ESSPD NEWSLETTER

ESSPD | European Society for the Study of Personality Disorders

Message from the President
September, 2015

Dear Colleagues

Martin Bohus

It`s a pleasure to present this newsletter of the ESSPD.

The major aims of the ESSPD are twofold: First to strengthen the public awareness about the need for adequate diagnosis, treatment and health reimbursement of people suffering from personality disorders. And second to improve the clinical competence of treatment providers in evidence based treatments in Europe.

The mental health care systems in Europe are characterized by diversity, which has advantages and disadvantages: On the one hand, diversity enables us to take different perspectives on treatments and the contexts in which it is delivered, and to learn from each other. On the other hand, this diversity weakens our political power and attenuates the influence of colleagues who dedicate their career to improve treatment perspectives for personality disorder.

We have launched several activities to further both of our primary aims, some of which are illustrated in this newsletter: We have started workshop conferences in Eastern Europe in order to disseminate evidence based clinical knowledge; and we are glad that the Tallinn conference was such a big success- many thanks to all the people who helped to get this first conference established! We are confident that we can establish these conferences on a regular basis.

Regarding the European diversity we started to provide an overview on the different treatment guidelines and mental health systems in Europe. This process will take time, but in the long run we aim to establish recommendations for European standards in the treatment of personality disorders.

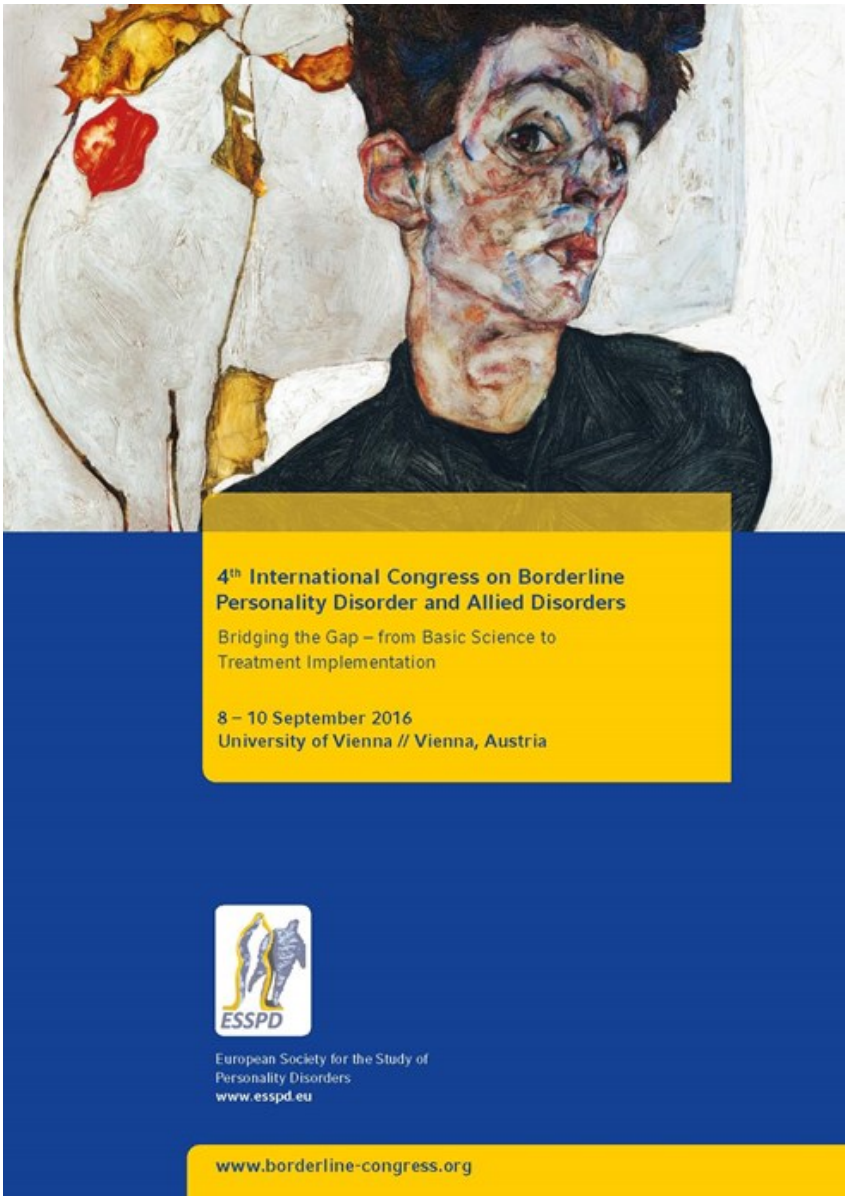
As nice as these activities may sound, they seem unimportant against the background of a more than compelling problem: The current proposal of the ICD 11 section on personality disorders. In its current format, it strictly promotes a dimensional approach and relinquishes any concrete and distinct diagnostic categorization. This means that terms like “borderline”, “antisocial” or “dependent personality disorder” will disappear. The loss of clear diagnostic entities threatens to dismiss scientific insights which have been conducted within the last 20 years of collaborative research. It also undermines the treatment reimbursements by health insurance companies. Most insurance companies rely on diagnostic terms and increasingly many of them will only pay for evidence based treatments. Since we do not have any data on successful treatments for dimensional personality constructs, it will be easy for health insurers to refuse any reimbursement. To say it clearly: From our perspective, the current ICD 11 proposal will ruin the entire field of personality disorder.

We have to combine all our resources and influence to prevent the WHO from establishing this proposal.

All the very best,

Martin Bohus, President of the ESSPD

Vienna Congress, 4th International Congress on Borderline Personality disorders—Vienna, September 8-10, 2016



After the highly successful meetings in Berlin, Amsterdam and Rome, the next International Congress on Borderline Personality will be held in the beautiful city of Vienna.

The major topic will focus on treatment implementation. After two decades of development of manualized treatments and their evaluation in RCTs, this issue becomes more and more important. How to bridge the gap between evidence based effective treatments and the clinical practice? How can we disseminate evidence based treatments to patients with borderline and other personality disorders to make sure that every patient will find a therapist who is capable? Experts in the field of implementation research will provide the latest data and experiences from clinical practice as well as health care systems in different countries.

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Stephan Doering, President of the local organising committee

Martin Bohus, ESSPD President

Vienna Congress, 4th International Congress on Borderline Personality disorders—Vienna, September 8-10, 2016

In addition our program will of course cover the whole field of research on borderline personality disorder and related conditions. We are proud to announce that two senior experts have already agreed to give lectures: Arnoud Arntz and Otto Kernberg.

Arnoud Arntz

Otto Kernberg

Other plenary lectures will focus on the exciting field of social cognition in BPD and its relevance for clinical practice.

We hope that a lot of our colleagues, friends, researchers, clinicians from Europe and the whole world will again join our conference and contribute their latest research and discuss and learn from each other —and enjoy late summer in Vienna.

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Vienna University main entrance

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Vienna University courtyard

The congress will take place in the old central building of the Vienna University in the famous Ringstrasse. The university is celebrating it's 650th anniversary in 2015. The main building, with it's amazing courtyard (which we will use for our coffee breaks) will host our conference. There are many hotels and restaurants nearby and the city centre is within walking distance.

We look forward to welcoming you to the ESSPD conference in September 2016 in Vienna.

The Tallin Conference, June 2015: Interviews with participants

The conference held in Tallin in June 2015 was very well attended with more than 170 participants. Our newsletter representative, Kjetil Bremer from Norway, interviewed some of the participants

Kjetil Bremer

Mart Juursoo is a clinical psychologist and works at the psychiatric ambulatory department at Tartu University Clinic. He's also head of the union of psychologists at the Tartu University Clinic. Aire Mill is a neuropsychologist working at the rehabilitation department in North system, New Medical Center in Tallin. They knew each other before the conference.

Why did you come to this workshop?

Mart: I came in the hopes of developing skills as a psychotherapist. My training is in cognitive behavioural therapy, so that's what I use. One of my goals was to develop skills working with personality disorders, which is not something that I specialize in, but something I still work with.

Aire: I was interested in these workshops, because you usually don't get enough information how to do things. Also, I've been working on my doctoral thesis about these emotional recognition and mind reading topics, and emotional regulation. That's why it was interesting.

What is your experience of the treatment offered to persons with personality disorders in your local areas?

Mart: Well, they don't get any special treatment. There is a specialized programme actually, but it's rather limited in scope, so in most cases they get the "treatment as usual" in a general psychiatric setting. They get psychotherapy, that's the main treatment, but still ….

But yes, there is a DBT programme in our clinic actually, it's group therapy. But since I'm not involved in that I can't elaborate further than that.

Maart Juursoo and Aire Mill

Do you know if there is any other such clinics in the country?

Mart: I'm not aware of any in Tartu and I don't know some much about programmes in Tallin.

Aire: Neither do I, I know about these psychosis patients, but I've not heard about special groups for personality disorders.

Today is the last day of the conference. What's you impression of the workshops so far?

Mart: I've basically got what I came for. I've seen and even done a few new things in the workshops concerning specific therapeutic techniques, and also like the therapeutic programmes approaches.

However, I was actually a bit surprised that my training as a CBT therapist had covered quite a few of the topics discussed here in these workshops, concerning working with personality disorders. Schema therapy was something that I hadn't known in so much detail so far. But concerning personality disorders I was a bit surprised that there was not so much new information for me. Well, I'm still waiting for the workshop of Giancarlo Dimaggio. I'm very interested to see what he has to offer.
Aire: I like all that I attended, especially that they showed these videos of real processes, how it's taking place. Otherwise you have to imagine what you have to do. So I actually quite liked the practical work.
Mart: Thinking about yesterday, I would have liked to hear more about what they think make their programmes so successful. There are these components to therapy which are applied elsewhere as well, but in their programmes they are combined in such a way which make them so successful. So I think that was one thing I missed a bit.

Do you think the experiences from the conference will be useful for your work with your patients?
Mart: Definitely.
Aire: Yes, absolutely.
Mart: I would definitely like to have some more thorough training in at least one of these specific therapies that were presented in these few days. My dearest hope is that there will be more of these events in the future.

Timo Sāamānen and Saana Sarparanta are from Finland, working in the same institution, Helsinki University Hospital. Timo works with adults with mood disorders and Saana with adolescents from thirteen to eighteen years old.

Timo Sāamānen and Saana Sarparanta

Why did you come to this workshop?
Timo: I'm excited about the topic, not enough attention is being giving to it. It's like a side note. We should do something about the personality disorder patients. It's still more focus on the depression, and because in terms of number that's bigger, it's understandable back home. But there are not many specialized groups, I would like to see more. May be it just excites me.
Saana: I'm into personality disorders, that's why I'm here.

What's your experience of the treatment offered to patients with personality disorders?
Timo: It's getting better all the time, at least where I work. DBT is being offered, and different views on personality disorder treatment are integrated in the field, I think. I'm pretty young academically, graduated a few years ago, and I guess my information is pretty new. But, there's a lot of people that are slowly learning it, I guess.

Interviews from Tallin

Saana: I think it's developing a lot nowadays. However, I think it's different in the youngster psychiatry. In Finland it's tradition of not diagnosing personality disorders in adolescents. It's common nowadays to diagnose these features, but basically the main diagnosis is always another than personality disorder. ButI think that personality disorder features shall be taken into account, even when you are treating adolescents with a developing disorder

Timo: It's usually always there, even if it's not being called a personality disorder. It's called something else, like a repetitive depressive disorder.

Congress Hall, Tallin

You've been here for one and a half days. What do you think of the workshop so far?

Timo: I've been enjoying it. Yesterday it was basic information, as they were preliminary lectures. I was happy with this morning, there was some practice and there was some main information.

Saana: I'm kind of happy, but I would have liked so much more.

Do you have any ideas of what you would like to have more of?

Timo: Well, there's a lot of theory. I've been trying to get to know the theory, but nobody is forcing me to practice. That's my problem of course, but it's like you don't have the time, you don't get to do it so much when you're back working. You're free to try, but then something requires more time. So I guess I would have liked more practical stuff. But then, if there's no lecture we cannot jump straight into the practical stuff, so on a time scale like this …. But still I'm happy that I came.

Saana: Yes, I would also have liked more practice.

We're still in the middle of the conference so it's probably a bit early to say, but do you think the experiences from this workshop will be useful in your further work with patients with personality disorders?

Timo: Yes. It's not skills, it's just a way to look at things and think about them, and that's a good thing.

Saano: Like new impressions and new frameworks for thinking, mental frameworks.

Improving Access to Psychological Treatment for people with Personality Disorder—an initiative in England and Wales *by Anthony Bateman*

Over the past 2 years the mental health division of the National Health Service (NHS) in England and Wales has increased the focus on personality disorder. The whole project is an extension of the Improving Access to Psychological Therapies (IAPT) project, which has been offering evidence based psychological treatment for people with anxiety and depression for many years. The new project is known as IAPT-Serious Mental Illness (schizophrenia, bipolar disorder, and personality disorder).

Anthony Bateman

In 2012 NHS England asked for competitive bids from clinical services to act as demonstration sites of services to people with personality disorder, or schizophrenia, or bipolar affective disorder. Three centres were awarded a contract to become demonstration sites for personality disorder, two centres for schizophrenia, and one centre for bipolar affective disorder. The centres selected for personality disorder were Halliwick Unit personality disorder service Barnet Enfield and Haringey Mental Health NHS Trust (BEHMHT), personality disorder service North East London Foundation Mental Health NHS Trust (NELFT), and the personality disorder service of Somerset Partnership Foundation NHS Trust (SPFT). The overall aim was for the demonstration sites to 'showcase' service pathways, increase interest in treatment of personality disorder nationally, and implement service level data collection to inform national development of services.

Over the past two years data has been collected and routine outcome monitoring implemented in the pilot sites. The number of people seen by the 3 sites over the review period was over 4500 so considerable data has been collected on the demography and clinical features of people with personality disorder who are referred to clinical services. This information will be published soon. Experience has been developed about how to introduce outcome monitoring in routine clinical services. It is difficult for a number of reasons: problems associated with organisation of services, difficulties with changing clinician behaviour, complications for patients, and agreeing the relevant data that is meaningful to managers, patients, and clinicians.

Services for personality disorder in England and Wales have a range of targets for numbers of patients seen and work performed. The result is that adding a requirement to collect data to administrative and clinician responsibilities increases work and reduces the time available for direct patient care. Clinicians naturally resist this. Patients can also find it difficult to focus on completion of questionnaires, can rapidly experience instrument fatigue, may not be gracious about giving information which they see as irrelevant, and language and literary problems, found in over 20% of referrals, confound the problems. Monitoring of treatment needs to be integrated into the assessment and treatment programmes if these problems are to be overcome. Both BEHMHT and NELFT introduced a web based data collection using a patient owned data (POD) system that allows patients and clinicians equal access to the data. POD graphically displays the data overtime. Change or lack of it is discussed in treatment on a regular basis.

There is a question of what data is relevant to clinicians and patients. After considerable discussion between a group of experts and service users, monitoring of a number of domains were agreed –

symptoms such as depression and well being using the patient health questionnaire (PHQ-9) and Warwick and Edinburgh Wellbeing Scale (WEMWBS), adaptation using Work and Social adjustment Scale (WSAS), behaviours such as violence, self harm and suicide attempts, and service use, for example GP visits, emergency room visits, hospitalisation.

It is likely that this project will come to an end during 2015/16 and all the data will be published in a final report. Work is currently being done on developing prototypical pathways for people with personality disorder to access evidence based treatment in the NHS and on ensuring that services for people with personality disorder are part of commissioning intentions for mental health care throughout England and Wales. In turn, services will have to implement routine outcome monitoring and meet performance targets in terms of numbers of patients treated and outcomes achieved. It is likely that the primary outcomes will be related to service use. Reductions in service use due to behaviours such as self-harm and suicide attempts and violence are important in terms of health care costs and patient well-being. But this applies mainly to people with borderline and antisocial personality disorders; other personality disorders will require different outcomes to be assessed.

Prof Anthony W Bateman MA, FRCPsych is Lead of IAPT–SMI demonstration site for people with personality disorder at Barnet, Enfield and Haringey Mental Health NHS Trust; Consultant Psychiatrist and Psychotherapist and MBT co-ordinator, Anna Freud Centre, London; Visiting Professor University College, London; Honorary Professor in Psychotherapy University of Copenhagen.

For further information email: anthony.bateman@ucl.ac.uk

Clinical pathways for personality disorders in Norway
by Øyvind Urnes

Øyvind Urnes

It is a clear goal in the Norwegian health care to establish clinical guidelines for medical diseases in order to improve co-ordination of care, make the treatment path clear to the patients, shorten the length of stay in hospital and to reduce costs. There are some ambiguities about the definitions of the different concepts: Patient-centred care pathway, Clinical pathways (Cochrane), Clinical practice guidelines (Australian Government) or Treatment and management guidelines (NICE). Here I will stick to the definition of Clinical pathway as a structured multidisciplinary care plan used by health services to detail essential steps in the care of patients with a specific clinical problem (Clinical pathways: effects on professional practice, patient outcomes, length of stay and hospital costs - The Cochrane Library - Rotter - Wiley Online Library).

In Norway there are no national treatment guidelines for any personality disorders. There is a guideline for making priorities of mental health disorders in specialist services, but personality disorders are not mentioned here. In spite of this, there is a great deal of interest and concern regarding patients with personality disorders.

At Oslo University Hospital there has been a clinical unit for personality disorders since 1978, now called the Department for Personality Psychiatry. This service started as a therapeutic community, evolving in 1994 to a day treatment programme for personality disorders and from 2008 has been an outpatient clinic for personality disorders, mainly borderline personality disorders. A research group for personality psychiatry was set up in 1980 and has produced a lot of publications since (http://www.dagbehandlingsnettverk.no/dninfo/dnpublik.htm). In Norway the health authorities have set up several competence centres for disorders where knowledge of how to diagnose and treat the disorders are lacking. In 2012 the National Health Authorities decided to establish the Norwegian National Advisory Unit on Personality Psychiatry (NAPP) connected to the Department for Personality Psychiatry.

In NAPP we started with getting an overview of the need for knowledge in the specialist services in Norway and got a clear message that there was no agreement how to diagnose and treat personality disorders inside the specialist services. Nor was there any agreement how to collaborate with primary health care. In primary care there was a lot of frustration as they often had to take care of very low-functioning patients with personality disorders without sufficient support from the psychiatric specialist services.

Oslo University Hospital decided to give NAPP the task to make a guideline for Clinical pathways for personality disorders for patients in the hospital's catchment area (about 300.000 people). The pathway should describe the treatment course from home, to primary health care, to specialist services, and back to home. The first issue to decide on was if we should make a pathway for just borderline personality disorder or for personality disorders in general. We landed on the last. Personality disorders are dimensional phenomena and there are strong arguments for investigating the full clinical picture of dysfunctional personality traits in order to get an overview before deciding on the management of the disorders. We then decided to put the main focus on the three clinically most important types, i.e.,

borderline, avoidant and antisocial personality disorder.

The Clinical pathway describes symptoms and problems, referral procedures, procedures for making the diagnosis, treatment, and follow up. Clarification of roles of the different health practitioners through the pathway was seen as important. The symptoms and problems section describes in plain language the general aspects of personality disorders inspired by DSM-5 (section III) self and interpersonal problems. It is meant for both patients and medical doctors. The guideline recommends a screening (A cross-sectional testing of The Iowa Personality disorder Screen in a psychiatric outpatient setting. - PubMed - NCBI) for patients with longstanding symptom disorders and suspected personality disorder, e.g., pervasive relational problems. The diagnostic procedures at psychiatric outpatient clinics are described with discussion of important differential diagnoses like autism spectrum disorders, ADHD and bipolar disorders. The guideline recommends SCID-II for diagnosing personality disorders and NAPP is running a two days SCID-II training course.

General advices regarding treatment goals are given, like reduction of symptoms and destructive behaviour, enhanced emotion regulation, improvement of interpersonal skills and understanding of interpersonal events, and strengthening the identity, as well as capacity for living a meaningful life with family, friends and work. Recommended treatment of borderline personality disorder is a structured outpatient psychotherapeutic treatment of minimum one year, including a treatment plan and a crises plan. The most disabled borderline patients should be referred to specialised programmes like Dialectic Behavioural Therapy or Mentalization Based Therapy. We generally try to get borderline patients off medication, or reduce medication to the lowest possible level with a single drug. Recommended treatment for avoidant personality disorder consists of systematic cognitive or psychodynamic psychotherapy for one year in private specialist practice. The most disabled patients should be referred to psychiatric services in outpatient clinics. There are no recommendation for antisocial personality disorder as such, but for treating co-occurring antisocial traits in borderline programmes after evaluating the degree of psychopathy. The guideline recommends course in anger mastery or treatment of violence in close relationships. Personality disordered patients with a moderate or mild level of dysfunction are referred to psychologists or psychiatrists in private practice.

The Clinical pathways guideline recommends information to the patients' primary care doctors during the treatment, as well as involvement of work rehabilitation authorities, planning for resuming of work or education. Optimally, the patients should be engaged in work or studies after one year of treatment.

The guideline was published in January 2015 on the hospital's internal website, and later on the Internet (in Norwegian). It is too early to know whether the Clinical pathways have influenced or changed practice.

Dr . Øyvind Urnes, Norwegian National Advisory Unit on Personality Psychiatry (NAPP), Oslo University Hospital, Division of Mental Health and Addiction, Department for Personality Psychiatry, Oslo, Norway
Email: oyvurn@ous-hf.no
Web: http://www.oslo-universitetssykehus.no/omoss_/avdelinger_/personlighetspsykiatri-nasjonal-kompetansetjeneste_

Guideline Based Treatment at the Trimbos-institute, Utrecht
by Ad Kaasenbrood

Ad Kaasenbrood

Background

In 2008 the Trimbos-institute in Utrecht, The Netherlands, edited the Multidisciplinary Guideline (MDG) on Diagnosis and Treatment of Personality Disorders. This was perceived as a major achievement. The treatment of personality disorders until then had been surrounded by a dark and negative aura: having a personality disorder was equated to being untreatable. Now there was optimism: four psychotherapeutic treatments had proven to be effective; psychotherapy is the main treatment for people with personality disorder and it brought together schools of very different theoretical orientations. Despite this optimism there were still doubts in the following areas: doubts on how firm the evidence on these four psychotherapies really was … and still is; doubts regarding the patients that weren't included in the guideline but needed care in daily practice and doubts that the Dutch MDG paid almost no attention to psychiatric management (for instance). Probably the most troubling doubt arose from a survey: researchers found that only 23% of all the people in treatment for a personality disorder actually had psychotherapy (Hermens et al. 2011).[1] One of the explanations was that most of the mental health institutions lacked the necessary psychotherapeutic expertise to put the guideline into practice.

The problem and a solution

Though the treatment of people with a personality disorder seemed to be well established, apparently there was too selective a focus on specialist psychotherapy. A lot of clients do not get specialist psychotherapy but Treatment as usual (TAU). We know TAU is of a variable nature and quality and that TAU has a considerable drop-out rate. So what we (Expertise Center Personality Disorders, ECPD, in The Netherlands) looked for was a program that integrated the following: all kinds of care that are needed to treat people with a personality disorder—psychotherapy, psychiatric management, crisis management, pharmacotherapy, vocational therapy etc and generally accepted common characteristics of effective treatments. That has become what we now call the Guideline Based Treatment (GBT). The ECPD developed it in close cooperation with representatives of twelve general mental health institutes and representatives of clients and families. The GBT is very much in line with (and is partly based on) Anthony Bateman's Structured Clinical Management (SCM) and John Gunderson's Good Psychiatric Management (GPM) – both these treatments are shown to be effective – and the ideas of Andrew Chanen and John Clarkin on effective treatment for personality disorders in general.

Guideline Based Treatment

A selection of the recommendations of the GBT will be presented in this newsletter. The GBT is broken down into four elements: General Principles for Treatment, Basic Attitude, General Treatment Strategies and Specific Treatment Strategies. The first three elements apply to all clinicians working in the personality disorder program in general mental health settings. Given the importance of an appropriate treatment environment and therapeutic frame for a successful treatment, the majority of the recommendations concern the creation of a consistent and comprehensive treatment environment with continuity of care. Next to these basic elements of care, specific interventions are added to specifically address the complaints of the patient.

[1] Hermens ML, van Splunteren PT, van den Bosch A, Verheul R. (2011). Barriers to implementing the clinical guideline on borderline personality disorder in the Netherlands. Psychiatr. Serv. 2011 Nov; 62

General principles for treatment

Most of these principles have been established as factors that are linked to treatment success:

- The treatment is structured (setting, appointments, availability of therapist, agreement on who is doing what, etcetera)
- The treatment is integrated (integration of necessary services and common factors)
- The treatment is consistent (general vision, handling of incidents, team members share vision on every treatment)
- Basic attitude of willingness to cooperate with the client
- Individually tailored treatment
- Treatment is goal oriented
- Treatment is active and if necessary outreaching
- Treatment focuses on motivation
- Treatment has an active focus on crisis management
- Treatment focuses on the therapeutic relationship
- Treatment focuses on reflection
- Treatment involves family and friends in the treatment
- Continuity of care (coordination of elements in the treatment, continuity of clinicians)
- Treatment mostly takes place in a team with clear leadership and mutual support and reflection of its members
- The organization shares the vision of the team and the clinicians and offers support to and reflection of the team.

Clinicians working with people with a personality disorder should display the following basic attitudes:

- Welcoming, enthusiastic and optimistic
- Organizations and clinicians should be mutually supportive
- Motivated to work with these clients
- Not knowing, curious, respectful, warm, authentic, flexible, willing to find the balance between validation and confrontation and supportive
- Engaging the client in an active role
- Monitoring the quality of the therapeutic alliance, display sensitivity to problems in the relationship and willing to repair break ups. Being able to maintain a positive attitude even when disliking the client
- Active, not remotely observing and reflecting
- Focusing on the consequences of the disorder for client's daily activities
- Plan therapy sessions on fixed moments
- Monitoring comments of the client on the treatment and the therapeutic alliance

General treatment strategies

Treatment strategies should be fixed elements of every treatment of a client with a personality disorder. These strategies represent steps in the process of care, which might overlap.

STEP 1: Entry

In the Netherlands most patients enter mental health institutions through the 'front door': a generalist intake setting. There is a substantial drop out of treatment during the intake. Basic attitude principles should be implemented in this 'front door'. Changes of therapist should be prevented and general principles maintained.

STEP 2: Comprehensive assessment

Not only classification of the disorder but also assessment of severity, functional deficits, risk,

social environment, status of work, course of the disorder, treatment history and biographical data

STEP 3: Diagnose and psycho-education

Clinician, client and relatives collate the complaints of the client and relatives as well as the symptoms of the disorder, so all parties understand how symptoms lead to problems in daily living. The clinician explains what treatment can do. He has an optimistic attitude

STEP 4: Treatment plan with hierarchy of treatment goals

Treatment goals are formulated SMART. Symptoms are coupled to repetitive patterns of disadaptive behaviors. In the treatment plan goals are prioritized, the interventions are described, there is a description of 'who is doing what' and of the evaluation of the treatment (moments, measures etc). All on basis of mutual agreement

STEP 5: Crisisplan and enduring monitoring and managing risks

The plan is put in explicit, operational terms (phases of crisis, signs, intervention, who is doing what, assessment of results). After every crisis the plan is evaluated and if necessary adjusted. Implications for the treatment plan are monitored. Risks are monitored permanently and addressed if necessary

STEP 6: Engaging and motivating client

Key concepts are: cooperation, validation, being involved, being available, giving actual support (e.g. help to write letters to official agencies), generating hope, involving relatives from the start, starting with small accessible goals, not trying to convince or confront prematurely, outreach in case of drop out. All on basis of mutual agreement

STEP 7: Evaluate and adjust treatment plan with all who are involved

Standard measures to monitor treatment progress are recommended. In case of treatment stagnations, reasons are analyzed. If necessary the treatment plan is adjusted

STEP 8: Monitoring therapeutic relationship and repairing

There is a constant focus on the quality of the therapeutic relationship. Ruptures in the bond are repaired before continuing therapy. In fact, repairing is therapy

STEP 9: End treatment/referral/goodbye/reductions in sessions

Take time to introduce changes in the therapeutic contact. Explain it, discuss it, and give the client time to adjust to it

Specific treatment strategies

The fourth element is a specific strategy to treat the complaints and symptoms of the patient. In fact it does not matter too much which one to choose as long as it is a well described intervention that is generally accepted as being appropriate and as long as it is executed systematically with fixed points of evaluation. In the IGT we gave the example of a problem solving module as the specific treatment strategy.

To conclude:

The GBT is not meant to replace the 'Big 4', as was suggested and feared by many psychotherapists in the Netherlands. With the GBT and a program for implementing audits in contributing institutions, we hope to improve TAU in general mental health settings in the Netherlands, to diminish drop out of treatment and to make the "Big 4" more accessible.

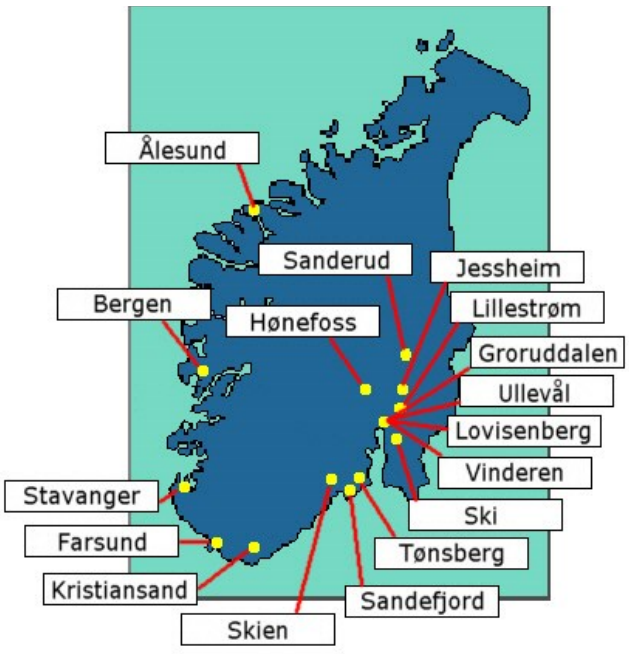
Dr Ad Kaasenbrood, MD PhD, Expert Center for Personality Disorders
Postbox 725, 3500 AS Utrecht, The Netherlands Email: akaasenbrood@trimbos.nl

The Norwegian network of personality-focused treatment programmes
by Geir Pedersen

Geir Pedersen

In 1992 the leaders of a number of treatment units came together and established the *Norwegian Network of Psychotherapeutic Day Hospitals* (Karterud, Pedersen et al., 1998). Their primary motivation was that the units were treating patients with comparable problems (Personality disorders) by comparable therapeutic interventions (Group therapy). Their main challenge was to measure and document treatment effects, since none of these relatively small units was able, within a reasonable time-frame, to collect a representative sample of patients powerful enough to answer such questions scientifically. The nucleus of the co-operation should be a system with schemata, tests and procedures woven together by a software program which had to be developed specifically for this purpose. After a period of domain and system specification, it was worked out a consensus about common basic routines and assessment procedures, as well as a user friendly computer system reflecting those basic elements.

Today the Network is called *The Norwegian Network of Personality-Focused Treatment Programs*, of which nineteen units in southern part of Norway are members, treating approximately 600 patients a year. The advantages and gains of this clinical and research cooperation is undisputable, both at an individual clinical level (Urnes et al., 1998), on ward level (Karterud, Wilberg, et al., 1998), and at a general health care level (Wilberg et al., 1998). Research on data from this collaboration has been comprehensive, both with respect to the understanding and treatment of patients with personality disorders (Karterud et al., 2003; Wilberg et al., 2003; Karterud & Pedersen, 2004, Kvarstein et al., 2014), the relationship between staff related variables and patient outcome (Halsteinli et al., 2008) and to an extensive psychometric research on several assessment instruments.



Visit www.dagbehandlingsnettverk.no/dninfo/dnpublik.htm for a complete list of publications

On a regular basis, all members of the Network send their anonymous data to the general manager of the Network for quality controls. Then, each unit receives a standardized report of their annual activity, with comparisons to former years. In addition to treatment durations, treatment incidents, drop-out rates and diagnostic frequencies, the reports describe patient characteristics such as levels on different areas of distress, patient satisfaction, and treatment outcome on several self- and observer reported clinical variables. Furthermore, the anonymous data from all units are merged into a large database. By this, the Network has a central database for clinical and psychometric research, continuously increasing in number of patients. Today this database counts thoroughly assessed clinical information from approximately 8000 patients.

The Norwegian network of personality-focused treatment programmes
by Geir Pedersen

In accordance with the view of Maurish (2000) the core philosophy of the Norwegian Network is that all activities and implementations are user-driven and that research and clinical interests are balanced. For many years, different courses in assessment and quality assurance are held repeatedly at each treatment unit. The computer system is easy to operate and clearly visualizes the clinical routines. It has functions for quick access to graphical presentation of individual test results, both at specific time sets as well as for longitudinal profiles.

Financially, the Network is a 'Dutch treat', with an annual fee of 4.640 EUR, covering partly the expenses for the Networks' general manager whose responsibility is in the field of coordinating the assessment routines, system engineering and research. He holds tight connection with the units by phone and mail and performs multiple and regular site visits to calibrate practical routines. Every six months, the leaders from each treatment unit meet to discuss current clinical challenges and interests, and once a year all units meets at a full day clinical conference, where the latest clinical findings or other relevant topics are presented.

During the last two decades the Norwegian Network has grown to be an honourable institution by its focus on quality assurance, the exchange of clinical knowledge cross- and between a large number of clinical units, and by building bridges between clinicians and researchers. It has enhanced the daily clinical routines with its focus on validity and reliability of assessment tools, and by this, generated one of the largest clinical databases of patients with personality disorders in the world.

By its nature the Norwegian Network has great potentials. In relatively short time it can give answers to important research questions related to specific disorders, treatment programs, or assessment methods and instruments.

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Geir Pedersen, PhD
General Manager / Senior Researcher, Oslo University Hospital - Ullevaal, Division of Mental Health and Addiction, Department for Personality Psychiatry, Oslo, Norway
E-mail: geir.pedersen@medisin.uio.no
Web: http://www.dagbehandlingsnettverk.no/

Theresa Wilberg

Newsletter Submissions

Submissions to the *ESSPD Newsletter* are accepted on an ongoing basis. Subject areas may include issues from clinical practice, views and comments on current development within PD, reports from affiliated societies, member information, national and international events and conferences, research updates on personality disorders and more.

We are interested in submissions from practitioners and researchers from within and outside of Europe. The length of submissions should be from 300-800 words and formatted in Word. We suggest that the authors limit their use of references. Please enclose author photos with the all text.

Submissions should be emailed to Theresa Wilberg at:
uxthwi@ous-hf.no