problem you are facing in this case study? What is difficult? Where do you want help?

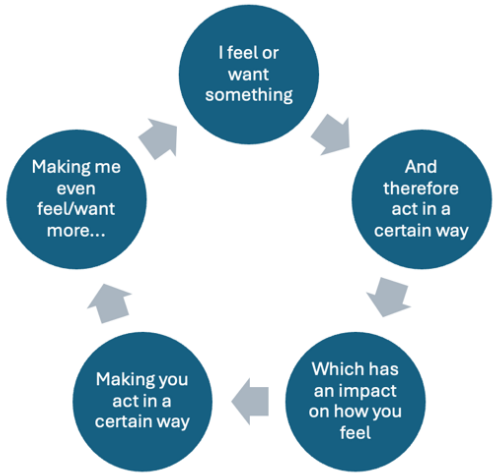
Context: Can the practitioner(s) tell you more about this case: registration and progress so far? The goal is mainly to provide some context to the bottleneck.

Focus on common factors:

- Motivation/collaboration: are you on the same page in terms of goals? Is there agreement on what this requires of everyone?
- Emotions/identity: are you avoiding something? Is there an elephant in the room?
- Ruptures/relationships: is there something going on in the contact? Is it clicking? Are you being honest? Do you like seeing him/her (still)?

Case discussion in case of stagnation

Focus on interpersonal trap (“what are you sucked into?”):



What do you feel/think about this case? What effect does the client have on you? What do other (team) members notice as they sympathize and sympathize with what the effect might be on the practitioner involved?

What exactly is the client doing that makes you think/feel that? What is in it?

What are you spontaneously inclined to do from what the case evokes in you? How might that affect the client?

Why would the client do it this way?

Case discussion in case of stagnation

Feedback to bottleneck:

Is there a connection between this interaction and the bottleneck?

Is there a connection between this interaction and the sign-off problems?

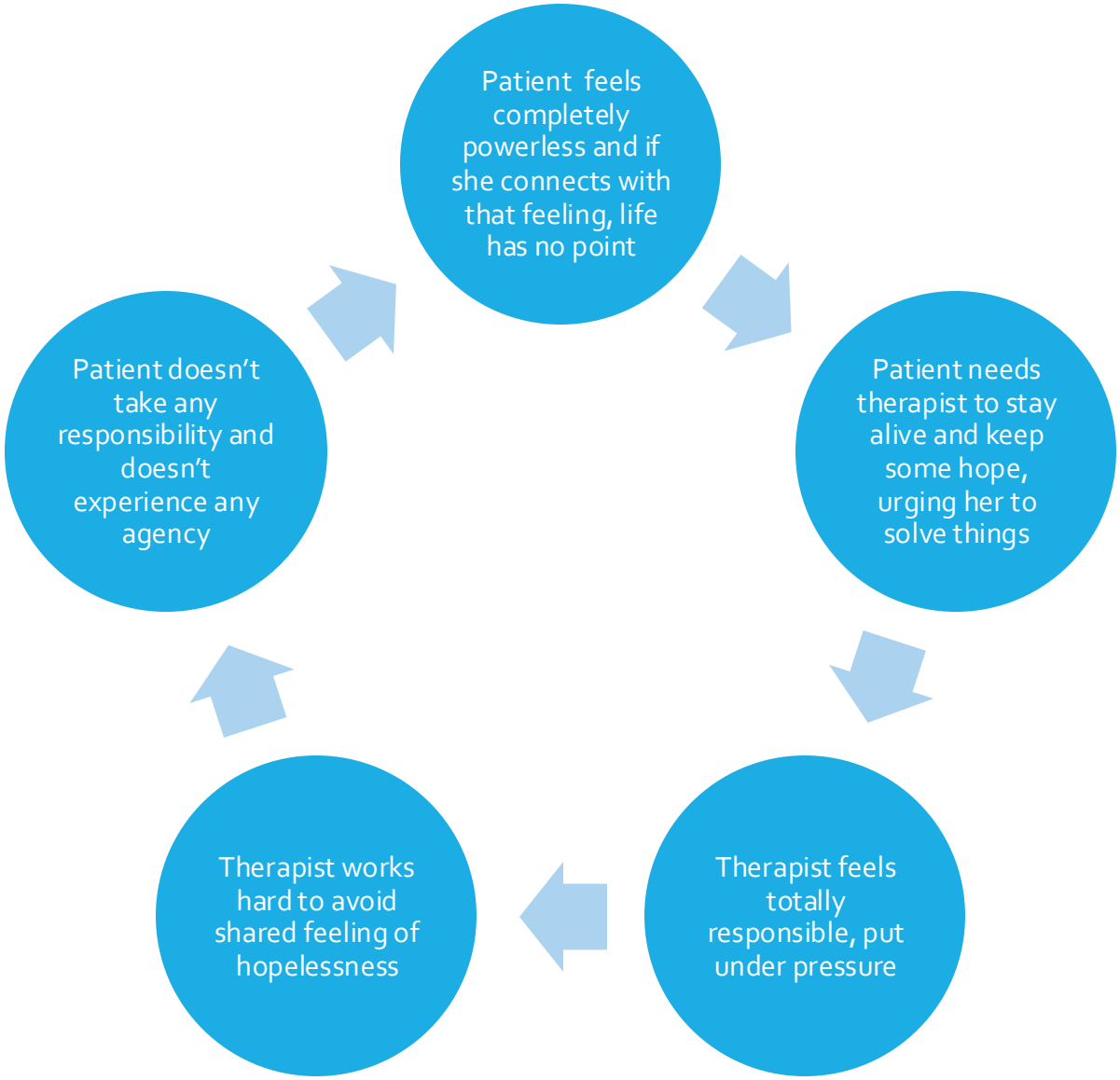
Policy: What could you do?

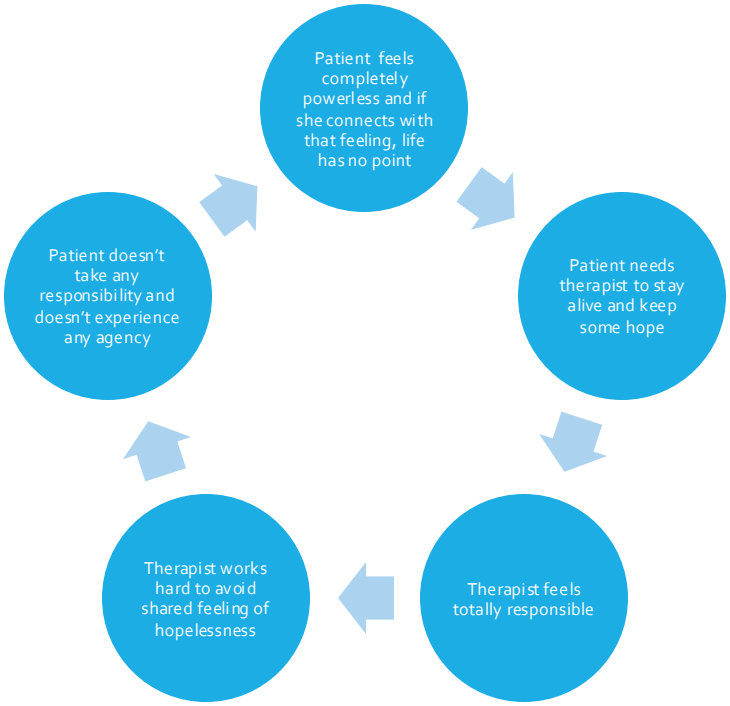
- What remains unaddressed? What is the “elephant in the room”? What needs to be on the table to re-establish an authentic relationship?
- What is there no consensus on? What is the client not doing that he/she should be doing, leaving too much responsibility for treatment on the practitioner?
- What is going on in the contact? What rifts remain under the table?

Video demonstration: case discussion in a team

- Sanne, suicidal and self-harming young woman
- Previous treatment review revealed stagnating treatment

- This review elaborates more on the 'interpersonal trap'
- Roles:
  - Chair
  - Therapist
  - Team member
  - Process monitor


Patient feels completely powerless and if she connects with that feeling, life has no point
Patient needs therapist to stay alive and keep some hope, urging her to solve things
Therapist feels totally responsible, put under pressure
Therapist works hard to avoid shared feeling of hopelessness
Patient doesn't take any responsibility and doesn't experience any agency

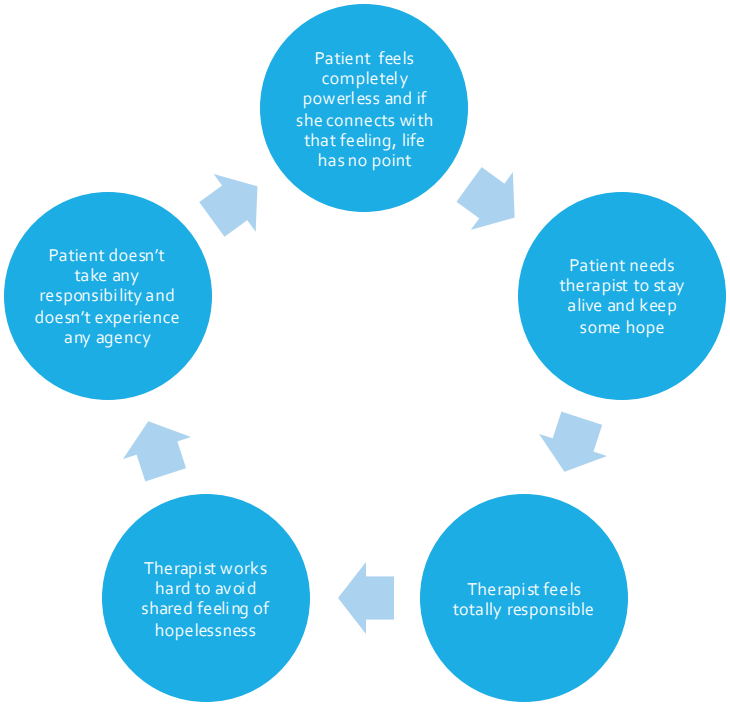


Interpersonal trap interferes with Common factors

Tasks/goals: Therapist takes on responsibility instead of patient

Emotions: Therapist avoids elephant in the room

Rupture: Therapist becomes less transparant, avoiding ruptures that could lead to suicide



Interpersonal trap 'feeds' core symptoms

Symptoms characterized by loss of control (self-harm etc)

Social isolation (peers/parents feeling too burdened by her 'dropping' her powerlessness)

Exercise

Make groups of 5

- Team member 1 brings in a case (a case that you get stuck in, that stagnates, that gets under your skin,…)
- Team member 2 questions team member 1 on the problem and checks the common factors (see next slides)
- Team member 3 questions team member 1 on the interpersonal trap (see next slides)
- Team member 4 summarizes the interpersonal trap and links it to the bottleneck
- Team member 5 is the process monitor: is everyone doing his/her task? If not: help get back to the task at hand

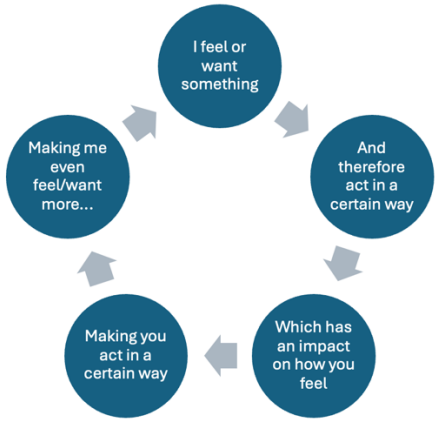
Exercise

- Team member 2: Starting point: what is the bottleneck/problem you are facing in this case? What is running into difficulty? What would you like help with? If necessary, ask for a little more context to the case.

- Team member 2: Focus on common factors:

  - Motivation/collaboration: Are you on the same page in terms of goals? Is there agreement on what this requires of everyone?
  - Emotions/identity: Are you avoiding something? Is there an elephant in the room?
  - Breaks/relationships: is there something going on in the contact? Is it clicking? Are you being honest? Do you like seeing him/her (still)?

Exercise



- Team member 3: Focus on interpersonal trap:
  - What do you feel/think about this case? What effect does the client/young person/parent(s) have on you? What do other (team) members notice as they sympathize and sympathize with what the effect might be on the practitioner involved?
  - What exactly is the client/young person/parent(s) doing that makes you think/feel that way? What is in it?
  - What are you spontaneously inclined to do from what the case evokes in you? How might that affect the client/young person/parent(s)?
  - From where would the client/young person/parent(s) do it this way?

Exercise

Team member 4:

- Summarize the interpersonal trap
- How does it relate to the bottleneck in treatment?
- How does it relate to core referral problems of this patient?

Resuming treatment

- **Emotions**: What remains unaddressed? What is the "elephant in the room"? What needs to be on the table to re-establish an authentic relationship?
- **Consensus on goals and tasks**: What is there no consensus on? What is the client not doing that he/she should be doing, leaving too much responsibility for treatment on the practitioner?
- **Alliance**: What is going on in the contact? What rupture remains under the surface?

Contact

- J.Hutsebaut@tilburguniversity.edu
- Joost.Hutsebaut@deviersprong.nl