Summary S3 Guideline: Diagnostics, therapy and rehabilitation of patients with severe impairment of personality functioning (LL-SBPF)

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The S3 guideline "Diagnostics, therapy and rehabilitation of patients with severe impairment of personality functions" was developed under the auspices of the DGPT. The guideline (LL) on severe impairment of personality functions (SBPF) is abbreviated as "LL-SBPF" below. A total of 33 specialist societies and professional associations were involved in drawing up the guideline and reaching a consensus. A list of all professional societies in German and English can be found in the guideline report (Table 50).

Table 1: Participating professional societies and mandate holders

	Professional society	**Mandate holders**
Arbeitsgemeinschaft Psychodynamischer Professorinnen und Professoren	Arbeitsgemeinschaft Psychodynamischer Professorinnen und Professoren e.V.	Prof Dr Susanne Singer, Deputy: Prof Dr Cord Benecke
BAG KT Bundesarbeitsgemeinschaft Künstlerische Therapien	Bundesarbeitsgemeinschaft Künstlerische Therapien e.V.	Cornelia Schumacher
BPtK	Bundespsychotherapeutenkammer	Dr Dietrich Munz, Dr Alessa Jansen, Dr Tina Wessels
familien selbsthilfe psychiatrie Bundesverband der Angehörigen psychisch erkrankter Menschen e.V.	Bundesverband der Angehörigen psychisch erkrankter Menschen e.V.	Kaveh Tarbiat
bvvp BUNDESVERBAND DER VERTRAGSPSYCHOTHERAPEUTEN E.V.	Bundesverband der Vertragspsychotherapeuten e.V.	Dipl.-Psych. Benedikt Waldherr
Bpω	Bundesverband Psychiatrie-Erfahrener e.V.	Jurand Daszkowski
DDPP Dachverband Deutschsprachiger PsychosenPsychotherapie e.V.	Dachverband deutschsprachiger PsychosenPsychotherapie e.V.	PD Dr Christiane Montag, Deputy: Prof Dr Dorothea von Haebler
Deutsche Arbeitsgemeinschaft Selbsthilfegruppen e.V.	Deutsche Arbeitsgemeinschaft Selbsthilfegruppen e.V.	Dipl.-Psych. Jürgen Matzat

Deutsche Ärztliche Gesellschaft für Verhaltenstherapie e.V.	Prof Dr Claas-Hinrich Lammers
Deutsche Fachgesellschaft für Psychiatrische Pflege e.V.	Jacqueline Rixe, M.Sc.
Deutsche Fachgesellschaft für tiefenpsychologisch fundierte Psychotherapie/Psychodynamische Psychotherapie e.V.	Dr Christian Dürich, Deputy: Prof Dr Klaus Michael Reininger
Deutsche Gesellschaft für Allgemeinmedizin und Familienmedizin e.V.	Olaf Reddemann, Deputy: Dr Thomas Steger
Deutsche Gesellschaft für Klinische Psychotherapie, Prävention und Psychosomatische Rehabilitation e.V.	Dr Wolfgang Kupsch, Deputy: Ute Engelhardt
Deutsche Gesellschaft für Medizinische Psychologie e.V.	Prof Dr Gabriele Helga Franke
Deutsche Gesellschaft für Pflegewissenschaft e.V.	Prof Dr Sabine Weißflog
Deutsche Gesellschaft für Psychiatrie und Psychotherapie, Psychosomatik und Nervenheilkunde e. V.	Prof Dr Sabine C. Herpertz, Deputy: Dr Hauke Felix Wiegand
Deutsche Gesellschaft für Psychoanalyse, Psychotherapie, Psychosomatik und Tiefenpsychologie e.V.	Dipl.-Psych. Georg Schäfer, Prof Dr Susanne Hörz-Sagstetter
Deutsche Gesellschaft für Psychologie e.V., Fachgruppe Klinische Psychologie und Psychotherapie	Prof Dr Katja Wingenfeld
Deutsche Gesellschaft für Psychosomatische Medizin und Ärztliche Psychotherapie e.V.	Prof Dr Johannes Kruse

	Deutsche Gesellschaft für Rehabilitationswissenschaften e.V.	Prof Dr Beate Muschalla
	Deutsche Gesellschaft für Sexualmedizin, Sexualtherapie und Sexualwissenschaft e.V.	Prof Dr Stefan Siegel
	Deutsche Gesellschaft für Soziale Arbeit e.V.	Prof Dr Dieter Röh, Deputy: Karsten Giertz
	Deutsche Gesellschaft für Suizidprävention e.V.	Prof Reinhard Lindner
	Deutsche Gesellschaft für Verhaltensmedizin und Verhaltensmodifikation e.V.	Prof Dr Thomas Kubiak
	Deutsche Psychoanalytische Gesellschaft e.V.	Prof Dr Cord Benecke
	Deutsche Psychoanalytische Vereinigung e.V.	Prof Dr Wolfgang Milch
	Deutsche Psychotherapeuten Vereinigung e.V.	Prof Dr Klaus Michael Reininger
	Deutsche Vereinigung für Soziale Arbeit im Gesundheitswesen e.V.	Prof Dr Judith Ommert, Deputy: Claudia Welk
	Deutscher Fachverband für Verhaltenstherapie e.V.	Dr Judith Siegl, Deputy: Dr Eva Fassbinder
	Deutscher Verband Ergotherapie e.V.	Hannah Eversmann, Deputy: Claudia Engel-Diouf
	Deutsches Kollegium für Psychosomatische Medizin e.V.	Prof Dr Carsten Spitzer
	Gesellschaft zur Erforschung und Therapie von Persönlichkeitsstörungen e.V.	Dr Birger Dulz, Deputy: Prof Dr Klaus Michael Reininger

SYSTEMISCHE GESELLSCHAFT	Systemische Gesellschaft – Deutscher Verband für systemische Forschung, Therapie, Supervision und Beratung e.V.	Dr Wolfgang Dillo

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Validity period and updating procedure
The first version of the LL-SBPF is valid from 25.07.2024 until 25.07.2029.
The LL-SBPF is to be updated 5 years after its first implementation.

Special note
Medicine is subject to a continuous development process, so that all information, in particular on diagnostic and therapeutic procedures, can only ever reflect the state of knowledge at the time of printing of the guideline. The recommendations of this guideline were given with the greatest diligence. The users themselves remain responsible for every diagnostic and therapeutic application.
Guidelines of the Scientific Medical Societies are systematically developed aids for doctors and therapists to help them make decisions in specific situations. They are based on the latest scientific findings and proven procedures in practice and ensure greater safety in medicine, but should also take economic aspects into account. These guidelines are not legally binding for doctors and therapists and therefore have neither liability-creating nor liability-releasing effect.
Errors and misprints in the publication of guidelines cannot be completely ruled out, even when the greatest possible care is taken. In addition, guidelines only ever consider abstract risk-benefit potentials. Therefore, the authors, members of the steering groups, experts, members of the consensus group and other persons involved in the guideline development process are not liable for damages resulting from incorrect or omitted diagnostics or treatment in individual cases.

Guideline as a decision-making aid

The LL-SBPF is a systematically developed decision-making aid. It shows the appropriate medical and therapeutic approach to specific health problems within the framework of structured medical care. It is therefore an orientation aid in the sense of suggestions for action and decisions, from which deviations are possible or even necessary in justified cases (Kassenärztliche Bundesvereinigung (KBV) 1997).

The decision whether to follow a particular recommendation must be made on a case by case basis and take into account individual patient variables and available resources (Recommendation Rec (2001)13 of the Council of Europe 2001).

A guideline becomes effective when its recommendations are applied in practice. The applicability of a guideline or its recommendations must be assessed in the respective situation and must be based on the principles of indication, counselling, communicating preferences and participatory decision-making (Arbeitsgemeinschaft der Wissenschaftlichen Medizinischen Fachgesellschaften (AWMF)-Standing Commission Guidelines 2020).

As with other medical guidelines, the LL-SBPF is explicitly *not* a guideline in the sense of a regulation of action or omission that has been agreed to, set out in writing, published by a legally legitimised institution and that is legally binding and whose non-observance entails defined sanctions (Kassenärztliche Bundesvereinigung (KBV) 1997).

Guideline report

The complete guideline development methodology can be found in the guideline report published simultaneously.

The guideline report is available at the following address:
https://register.awmf.org/de/leitlinien/detail/134-001

The guideline management and coordination was carried out in cooperation with the Department of Epidemiology and Health Services Research, Institute of Medical Biometry, Epidemiology and Informatics (IMBEI), University Medical Center of Johannes Gutenberg University Mainz and the Departments of Clinical Psychology and Psychotherapy and of Differential and Personality Psychology, Institute of Psychology, University of Kassel.

Involved in the consensus process:

The guideline was drawn up with the direct involvement of patient representatives: Mr Jurand Daszkowski, Mr Kaveh Tarbiat and Mr Jürgen Matzat were entitled to vote.

Steering group

The steering group was the guideline development committee that set the direction. The group developed and was responsible for formulating and prioritising the key questions that structure this guideline and on the basis of which the recommendations and statements for patients with severe impairment of personality functions were formed. It was therefore essential that representatives from various disciplines and care sectors were involved. Nevertheless, it needed to be small enough to work efficiently. In addition to the guideline coordinator, the methodologist, the leading professional society and the consortium partner Prof Zimmermann (Differential and Personality Psychology, University of Kassel), representatives from psychiatry, psychosomatics, psychotherapy, psychiatric nursing and social work took on this leadership role. The colleagues each belong to different professional societies. The group was made up as follows:

Table 2: Composition of the steering group

Member of the steering group	Responsibility/Expertise
Dipl.-Psych. Georg Schäfer	Leading professional society
Prof Dr Cord Benecke	Guideline coordination
Prof Dr Susanne Singer	Evidence-base, methodology, secretariat
Dipl.-Psych. Jürgen Matzat	Patient perspective
Dr Christian Dürich	Outpatient psychotherapy
Prof Dr Johannes Kruse	Psychosomatic medicine
Prof Dr Johannes Zimmermann	Differential and personality psychology, diagnostics
Prof Dr Claas-Hinrich Lammers	Medical psychotherapy
Prof Dr Sabine Herpertz	Psychiatry and psychotherapy
Dr Hauke Wiegand	Psychiatric care research
Jacqueline Rixe	Psychiatric care
Prof Dr Reinhard Lindner	Social work

Research assistants

Yannik van Haaren, Clinical Psychology and Psychotherapy, Institute of Psychology, University of Kassel;

Deborah Engesser, Department of Epidemiology and Health Services Research, Institute of Medical Biometry, Epidemiology and Informatics (IMBEI), University Medical Center of Johannes Gutenberg University Mainz ;

Eva Klein, Clinical Psychology and Psychotherapy, Institute of Psychology, University of Kassel (during the first 10 months);

Lena Dotzauer, Department of Epidemiology and Health Services Research, Institute of Medical Biometry, Epidemiology and Informatics (IMBEI), University Medical Center of Johannes Gutenberg University Mainz ;

Leon Wendt, Differential and Personality Psychology, Institute of Psychology, University of Kassel.

Monitoring and support by the AWMF

Dr Monika Nothacker and Prof Dr Ina Kopp from the Arbeitsgemeinschaft der Wissenschaftlichen Medizinischen Fachgesellschaften (AWMF) were responsible for advising on the AWMF guidelines and moderating the consensus-building process.

Versions of the guideline

The LL-SBPF is published with the following components:

- Long version: Graduated recommendations and presentation of the evidence base (evidence and further considerations);
- Summary: Overview of the graduated recommendations - the present document;
- Guideline report with evidence tables;
- Patient guideline;
- Two-page summaries for laypersons in the following versions: easy language, Arabic, English, Farsi, French, Hindi, Polish, Russian, Somali, Spanish and Turkish

https://register.awmf.org/de/leitlinien/detail/134-001

Key questions

The steering group developed several key questions that structured the content of the guideline. The key questions were discussed and agreed by the mandate holders. They cover relevant areas of care.

Several working groups (WGs) were formed to deal with the key issues. The participation in the respective WGs is shown in Table 3.

A systematic *de novo* literature search was conducted for the first five key questions; a systematic literature search was conducted at a later date for key questions 9 and 11. For the other key questions, recommendations were formulated based on published AWMF guidelines and meta-analyses as well as individual studies.

Table 3: Working groups and persons involved

With systematic literature research	
Key question	**Members of the working group**
1. Do patients with severe impairment of personality functioning who receive outpatient psychotherapy have a better outcome than those who receive an unspecified control condition?	Deborah Engesser, Lena Dotzauer, Dr Katherine J. Taylor, Prof. Dr Cord Benecke, Yannik van Haaren, Leon Wendt, Prof. Dr Johannes Zimmermann, Prof. Dr Susanne Singer
2. Do patients with severe impairment of personality functioning who receive online interventions without continuous face-to-face medical-therapeutic support have a worse outcome than those who receive an unspecified control condition?	Deborah Engesser, Lena Dotzauer, Dr Katherine J. Taylor, Prof. Dr Cord Benecke, Yannik van Haaren, Leon Wendt, Prof. Dr Johannes Zimmermann, Prof. Dr Susanne Singer
3. Do patients with severe impairment of personality functioning who receive coordinated outpatient and inpatient care have a better outcome than those who receive an unspecified control condition?	Deborah Engesser, Lena Dotzauer, Dr Katherine J. Taylor, Prof. Dr Cord Benecke, Yannik van Haaren, Leon Wendt, Prof. Dr Johannes Zimmermann, Prof. Dr Susanne Singer
4. Do patients with severe impairment of personality functioning who live under one roof in "special forms of housing" have a better outcome than those who receive an unspecified control condition?	Deborah Engesser, Lena Dotzauer, Dr Katherine J. Taylor, Prof Dr Cord Benecke, Yannik van Haaren, Leon Wendt, Prof Dr Johannes Zimmermann, Prof Dr Susanne Singer
5. Do patients with severe impairment of personality functioning who receive outpatient coordinated care have a better outcome than those who receive an unspecified control condition?	Deborah Engesser, Lena Dotzauer, Dr Katherine J. Taylor, Prof Dr Cord Benecke, Yannik van Haaren, Leon Wendt, Prof Dr Johannes Zimmermann, Prof Dr Susanne Singer
9. Do patients with severe impairment of personality functioning who have a fixed reference mental health care professional have a better outcome than those who do not?	Working group leader: Prof Dr Susanne Singer Collaboration: Dr Wolfgang Dillo, Benedikt Waldherr, Prof Dr Wolfgang Milch, Prof Dr Claas-Hinrich Lammers, PD Dr Christiane Montag, Prof Dr Dorothea von Haebler, Jacqueline Rixe
11. Does dimensional diagnostics have an advantage over non-dimensional diagnostics for patients and/or providers (e.g. better doctor-patient	Working group leaders: Prof. Dr Johannes Zimmermann and Leon Wendt, collaboration: Prof. Dr Thomas Kubiak,

communication, greater satisfaction with treatment, reduced experience of stigmatization)?	Prof. Dr Sabine C. Herpertz, Prof. Dr Gabriele Helga Franke, Karsten Giertz

Without systematic literature research	
Key question	**Members of the working group**
6. Do patients with severe impairment of personality functioning who receive outpatient support have a better outcome than those who receive an unspecified control condition? This working group also drew up the chapter 4.1 "Overarching understanding"	Working group leaders: Jacqueline Rixe, and Prof. Dr Sabine Weißflog Collaboration: Cornelia Schumacher, Hannah Eversmann, Prof. Dr Judith Ommert, Karsten Giertz, Claudia Engel-Diouf, Jurand Daszkowski
7. Is psychotherapy with a treatment contract more effective for patients with severe impairment of personality functioning than without a treatment contract?	Working group leader: Prof. Dr Susanne Hörz-Sagstetter Collaboration: Prof. Dr Klaus Michael Reininger, Jurand Daszkowski, Karsten Giertz, Dr Judith Siegl
8. When should patients with severe impairment of personality functioning be admitted as (partial) inpatients?	Working group leaders: Prof. Dr Carsten Spitzer, Hauke Felix Wiegand MD/PhD, Prof. Dr Johannes Kruse Collaboration: Dr Wolfgang Kupsch, Dr Christian Dürich, Prof. Dr Katja Wingenfeld, Dr Eva Fassbinder,
10. Do patients with severe impairment of personality functioning who receive long-term/continuous care from general practitioners have a better outcome than those who do not receive such consultations?	Working group leaders: Olaf Reddemann and Dr Thomas Steger Collaboration: Prof. Dr Beate Muschalla, Prof. Dr Reinhard Lindner, Kaveh Tarbiat
12. Are there indications for psychopharmacological therapy in cases of severe impairment of personality functioning and if so, which ones?	Working group leader: Hauke Felix Wiegand, MD/PhD Collaboration: Dr Christian Dürich

External peer review

To legitimise the guideline to other professions, the guideline could be commented on between 27.05.2024 and 09.06.2024. To this end, the participating professional societies were asked to send the guideline for comment via their mailing lists. The guideline was also published on the AWMF website.

Language rules

The generic feminine plus colon is used. On the one hand, this is intended to emphasise that all people are addressed equally and, on the other hand, to ensure fluent readability.

The guideline also uses the term "relatives" for all people who have a significant connection to the person affected.

The term "practitioner" is used at various points in the guideline. This refers to *all* professional groups who work directly with patients, such as nurses, social workers, psychologists and doctors. We would like to expressly distance ourselves from how this term was used during the National Socialist era.

To the short version

This short version contains an abridged version of the LL-SBPF long version. Among other aspects, the methods section and the evidence tables have been removed. Furthermore, the abridged version focuses on the concept of personality functioning, which is described in the same way as in the long version, and on the individual recommendations. The background texts and a large part of the description of the evidence for the evidence-based recommendations have been abridged or omitted. The long version should therefore be consulted for the complete list of references. The long version and the guideline report can be found here: https://register.awmf.org/de/leitlinien/detail/134-001

The most important recommendations

1.1	Consensus-based recommendation	New
Expert consensus	The bio-psycho-social model on which the ICF is based and the person-centred approach associated with it should form the basis of diagnosis and intervention processes for people with severe impairment of personality functioning for all actors in the health and social services.	
	Literature: WHO Mental Health Report, UN-BRK and SGB IX	
	Consensus strength: 100%	

2.1	Evidence-based recommendation	New
Degree of recommendation: **B**	The diagnosis of severe impairment of personality functioning should be dimensional and not limited to categorical personality disorder diagnoses.	
Quality of the evidence:	Systematic evidence research; Two meta-analyses, five individual studies	
Validity: ⊕⊕⊕⊕ Reliability: ⊕⊕⊕⊕ Clinical usefulness ⊕⊕⊖⊖⊖	Haslam et al. (2020) Markon et al. (2011) Weekers et al. (2023) Wendt et al. (2024b) Zimmermann et al. (2023), therein: Buer Christensen et al. (2020) Morey et al. (2013) Morey et al. (2014)	
	Consensus strength: 100%	

3.5	Consensus-based statement	New
Expert consensus	Patients with severe impairment of personality functioning usually require longer and sufficiently highly frequent psychotherapeutic treatment.	
	Literature: cf. S3 Guideline Borderline Personality Disorder; NICE, 2009; Kool et al. 2018; Bruijniks et al. 2020; Bone et al. 2021; Woll and Schönbrodt 2020; Shefler et al. 2023	

	Consensus strength: 100%

5.2	Consensus-based recommendation	New
Expert consensus	If patients with severe impairment of personality functioning receive both outpatient and inpatient care, this care should be coordinated, taking into account the wishes of the patient and, if applicable, their relatives.	
	Consensus strength: 100%	

7.4	Evidence-based recommendation	New
Degree of recommendation: **B**	If multi-professional outpatient treatment is required, this should be coordinated by a person involved in this treatment.	
Quality of the evidence:	Systematic literature research, two meta-analyses:	
Mental quality of life: ⊕⊕⊖⊖ Functioning st: ⊕⊕⊕⊖ Functioning mt: ⊕⊕⊖⊖ Functioning according to ⊕⊕⊕⊖ Employment status mt: ⊕⊕⊖⊖ Employment status according to ⊕⊕⊖⊖	Lim et al. (2022) Dieterich et al. (2017) Dieterich et al. (2017) Dieterich et al. (2017) Dieterich et al. (2017) Dieterich et al. (2017)	
	Consensus strength: 96%	

The quality of the evidence was assessed for psychosocial functioning and employment status according to time periods, st - short term, mt - medium term, lt - long term

8.2	Evidence-based recommendation	New
Degree of recommendation: **A**	As part of the diagnosis and treatment of patients with severe impairment of personality functioning, a sustainable therapeutic relationship should be established. For people with severe impairment of personality functioning, this should be seen as the basis for all further therapy steps, and, depending on the severity of the impairment of personality functioning, even as a treatment goal.	
Quality of the evidence:		
Result of the psychotherapy: ⊕⊕⊕⊖ Change in psychiatric symptoms: ⊕⊕⊕⊖ Change in psychotic symptoms: ⊕⊕⊖⊖ Change in PTSD symptoms: ⊕⊕⊕⊖	Formulation originally based on: S3 Guideline on the Diagnosis and Treatment of Eating Disorders [there Expert Consensus, recommendation 3, p.59; "psychotherapy" changed to "therapy". Added as basis of therapy and as therapy goal]. Subsequently de novo research of meta-analyses.	

Relevance trusting and long-term relationship: ⊕⊕⊕⊕	New literature: Flückiger et al. (2018); Bourke et al. (2021); Browne et al. (2021); Howard et al. (2022); Haw et al. (2023)
	Consensus strength: 100%

9.7	Consensus-based recommendation	New
Expert consensus	Trialogue cooperation between patients with severe impairment of personality functioning, their relatives and professionals should be offered. The trialogue aspect should be taken into account in professional training and seminars, e.g. through the direct participation of those affected and their relatives. Trialogue forums should be offered to patients with severe impairment of personality functioning and their relatives.	
	Literature: S3 Guideline Diagnostics and Therapy of Bipolar Disorders; S3 Guideline Psychosocial Therapies for Severe Mental Illnesses	
	Consensus strength: 100%	

10.1	Consensus-based recommendation	New
Expert consensus	Patients with severe impairment of personality functioning should be offered a specific treatment contract as part of psychotherapy.	
	Consensus strength: 100%	

11.1	Consensus-based recommendation	New
Expert consensus	If severe impairment of personality functioning is present, inpatient or day-care treatment may be appropriate for diagnostic and/or therapeutic reasons. The principle of outpatient treatment before partial inpatient treatment before full inpatient treatment should be followed while maintaining participatory decision-making. When determining the indication for hospital treatment, it should be carefully examined together whether the desired therapeutic goals are in line with the respective treatment options of the institution. Hospitalisation should be carried out in accordance with the Table 6 listed in Table 6 or in an emergency.	
	Literature: S3 Guideline National Care Guideline Unipolar Depression; S3-Guideline Schizophrenia; S3 Guideline Obsessive-Compulsive Disorder; S3-Guideline Diagnostics and Therapy of Bipolar Disorders; S3-Guideline Borderline Personality Disorder; S3 Guideline Psychosocial Therapies for Severe Mental Illnesses; S3-Guideline Diagnostics and Treatment of Eating Disorders; S3-Guideline Functional Body Complaints; S2k Guideline Emergency Psychiatry; S3-Guideline Posttraumatic Stress Disorders	
	Consensus strength: 100%	

12.1	Consensus-based recommendation	New
Expert consensus	Patients with severe impairment of personality functioning should be recommended continuous long-term monitoring by a general practitioner (GP). The treatment of patients with severe impairment of personality functioning should be carried out cooperatively with the involvement of long-term support from the GP. The conscious, reliable, active and structuring organisation of the patient-doctor and patient-treatment team relationship is a decisive factor in the long-term care of patients with severe impairment of personality functioning. This should be addressed in GP research, further education and training.	
	Consensus strength: 100%	

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List of abbreviations

Abbreviation	Explanation
AMPD	Alternative Model of Personality Disorder
AWMF	Arbeitsgemeinschaft der Wissenschaftlichen Medizinischen Fachgesellschaften
BPF	Impairment of personality functions
BPS	Borderline personality disorder
DBT	Dialectical-behavioural therapy
DSM	Diagnostic and Statistical Manual of Mental Disorders
EK	Expert consensus
EUTB	Supplementary independent participation counselling
GAF	Global Assessment of Functioning
G-BA	Joint Federal Committee
GP	General practitioner
GRADE	Grading of Recommendations, Assessment, Development and Evaluation
HiTOP	Hierachical Taxonomy of Psychopathology (Hierarchical Taxonomy of Psychopathology)
ICD	International Statistical Classification of Diseases and Related Health Problems
ICF	International Classification of Functioning, Disability and Health
IMBEI	Institute of Medical Biometry, Epidemiology and Informatics
KBV	National Association of Statutory Health Insurance Physicians

KSVPsych-Rl	Directive on interprofessional, coordinated and structured care, especially for seriously mentally ill insured persons with complex psychiatric or psychotherapeutic treatment needs
LL	Guideline
LL-SBPF	Guidelines for the diagnosis, treatment and rehabilitation of patients with severe impairment of personality functioning
LPFS	Level of Personality Functioning Scale
LPFS-BF	Level of Personality Functioning Scale-Brief Form
LPFS-SR	Level of Personality Functioning Scale-Self-Report
lt	Long term
mt	Medium term
NICE	National Institute for Health and Care Excellence
OPD	Operationalised psychodynamic diagnostics
PF	Personality functioning
PICO	Population/patients, Intervention, Comparison (comparison/control group) and Outcome (treatment goal)
PPP DIRECTIVE	Staffing in psychiatry and psychosomatics guideline
SBPF	Severe impairment of personality functioning
SCID-AMPD	Structured Clinical Interview for the Level of Personality Functioning Scale (DSM-5 - Alternative Model for Personality Disorders)
SE	Supported Employment
SGB IX	Ninth Book of the German Social Code - Rehabilitation and participation of people with disabilities
SGB V	Fifth Book of the Social Code - Statutory Health Insurance
SIGN	Scottish Intercollegiate Guidelines Network
st	short term
STiP 5.1	Semi-Structured Interview for Personality Functioning DSM-5 (German: Semistrukturierten Interviews zur Erfassung der DSM-5 Persönlichkeitsfunktionen)
STIPO	Structured Interview on Personality Organisation
TAU	Treatment as usual
UN CRPD	United Nations Convention on the Rights of Persons with Disabilities
WfbM	Workshop for disabled people

1 Introduction

This guideline was developed as a result of financing announcement by the Innovation Committee of the Federal Joint Committee for topic-specific funding of health services research in accordance with Section 92a (2) sentence 4 second alternative of the Fifth Book of the German Social Code (SGB V): Projects for the development or further development of selected medical guidelines for which there is a particular need in healthcare (BAnz AT 12.10.2020 B5). One funded topic area covered the care of people with mental illnesses and complex treatment needs. The guideline **Diagnostics, therapy and rehabilitation of patients with severe impairment of personality functioning (LL-SBPF)**, under the auspices of the Deutschen Gesellschaft für Psychoanalyse, Psychotherapie, Psychosomatik und Tiefenpsychologe e.V. (DGPT), addresses this topic (funding code 01VSF21013). The guideline was also kindly supported by the following professional societies: Deutsche Fachgesellschaft für tiefenpsychologisch fundierte Psychotherapie/Psychodynamische Psychotherapie e.V. (DFT), Gesellschaft zur Erforschung und Therapie von Persönlichkeitsstörungen e.V. (GePs), Deutsche Fachgesellschaft für Psychiatrische Pflege e.V. (DFPP), Deutsche Gesellschaft für Psychiatrie und Psychotherapie, Psychosomatik und Nervenheilkunde e.V. (DGPPN), Deutsche Gesellschaft für Verhaltensmedizin und Verhaltensmodifikation e.V. (DGVM), Deutsche Arbeitsgemeinschaft Selbsthilfegruppen e.V. (DAG SHG), Deutsche Gesellschaft für Suizidprävention e.V. (DGS), Deutsche Gesellschaft für Psychosomatische Medizin und Ärztliche Psychotherapie e.V. (DGPM), Systemische Gesellschaft e.V. (SG), Deutsche Gesellschaft für Allgemeinmedizin und Familienmedizin e.V. (DEGAM), Deutsche Gesellschaft für Soziale Arbeit e.V. (DGSA), Deutsches Kollegium für Psychosomatische Medizin e.V. (DKPM), Deutsche Psychoanalytische Vereinigung e.V. (DPV), Bundespsychotherapeutenkammer (BPtK), Deutsche Gesellschaft für Rehabilitationswissenschaften e.V. (DGRW), Deutsche Gesellschaft für Sexualmedizin, Sexualtherapie und Sexualwissenschaft e.V. (DGSMTW), Deutscher Fachverband für Verhaltenstherapie e.V. (DVT), Deutscher Verband Ergotherapie e.V. (DVE), Deutsche Psychotherapeuten Vereinigung e.V. (DPtV), Deutsche Gesellschaft für Medizinische Psychologie e.V. (DGMP), Deutsche Ärztliche Gesellschaft für Verhaltenstherapie e.V. (DÄVT), Arbeitsgemeinschaft Psychodynamischer Professorinnen und Professoren e.V. (APPP), Deutsche Psychoanalytische Gesellschaft e.V. (DPG), Bundesverband der Vertragspsychotherapeuten e.V. (bvvp), Deutsche Gesellschaft für Klinische Psychotherapie, Prävention und Psychosomatische Rehabilitation e.V. (DGPPR), Deutsche Gesellschaft für Psychologie, Fachgruppe Klinische Psychologie und Psychotherapie e.V. (DGPs), Bundesverband Psychiatrie-Erfahrener e.V. (Bpe), Dachverband deutschsprachiger PsychosenPsychotherapie e.V. (DDPP), Bundesarbeitsgemeinschaft Künstlerische Therapien e.V. (BAG KT), Deutsche Vereinigung für Soziale Arbeit im Gesundheitswesen e.V. (DVSG), Bundesverband der Angehörigen psychisch erkrankter Menschen e.V. (BApK), Deutsche Gesellschaft für Pflegewissenschaft e.V. (DGP).

2 Classification of the LL-SBPF

The *guideline for diagnostics, therapy and rehabilitation of patients with severe impairment of personality functioning (LL-SBPF)* provides recommendations and statements for the diagnostics, therapy and rehabilitation of this patient group.

Firstly, it describes why the care of patients with severe impairment of personality functioning (SBPF) should be improved, before introducing the concept of personality functioning in more detail. The special feature of this guideline is then explained, namely that it does not consider individual disorders, but instead applies an overarching concept. Reference is also made to other

guidelines and a case study is given. This is followed by the recommendations and statements corresponding to the key questions. Contextual information is also provided in the background texts.

2.1 Aim of the guideline

The LL-SBPF was developed to improve the care of people with mental illness and complex treatment needs. The guideline focusses on the group of affected persons whose mental illness and complex treatment needs are based on or accompanied by severe impairment of personality functioning (SBPF). The guideline is intended to contribute to the care of this group of people by providing recommendations and statements that specifically concern the improvement of the quality and efficiency of care, the elimination of care deficits in statutory health insurance and the special proximity to practical patient care. The guideline is intended to strengthen the patient population and promote patient empowerment.

The objectives of improved care can be divided into three areas:

1. *Patient-orientation*: Access to psychiatric, psychotherapeutic and psychosocial care should be adapted to the specific impairments of personality functioning, improved, and participation in social life (employment, social activities) facilitated. Patients and relatives should be informed about the treatment options available and encouraged to make use of them (empowerment). The aim is to ensure equitable care by not excluding disadvantaged people from the care they need.
2. *Organisational, procedural and structural innovation:* The diagnosis of personality functioning is intended to improve the recognition of care needs and address them at an early stage. Problems in the care process (e.g. due to breaks at sector boundaries, access barriers, incorrect treatment) are to be identified and coordinating solutions developed. In particular, this includes recommendations for the implementation of coordinated cooperation between the various professional groups and care facilities in sequential treatment. Their implementation often fails because the healthcare system does not take these steps into account on its own initiative across all sectors. The impairment of personality functioning prevents those affected from doing so on their own initiative. Accordingly, the guideline is intended to improve cooperation between the professions. This should also reduce the frequency and duration of inpatient stays.
3. *Improvement of patient-relevant endpoints*: Care tailored to the severity of impairment of personality functioning should improve patient-relevant outcomes (see chapter 4 and chapter 3.1.3 of the guideline report).

2.2 Personality functioning (PF) as a central cross-disorder dimension of the guideline

The LL-SBPF focuses on personality functioning instead of categorical diagnoses. Personality functioning can be described independently of the specific disorder and recorded on a dimensional scale in terms of their impairment.

2.2.1 What is personality functioning?

Personality functioning describes basic mental abilities that are assumed to be necessary for coping with a wide range of internal and external demands (Bender and Skodol 2007; Bender et al. 2011). The concept of personality functioning has a long tradition in psychoanalytic thinking ("ego functions") and has recently been updated for the diagnosis of personality disorders in the DSM-5 and ICD-11. It is assumed that the extent of personality functioning availability is relevant for all mental disorders, as availability or impairment also varies within categorical

diagnostic groups and these variations have implications for treatment planning (e.g. Henkel et al. (e.g. Henkel et al. 2018; Ehrenthal and Benecke 2019).
In the DSM-5, personality functioning is divided into functions of the self (with the areas of *identity* and *self-direction*) and interpersonal relationships (with the areas of *empathy* and *intimacy*). These skill areas are summarised in Table 4 and can be regarded as relatively stable core components of a person's intrapsychic system (Sharp and Wall 2021; Herpertz in preparation). Impairments of personality functioning can be an important cause for the development of mental disorders in the sense of a general risk or vulnerability factor (Bender and Skodol 2007; Bender et al. 2011; Sharp and Wall 2021), but they can also be the result of mental illness. In this respect, impairments in personality functioning are often correlated with the extent of comorbidity or the chronicity of disorders (cf. Zimmermann et al. 2023; Kerber et al. 2024). At the same time, a number of psychotherapy goals are based on the personality functioning (Hutsebaut 2023). Personality functioning is therefore also changeable despite its relative stability.

Table 4: Areas of personality functioning according to the DSM-5

Self:
1. Identity: experience of autonomy of self, with clear boundaries between self and others; stability of self-worth and accuracy of self-assessment; ability to experience and regulate a range of emotions
2. Self-direction: pursuit of coherent and meaningful short- and long-term goals; orientation towards constructive and prosocial standards of behaviour; ability for productive self-reflection
Interpersonal function:
1. Empathy: understanding and recognition of the experiences and motives of others; tolerance of different points of view; understanding the effects of one's own behaviour on others
2. Intimacy: depth and duration of positive relationships with others; desire and ability to be close to others; mutual respect demonstrated in interpersonal behaviour

The LL-SBPF bases its understanding of personality functioning on the operationalisation of the alternative DSM-5 model for personality disorders (alternative model of personality disorder, AMPD; American Psychiatric Association 2013; for the German version see Falkai et al. 2018), which was developed using the "Level of Personality Functioning Scale" (LPFS; Bender et al. 2011) describing personality functioning and its various degrees of impairment. The LPFS is generally considered to be well validated (Zimmermann et al. 2023; see chapter 4.2.2). Personality functioning also forms the central criterion for personality disorders in the ICD-11 (WHO 2022), although the operationalisations of personality functioning in the DSM-5 and ICD-11 are very similar overall (McCabe and Widiger 2020; Oltmanns and Widiger 2019; Bach et al. 2017; Tyrer et al. 2019). On an empirical level, substantial correlations were found between impairments in personality functioning with a variety of theoretically related constructs, such as impairments in mentalisation ability, psychosocial functioning in everyday life, psychodynamic conceptualisations of personality functions, suicidality, maladaptive schemas and low well-being (for a further overview, see Zimmermann et al. 2023).
Personality functioning is primarily used in the DSM-5 and ICD-11 to define personality disorders. At the same time, it is assumed in both systems that the severity continuum described by personality functioning extends beyond the range of personality disorders. Personality functioning can be used, for example, to map impairments below the threshold of disorder severity

(American Psychiatric Association 2013, p. 772) or to assess treatment planning and progression for individuals with other diagnoses (American Psychiatric Association 2013, p. 774).
The LPFS is summarised in abbreviated form in Table 5. The AMPD provides a global rating in which an assessment is made across all four domains. However, it is also possible for the clinician to assess the level of functioning for each domain separately and aggregate the assessments into an overall score (see chapter 4.2.2; Bach and Simonsen 2021 cf. e.g. Zimmermann et al. 2014).

Table 5: Brief description of the stages of the LPFS

No or minor impairments (0)	Slight impairments (1)	Moderate impairments (2)	Severe impairments (3)	Extreme impairments (4)
Clear self-concept and experience of autonomy; stable and positive self-esteem and accurate self-assessment; multifaceted emotional life and ability to regulate emotions	Relatively intact self-concept, which is less clearly delineated under stress; temporarily reduced self-esteem; situationally restricted emotional life	Self-concept excessively centred on others; vulnerable self-esteem with compensatory inflated or reduced self-assessment; strong emotions when self-esteem is threatened	Weakly or very rigidly defined self-concept with little experience of autonomy; fragile self-worth with incoherent, distorted self-assessment; rapid changes in emotions or chronic despair	Lack of self-concept and experience of autonomy; severely distorted or confused self-image; inappropriate, extreme emotions
Reasonable, realistic goal setting; orientation towards appropriate personal standards, as well as experiencing meaning and satisfaction in many areas of life; constructive self-reflection	Conflicting or overly ambitious goals; sometimes exaggerated personal standards that limit the experience of satisfaction in certain situations; relatively intact self-reflection, but with certain overemphasised aspects of self-perception	Objectives determined by others and focussed on the confirmation of others; inappropriate personal standards and lack of authenticity; limited self-reflection	Fundamental difficulties with goal setting; unclear or contradictory personal standards and experience of meaninglessness or threat; significantly limited self-reflection	Incoherent, unrealistic goals; lack of personal standards and lack of idea of personal fulfilment; profoundly impaired self-reflection in which own motives are misjudged
Ability to understand the experience of others in most situations; understanding and tolerance for the views of others, even if they are not shared; awareness of the effect of one's own behaviour on others	Slightly limited ability to understand the experience of others (e.g. attribution of inappropriate expectations); rather reluctant consideration of the views of others; situationally limited awareness of the effect of one's own behaviour on others	Sensitivity to the experience of others only in terms of its relevance to oneself; excessive self-centredness and significantly limited ability to consider alternative perspectives; unrealistic assessment or ignorance of the effect of one's own behaviour on others	Significantly impaired ability to understand the experience of others (with the exception of certain aspects such as vulnerability and suffering); severely threatened by dissenting views; confusion or lack of awareness of the effect of one's own behaviour on others	Pronounced inability to understand the experience of others; inability to perceive or take into account the views of others; confusing or disturbing social interactions
Numerous stable and satisfying relationships; desire for and ability to maintain caring, close and reciprocal relationships; desire for co-operation and mutual benefit and ability to respond flexibly to others	Stable relationships with limitations in terms of depth and perceived satisfaction; inhibitions in relationships when strong emotions or conflicts arise; unrealistic standards make co-operation difficult in some cases and slightly limited ability to respond flexibly to others	Mostly superficial relationships; self-esteem regulation at the expense of relationships and unrealistic expectation of being perfectly understood by others; co-operation primarily sought out of self-interest	Significantly impaired ability to form positive and lasting relationships; fluctuation between fear, rejection and desperate desire for closeness; little reciprocity and failure to cooperate due to experienced offence	Distanced, chaotic, or consistently negative interactions with others; disinterest in relationships or expectation of hurt; lack of reciprocity in interpersonal behaviour

For a more differentiated approach, the LL-SBPF uses a categorisation of impairment of personality functioning with intermediate levels (i.e. 0, 0.5, 1.0, 1.5 ... 3.5, 4.0). The LL-SBPF focuses on persistent, severe and extreme impairment of personality functioning that achieves a score of 2.5 or higher on the LPFS, but not on short-term weakening of the personality functioning, e.g. in the context of acute crises or organically induced impairments.
Since personality functioning describes basic mental abilities that are mapped on a dimensional scale ranging from no to extreme impairment and can be described for all people, the LPFS is suitable for determining a person's psychological vulnerability.

2.3 Special features of a guideline for people with severe impairment of personality functioning

2.3.1 Conceptual categorisation against the background of categorical classification systems

Patients with severe impairment of personality functioning can have a broad spectrum of mental disorders, of which several usually occur simultaneously and which can be characterised by a wide variety of symptoms (Kerber et al. 2024). These comorbidities represent a considerable difficulty in treatment and conceptualisation. It can then be unclear which symptoms and disorders are in the foreground and how they influence each other. Since existing guidelines are usually tailored to specific disorders according to categorical conceptualisations of mental disorders, they can sometimes only provide incomplete guidance for patients with many comorbidities. Of course, this does not exclude the possibility that the respective disorder-specific guidelines should also be taken into account for such comorbidities in order to arrive at an individualised treatment decision.

Personality functioning is suitable for determining a baseline level of psychological functioning. In patients with complex treatment needs, this level of functioning can be seen as an internal cause (in the sense of vulnerability) alongside other causes of mental illness. This provides an explanatory model for the regularly occurring comorbidities and a common starting point for treating them (Kerber et al. 2024). For example, anxiety and impulsive behaviour could be associated with a lack of self-direction. Furthermore, personality functioning can serve as an explanatory model for the heterogeneity within a disorder category. Patients with depression, for example, can exhibit varying degrees of impairment of personality functioning, which can (partially) explain the different manifestations of depression and result in different prognoses.

There can also be major differences between people who have the same level of personality functioning. For example, it can be assumed that a person with severe impairment of personality functioning and *dissociative identity disorder* differs from a person with severe impairment of personality functioning and *antisocial personality disorder* in aspects relevant to treatment. This would be a symptom-led differentiation that can be based on existing disorder-specific guidelines. The personality functioning itself may differ in the example described in that the impairments in the various areas (e.g. identity vs. empathy) are of varying severity.

If differentiation at a symptom level is necessary, the guideline group has decided to do this using HiTOP spectra ("Hierachical Taxonomy of Psychopathology"); Kotov et al. 2017; Kotov et al. 2021; Zimmermann et al. 2024) to be carried out. HiTOP is a quantitatively developed classification system that arranges psychopathological phenomena according to their breadth and correlation in a hierarchical model (https://www.hitop-system.org/). In the HiTOP system, six spectra were identified at a higher level: the *somatoform spectrum*, the *internalising spectrum*, the *spectrum of thought disorders*, the *spectrum of closedness,* the *disinhibited-externalising spectrum* and the *antagonistic-externalising spectrum*. Disorders according to DSM and ICD can also be assigned to these spectra, although only their symptoms in the narrower sense are part of the HiTOP model. The combination of the LPFS with the HiTOP spectra enables clinically relevant differentiations to be made without necessarily having to revert to the categorical disorder categories (Remmers and Zimmermann 2022). For example, treatment recommendations for patients with severe impairment of personality functioning in the internalising spectrum could differ from those for patients with severe impairment of personality functioning in the disinhibited-externalising spectrum.

From a long-term perspective, the present LPFS should help to enable a clinically valid and accurate determination of complex treatment needs in patients with severe impairment of personality functioning and various F diagnoses or 06 diagnoses in ICD-11. With the help of the LPFS, patients can be assessed with regard to their individual level of personality functioning. This gives the diagnosis greater specificity and clarifies the extent of vulnerability. The expert survey conducted as part of the guideline development (Wendt et al. 2024b) also makes it possible to estimate the average expected severity of impairment in personality functioning or the expected proportion of people with severe impairment of personality functioning for various categorical diagnoses. This makes it possible to consider the evidence to date with regard to categorical diagnosis groups from the perspective of personality functioning. In addition, the survey showed that the use of a dimensional scale allows a similarly precise prediction of treatment-relevant variables, such as the necessary treatment intensity, as the use of almost 40 categorical diagnoses. It is also assumed that stigmatisation is lower when dimensional scales are used (Wendt et al. 2024b).
The conceptual basis of LL-SBPF has important implications for future research. For example, it suggests that patients with severe impairment of personality functioning should no longer be excluded from the vast majority of studies on the basis of exclusion criteria, but instead that impairment in personality functioning should be included as a clinically relevant variable in research designs as standard. The contents of the LL-SBPF can also be integrated into the training and further education of doctors, psychotherapists and healthcare professionals in order to teach the diagnosis of personality functioning and their implications for clinical practice.

2.3.2 Reference to other guidelines

Personality functioning has many points in common with areas of other guidelines. How these points were integrated into the guideline is described in Chapter 3.1.2 of the methodological report. The points of commonality were that impairment in personality functioning can be seen as a risk or vulnerability factor for most mental disorders and that certain problems in many disorders can be interpreted in terms of impairment in personality functioning. For example, patients with autism spectrum disorders or disorders from the schizophrenic spectrum regularly have impairments in their ability to empathise. From the recommendations and statements of thematically related AWMF guidelines, guideline mapping (Wendt et al. 2024a) was created, which supported the work in the working groups on key questions 6 - 12. Guideline mapping provides a comprehensive collection of data on points of contact between the key questions of the LL-SBPF and related AWMF guidelines. For the guideline mapping procedure, see the long version of the guideline, Wendt et al. (2024a) and https://doi.org/10.17605/OSF.IO/Q2FKJ.

2.3.3 How does the focus on severe impairment of personality functioning differ from other concepts of severity?

The LPFS describes different degrees of impairment of personality functioning. Personality functioning is conceptualised as *basic mental abilities that* a person can be sure to possess (level 0: no or minor impairment), or that are mildly (level 1), moderately (level 2), severely (level 3) or extremely (level 4) impaired (see above). Impairment of personality functioning can represent a significant *vulnerability* for the development of mental disorders; above a certain level of impairment, this itself is considered to be a medical condition (according to AMPD and ICD-11, a personality disorder may then be present if other general criteria are met). The question of the causal significance of personality functioning for the development of mental disorders

and the operationalisation of the causes of disorders in contrast to the consequences of disorders are two of the central research questions for the future, which require longitudinal study designs. Although the extent of impairment of personality functioning correlates with various other measures of severity (e.g. number of symptoms, level of psychosocial functioning), personality functioning is not congruent with these. Rather, impairment of personality functioning is recognised as a major causal component (in combination with other components) for the development of symptoms and/or a decline in psychosocial functioning (e.g. according to GAF; American Psychiatric Association 1987). For example, the GAF *describes* different degrees of impairment in coping with life/everyday life - the LPFS contributes to a possible *explanation of* these impairments in coping with life/everyday life.
Widiger et al. (2019) hypothesise that personality functioning could represent a general psychopathology factor (p-factor). This could represent the highest level in HiTOP (Widiger et al. 2019) and could be suitable for measuring a person's susceptibility to mental disorders and comorbidities (Caspi and Moffitt 2018; Caspi et al. 2014). However, it is ultimately not clear what exactly constitutes this p-factor, what it does and does not include (Watts et al. 2024).

2.3.4 Case examples of patients with severe impairment of personality functioning

Mrs E. (according to Henkel et al. 2018)
Mrs E. wears her dark hair in two plaits. The patient appears mistrustful and dismissive on contact. The conversation is difficult because the patient remains silent for a long time. She also frequently says that she can't think at the moment or that she doesn't want to talk or think about issues. Fear and hatred are the main affects of the conversation. The latter refers both to herself and to others.
Mrs E. cannot say what is actually bothering her, most likely her life situation, the senselessness and the chaos, whereby it is not clear what she actually means by this. She can only describe herself in one word: "pointless". In the course of the conversation, the suspicion arises that the patient is hurting herself, based on hints that she wants to create states in which she feels herself; however, she does not say this, even when asked. She reports that she finds it difficult to be alone. She cannot do anything with herself then and has to keep herself busy somehow.
The patient's parents divorced 1.5 years after her birth. Her mother remarried and had two children. Her father also started a new family later, but she still visited him regularly. She probably had a good childhood; she sees smiling faces in photos and videos. However, the patient has pronounced amnesia regarding her experiences up to the age of 12, and she wonders whether she is really seeing herself in the photos. She finds it difficult to describe her mother and does not dare to mention negative characteristics because she would be doing her an injustice. Her "fathers" are very different: her stepfather takes care of formalities and is interested in the patient's life, but is emotionally cold and distant. Her biological father showed her through hugs and words that he loved her, but did not really seem to be interested in her life. The patient's descriptions of her childhood give rise to the suspicion of traumatic experiences, particularly because of the pronounced childhood amnesia, but also because of the descriptions that seem less integrated.
With regard to partner relationships, the patient reported an ex-boyfriend (separation 2 weeks before the interview) with whom she had been in an on-off relationship for about two years. At the beginning it had been good and he had been interested in her. Then "it all became too much" for her and she broke it off, followed by a back and forth. It became clear that the "too much" described by the patient was connected to her sexuality as a partner. She had a pronounced fear of intimacy, but did not know why. The patient hated her own body.

Mrs E. exhibits **severe impairment of personality functioning** in almost all areas. In the area of *identity* and self-perception, it is noticeable that the patient fears that expressing her thoughts and fantasies will make them "real". Here, the patient is very uncertain about distinguishing between reality and thoughts. In terms of *self-direction*, she appears to be rather under-controlled, i.e. negative affects trigger strong confusion and can hardly be regulated, resulting in impulse outbursts (e.g. measures to "feel oneself"). In the area of *empathy*, the patient finds it difficult to get in touch with herself, but also with others. *Intimacy* hardly seems possible, and the ability to form positive and lasting attachments is clearly impaired.

Further case studies can be found in the long version of the guideline.

3 Methodological approach

See the long version of the guideline (https://register.awmf.org/de/leitlinien/detail/134-001) for the guideline development procedure, the development of recommendations according to GRADE, the systematic literature search procedure, the consensus process and the methodological review. For the handling of study results that are primarily orientated towards categorical diagnoses and the concept of personality functioning, see also Wendt et al. (2024b).

4 Key questions and recommendations

The guideline group developed key questions, which were commented on by the steering group and then discussed and agreed by the members of the professional societies. A total of 12 key questions were formulated according to the PICO principle (population/patient, intervention, comparison (comparison/control group), outcome (treatment objective)).
The *population* to which the LL-SBPF refers are patients with severe impairment of personality functioning. The *comparison* in the key questions should be directed against an "unspecified control condition". *Unspecified control condition* here means that no specific comparison group was defined. Instead, the study results were reported separately according to the comparison groups present in the studies. However, comparisons with an intervention of the same dose, duration and/or frequency, a pre-post comparison without a control group and comparisons between drug-assisted psychotherapy and psychotherapy without drug support or other drug support were excluded.
Similarly, the unspecified *outcome* means that the study results are reported separately according to the outcomes investigated in the studies.

4.1 Overarching understanding

The recommendations and statements of the LL-SBPF are based on a fundamental understanding, which is presented in the following sections.

4.1.1 Basic biopsychosocial understanding

The bio-psycho-social model on which the ICF (International Classification of Functioning, Disability and Health) is based is regarded as essential. This combines both a medical and a social model, which is particularly important in the area of severe impairment of personality functioning, as this can have a strong impact on both areas and there are interactions. In order to do justice to the bio-psycho-social model, cooperation between various actors in the health and social services is required.

1.1	Consensus-based recommendation	New
Expert consensus	The bio-psycho-social model on which the ICF is based and the person-centred approach associated with it should form the basis of diagnosis and intervention processes for people with severe impairment of personality functioning for all actors in the health and social services.	
	Literature: WHO Mental Health Report, UN CRPD and SGB IX	
	Consensus strength: 100%	

4.1.2 Resilience

Rönnau-Böse et al. (2022) examine research into resilience and protective factors, which began in the 1970s. Resilience, originally from developmental psychopathology and influenced by the salutogenesis model, refers to psychological resilience and healthy development despite adverse circumstances or traumatic events. A distinction is made between chronically adverse circumstances and one-off traumatic events, with different protective factors at work.
Resilience is promoted through personal protective factors (individual life skills) and social protective factors. Flexible self-regulation is considered an important personal protective factor. Hope is an important psychological protective factor, which is according to Snyder and Lopez (2002) characterised by defining goals, ways to achieve them (pathways thinking) and the confidence to achieve these goals (agency thinking) (Shorey et al. 2003). Hope leads to greater professional success and social competence (Snyder and Lopez 2002).
The literature search in March 2023 did not provide any specific evidence in favour of recommending the concept of resilience as a basis for the treatment of people with severe impairment of personality functioning. However, it can be deduced from the study results that a high level of resilience is an important resource in dealing with a mental illness. Strengthening resilience as a resistance can contribute to a positive change in the life situation.

1.2	Consensus-based recommendation	New
Expert consensus	People with severely impaired personality functioning should have their protective and resilience factors strengthened.	
	Consensus strength: 100%	

4.1.3 Recovery

Patricia Deegan and Dan Fischer founded the recovery movement, which defines recovery from mental illness as a self-directed process. Recovery means finding meaning and purpose in life again and includes progress as well as setbacks. Important elements are connection, hope, identity, meaning in life and empowerment. Mental health professionals should provide support without removing the possibility of mistakes. Clinically, recovery means symptom reduction and remission. In German-speaking countries, there are various materials to support recovery.

1.3	Consensus-based recommendation	Modified (status 2018)
Expert consensus	People with severe impairment of personality functioning should be supported in their individual recovery process. This includes interventions that ▪ offer support within the framework of their individual goals and wishes, ▪ strengthen their autonomy and individuality, and ▪ promote inclusion in all areas of life and quality of life. The basis for this lies in a recovery orientation in all areas of care and a common understanding of recovery.	
Guideline adaptation	S3 Guideline Psychosocial Therapies for Severe Mental Illness (Recommendation 2 (p. 55)) See also Leamy et al. (2011); Deegan (1995)	
	Consensus strength: 100%	

4.1.4 Relationship management and participatory decision-making

The quality of the therapeutic relationship is crucial in inpatient, rehabilitative and outpatient settings. The effective component model of Grawe (2000) serves as the basis for psychosocial action in outpatient counselling for people with severe impairment of personality functioning. It includes resource activation, problem-specific and clarification-promoting interventions and the change of motivational schemata, which can have positive effects on the therapeutic relationship and the healing process.

The shared decision making model emphasises an equal, active interaction between patient and therapist based on shared information and communication. Benefits include symptom reduction, improved self-esteem and greater motivation for treatment, although there are barriers to implementation.

Studies show positive effects of participatory decision-making in various disorders, including depression and schizophrenia. However, implementation may be less useful in crisis or emergency situations. Further research supports the strengthening of participatory decision-making, which slightly improves the therapeutic relationship and communication.

1.4	Evidence-based recommendation	New
Degree of recommendation: **B**	Diagnostic, therapeutic and care-related decisions should be made in accordance with the concept of participatory decision-making.	
Quality of the evidence:		
Strengthening the therapeutic relationship: ⊕⊕⊕⊖	Literature: Stovell et al. (2016)	
	Consensus strength: 100%	

4.1.5 Self-management and self-help

Self-help plays an important role in the treatment of people with severe impairment of personality functioning. The benefits of self-help are undisputed. However, there is no standardised understanding or clear terminology for self-help.

1.5	Consensus-based statement	New
Expert consensus	Self-help is now an integral part of the support system for people with severe impairment of personality functioning. It supports self-management skills, promotes the exchange and activation of resources and self-healing powers and helps people to better understand and deal with the illness.	
Guideline adaptation	S3 Guideline Psychosocial Therapies for Severe Mental Illness (Statement 2, p. 64)	
	Consensus strength: 100%	

Note: The statement from the S3-LL Psychosocial therapies for severe mental illnesses (DGPPN 2018, p. 64) was modified to emphasise a better understanding and better management of the illness rather than the acceptance of the illness as originally intended.

Within the framework of self-management and self-help, various services and options have been established, which are presented in the following sub-chapters.

4.1.5.1 Self-regulation and media-supported education

Self-management or self-regulation is understood as the ability to shape one's own development independently and to deal with illness-related limitations. Self-management programmes can help people with severe impairment of personality functioning to cope with these limitations. Media-supported education, such as written guides and internet-based self-help programmes, can be useful in self-help.

1.6	Consensus-based recommendation	New
Expert consensus	Self-management is an important part of coping with an illness and should be intensively supported throughout the entire treatment and care process. Guides and self-help manuals should be independent of interests, easy to understand *(also translated into easy language*) and of high quality.	
	S3 Guideline Psychosocial Therapies for Severe Mental Illness (recommendation 5 and 6 (p. 65f))	
	Consensus strength: 100%	

Note: The recommendation was modified and the term "care" was added in order to include support not only as in recommendation 5 from the S3 guideline Psychosocial therapies for severe mental illness (p. 65) (p. 65) in the area of treatment (in the narrower sense according to SGB V), but also in other areas of care, such as integration assistance according to SGB IX.

4.1.5.2 Self-help groups, self-help organisations and self-help contact points

Self-help groups vary in organisation and size, can be open or closed and can be independent or part of larger self-help organisations such as the Bundesverband Psychiatrie-Erfahrener

(BPE). The BPE offers counselling, e.g. via EUTB offices, and represents members politically. Self-advocacy can make a positive contribution to coping with illness, empowerment and recovery for people with severe impairment of personality functioning. Regional self-help contact centres provide information about self-help groups and support their formation.

1.7	Consensus-based recommendation	New
Expert consensus	Patients with severe impairment of personality functioning should be informed about self-help groups, self-help organisations and self-help contact points and, if desired, supported in making contact.	
Guideline adaptation	S3 guideline Psychosocial Therapies for Severe Mental Illness (Recommendation 8 (p. 71))	
	Consensus strength: 100%	

Note: Recommendation 8 from the S3 guideline Psychosocial therapies for severe mental illnesses was modified, transferred to the target population, the range of contact points for self-help extended and the recommendation slightly reformulated.

4.1.5.3 Peer support experts from experience

The involvement and collaboration of peers as recovery counsellors is also becoming increasingly important in the treatment and care of people with severe impairment of personality functioning. This is reflected, among other things, in the fact that the current PPP guidelines (Psychiatry and Psychosomatics Staffing Guidelines) issued by the Federal Joint Committee in Section 9 (2) recommend the use of recovery counsellors regardless of diagnoses in adult psychiatry and psychosomatics as a quality recommendation (G-BA 2024).
Peer support is also an important response to the promotion of autonomy and participatory decision-making, which is desired by many of those affected and is important for the recovery process, and supports the steps towards user-orientated transformation of psychiatric and psychosocial institutions and services.

1.8	Consensus-based recommendation	New
Expert consensus	People with severe impairment of personality functioning should be offered peer support, taking into account their wishes and preferences, to strengthen the recovery process and encourage active participation in treatment.	
	See also S3 guideline Psychosocial Therapies for Severe Mental Illness (Recommendation 9 (p. 90))	
	Consensus strength: 96%	

4.2 Recommendations based on systematic literature research

Using the definitions described above, the working group in Mainz conducted a systematic literature search for key questions 1-5. The aim was to identify the best available evidence (Blümle et al. 2020). On the advice of the AWMF, key questions 9 and 11 were also systematically researched by the respective working groups following the consensus conference on 14 February 2023. The corresponding evidence tables can be found in chapter 6 and in the guideline report under Chapter 3.1.4.

4.2.1 Findings from qualitative studies as part of the systematic literature review

The systematic literature review identified two qualitative studies that provide insights into how patients with severe impairment of personality functioning experience different interventions such as psychotherapy and community psychiatric care.

Little et al. (2018) investigated how patients with borderline personality disorder experience dialectical behavioural therapy (DBT). Important aspects from the patient's perspective were the therapeutic relationship, self-efficacy and a change of perspective regarding their own self and the future. Therapists who were attentive, non-judgemental and respectful were perceived positively. Group therapy was described as supportive, but also potentially overwhelming. Obstacles according to Little et al. (2018) were both the language of DBT, which was described as complex, and the negative effects of behavioural changes on relationships.

Sheridan Rains et al. (2021) examined the experiences of patients with personality disorders in community psychiatric services. Important aspects were the long-term perspective, individualised and holistic treatment, access and quality of services. Patients wanted continuous, understandable and competent care. The therapeutic relationship was considered to be of central importance; therapists should be trusting, open, honest and empathetic. The diagnosis of personality disorder was sometimes perceived as stigmatising and sometimes helpful for specialised treatments.

These findings should be taken into account for implementation in the German healthcare system. Important aspects are a good therapeutic relationship, appreciation and orientation in life and in the healthcare system.

4.2.2 Key question 11: Does dimensional diagnostics have an advantage over non-dimensional diagnostics for patients and/or providers (e.g. better doctor-patient communication, greater satisfaction with treatment, less experience of stigmatisation)?

Empirical studies show that mental disorders are usually distributed continuously, with no clear distinction between those affected and those not affected (Haslam et al. 2020). For example, the symptoms of personality disorders show distributions that are better aligned with a dimensional understanding of the underlying differences (Ahmed et al. 2013; Aslinger et al. 2018; Conway et al. 2012). Categorical diagnoses can lead to arbitrary categorisations, impaired reliability and validity and reduce the information value, especially for treatment-relevant variables (Clark et al. 2017; Markon et al. 2011; Wendt et al. 2019). Clinical usefulness is also a decisive factor. There are positive assessments regarding the clinical usefulness of LPFS instruments (Bach and Tracy 2022; Hopwood 2018; Milinkovic and Tiliopoulos 2020).

The following instruments for recording the LPFS are available in German:

- Scale for assessing the level of personality functioning: Included in the German DSM-5 edition (Falkai et al. 2018).
- STiP-5.1: German translation available (Hutsebaut et al. 2017; Zettl et al. 2020).
- SCID-AMPD Module 1: German translation available (Bender et al. 2018; Hörz-Sagstetter et al. 2024).
- LPFS-BF: German short forms available (Spitzer et al. 2021; Zimmermann et al. 2020).

2.1	Evidence-based recommendation	New
Degree of recommendation: **B**	The diagnosis of impairments of personality functioning should be dimensional and not limited to categorical personality disorder diagnoses.	

Quality of the evidence:	Systematic evidence research; Two meta-analyses, five individual studies:
Validity: ⊕⊕⊕⊕ Reliability: ⊕⊕⊕⊕ Clinical usefulness ⊕⊕⊖⊖⊖	Haslam et al. (2020) Markon et al. (2011) Weekers et al. (2023) Wendt et al. (2024b) Zimmermann et al. (2023), therein: Buer Christensen et al. (2020) Morey et al. (2013) Morey et al. (2014)
	Consensus strength: 100%

2.2	Evidence-based recommendation	New
Degree of recommendation: **B**	The severity of impairment of personality functioning should be assessed using the LPFS with appropriate clinical interviews. 1) For this purpose, specially developed structured interviews should be used, for example the *Structured Clinical Interview for the Alternative DSM-5 Model for Personality Disorders Module I* (SCID-5-AMPD-I) or the *Semistructured Interview for the Assessment of DSM-5 PF (STiP-5.1)*. 2) Alternatively, interviews that focus on very similar psychodynamic constructs of structural level or personality organisation can be used, for example the *OPD interview* or the *Structured Interview on Personality Organisation* (STIPO).	
Quality of the evidence:	Systematic evidence research; Two meta-analyses, five narrative reviews:	
Validity: ⊕⊕⊕⊖ Reliability: ⊕⊕⊕⊖ Clinical usefulness ⊕⊕⊖⊖⊖	Birkhölzer et al. (2021) Hörz-Sagstetter et al. (2021) Morey et al. (2022) Sharp and Wall (2021) Young and Beazley (2023) Zimmermann et al. (2023)	
	Consensus strength: 100%	

2.3	Evidence-based recommendation	New
Degree of recommendation: **0**	Specially developed self-report questionnaires can be used for screening purposes, for example the German version of the *Level of Personality Functioning Scale-Self-Report* (LPFS-SR) or the *Level of Personality Functioning Scale-Brief Form* (LPFS- BF 2.0). Established instruments for closely related constructs such as the OPD structure questionnaire can also be used.	
Quality of the evidence:	Systematic evidence research; Five narrative reviews:	

Validity: ⊕⊕⊕⊖ Reliability: ⊕⊕⊕⊖ Clinical usefulness ⊕⊕⊖⊖⊖	Birkhölzer et al. (2021) Hörz-Sagstetter et al. (2021) Morey et al. (2022) Sharp and Wall (2021) Zimmermann et al. (2023)
	Consensus strength: 100%

What special requirements are there in the diagnostics of certain groups of people?
The diagnosis of certain groups of people requires the consideration of characteristics such as age, gender, sexual orientation and cultural background, as they can influence the measurements. So far, no biases due to cultural differences or gender have been found in the LPFS-BF 2.0 (Natoli et al. 2022; Le Corff et al. 2022).
However, data on measurement invariance for age groups, cognitive abilities and the influence of sociocultural background are still lacking. In related tests such as the PID-5, LGBTQ+ people show deviating results, possibly due to their often more difficult life circumstances. This emphasises the importance of contextualising individual circumstances when interpreting test results.

What research gaps are there?
See long version.

4.2.3 Key question 1: Do patients with severe impairment of personality functioning who receive outpatient psychotherapy have a better outcome than those who receive an unspecified control condition?

It is generally recognised that outpatient psychotherapy is effective for many mental illnesses. However, no meta-analyses are yet available on the effectiveness for patients with severe impairment of personality functioning. Accordingly, meta-analyses were sought for disorder categories in which severe impairment of personality functioning can be assumed and whether outpatient psychotherapy can be described as effective for this patient group.

Evidence:
The studies on the evidence and the assessment of the outcomes are presented in the long version of the LL-SBPF. The evidence is presented separately by outcome in the recommendations. For example, with regard to the change in symptom severity after intervention in patients with treatment-resistant depression, a distinction is made between a comparison of psychotherapy with treatment as usual (TAU; medication) and psychotherapy in addition to TAU (medication).

3.1	Evidence-based recommendation	New
Degree of recommendation: **B**	Outpatient psychotherapy should be offered to improve disorder-specific symptoms in patients with severe impairment of personality functioning.	
Quality of the evidence:	Systematic literature research; Eleven meta-analyses, one Cochrane Review:	
Disorder-specific symptoms Comparison with treatment as usual		

Diseases from the schizophrenia spectrum	
Auditory hallucinations after intervention: ⊕⊕⊖⊖ Delusions after intervention: ⊕⊖⊖⊖ Delusions after intervention: ⊕⊖⊖⊖ Delusions after 47 weeks: ⊕⊕⊖⊖	Turner et al. (2020) Turner et al. (2020) Mehl et al. (2019) Mehl et al. (2019)
Borderline personality disorder	
Borderline personality disorder symptoms after intervention: ⊕⊖⊖⊖ Para/suicidality after intervention: ⊕⊖⊖⊖	McLaughlin et al. (2019) McLaughlin et al. (2019)
Treatment-resistant depression	
Change in symptom severity after intervention: ⊕⊕⊕⊖ Change in symptom severity after intervention: ⊕⊕⊕⊖ Symptom severity after 12 months: ⊕⊕⊕⊖ Depressive symptoms st: ⊕⊕⊖⊖ Depressive symptoms st: ⊕⊖⊖⊖ Depressive symptoms st: ⊕⊕⊖⊖ Depressive symptoms st: ⊕⊕⊕⊖ Depressive symptoms mt: ⊕⊕⊖⊖	van Bronswijk et al. (2019) van Bronswijk et al. (2019) Li et al. (2018) Ijaz et al. (2018) Ijaz et al. (2018) Ijaz et al. (2018) Ijaz et al. (2018) Ijaz et al. (2018)
<u>Comparison with active control condition</u> *Diseases from the schizophrenia spectrum*	
Auditory hallucinations after intervention: ⊕⊕⊕⊖ Delusions after intervention: ⊕⊖⊖⊖ Delusions after intervention: ⊕⊕⊖⊖ Delusions after 35 weeks: ⊕⊕⊖⊖	Turner et al. (2020) Turner et al. (2020) Mehl et al. (2019) Mehl et al. (2019)

Post-traumatic stress disorder	
Symptom reduction after intervention: ⊕⊖⊖⊖ Symptom reduction after intervention: ⊕⊖⊖⊖ Symptom severity after intervention: ⊕⊕⊖⊖ Symptom severity after intervention: ⊕⊕⊖⊖ Symptom severity after intervention: ⊕⊕⊖⊖ Symptom severity at follow-up: ⊕⊕⊖⊖ Symptom severity at follow-up: ⊕⊖⊖⊖ Symptom severity at follow-up: ⊕⊖⊖⊖ Symptom severity at follow-up: ⊕⊕⊖⊖ Fulfilment of diagnostic criteria after intervention: ⊕⊖⊖⊖	Wei and Chen (2021) Sonis and Cook (2019) Asmundson et al. (2019) Merz et al. (2019) Merz et al. (2019) Asmundson et al. (2019) Merz et al. (2019) Merz et al. (2019) Thompson et al. (2018) Wei and Chen (2021)
Post-traumatic stress disorder and/or depression	
Symptom reduction at follow-up: ⊕⊕⊕⊖	Althobaiti et al. (2020)
<u>Comparison with inactive control condition</u> *Post-traumatic stress disorder*	
Symptom reduction after intervention: ⊕⊖⊖⊖ Symptom severity after intervention: ⊕⊕⊖⊖ Symptom severity at follow-up: ⊕⊕⊖⊖ Fulfilment of diagnostic criteria after intervention: ⊕⊕⊖⊖	Wei and Chen (2021) Asmundson et al. (2019) Asmundson et al. (2019) Wei and Chen (2021)
	Consensus strength: 100%

The quality of the evidence was assessed for depressive symptoms according to time periods, st - short term, mt - medium term

3.2	Evidence-based recommendation	New
Degree of recommendation: **0**	Outpatient psychotherapy can be offered to improve the psychosocial functioning of patients with severe impairment of personality functioning.	
Quality of the evidence:	Systematic literature research; A meta-analysis:	
Psychosocial functioning Comparison with treatment as usual		
Psychosocial functioning after intervention: ⊕⊕⊖⊖	Laws et al. (2018)	
Comparison with active control group		
Psychosocial functioning after intervention: ⊕⊖⊖⊖	Laws et al. (2018)	
	Consensus strength: 100%	

3.3	Evidence-based statement	New
	There is insufficient evidence for a reduction in hospitalisation and emergency admissions by patients with severe impairment of personality functioning after outpatient psychotherapy.	
Quality of the evidence:	Systematic literature research; A meta-analysis:	
Utilisation of the healthcare system Comparison with treatment as usual		
Hospitalisations after intervention: ⊕⊕⊖⊖ Visit the emergency room after intervention: ⊕⊕⊖⊖	McLaughlin et al. (2019) McLaughlin et al. (2019)	
	Consensus strength: 100%	

Conclusion of the evidence for outpatient psychotherapy for patients with SBPF:
Overall, the evidence suggests that outpatient psychotherapy is effective for patients with severe impairment of personality functioning. This evidence is consistent with clinical experience that improvement can be achieved through psychotherapy. However, the effects are often rather low and the quality of the evidence is weak to moderate at best.

Further information:
The recommendation of outpatient psychotherapy leaves open how it should be organised so that patients with severe impairment of personality functioning can benefit from it in the best possible way. This requires studies that explicitly address this question. In the meta-analyses and Cochrane Review on key question 1, isolated analyses were conducted on group therapy

and dose, which are described in the long version. Additional literature shows the following results:

Comparison of group and individual settings:

As patients with severe impairment of personality functioning often have interpersonal problems, group therapies can be beneficial as they can alleviate interpersonal problems (e.g. Rabung et al. 2005). The interpersonal functions of empathy and closeness can be strengthened in a group setting, as this setting can focus on interaction with several other people. Of course, this does not rule out the effectiveness of group therapy for patients without interpersonal problems.

The extent to which group therapy is preferable to individual therapy is not empirically clear (e.g. Arntz et al. 2022). The specific selection of the group setting is also decisive for the effectiveness of group therapy. For example, the effect of a psychoanalytic-interactional group may be different from that of a skills training group as part of DBT.

3.4	Consensus-based recommendation	New
Expert consensus	A group setting can be offered to patients with severe impairment of personality functioning.	
	Literature e.g. Rabung et al. 2005	
	Consensus strength: 90%	

Compare with the treatment dose:

A frequency of two sessions per week appears to be associated with a better outcome (Kool et al. 2018). This finding is also shown in the study by Bruijniks et al. (2020).

For patients with borderline personality disorder, the NICE guidelines recommend no treatment for less than three months and a frequency of two sessions per week (NICE, 2009). The S3 guideline Borderline Personality Disorder states that the frequency should not be less than one session per week and that one third of patients with borderline personality disorder achieve remission after one year, another third require two years and the final third require an even longer period. Different patients were examined in the listed studies and the guideline. If one applies the assumptions according to Wendt et al. (2024b), it can be assumed that personality functioning was at least severely impaired in most of the patients examined.

Based on the above findings, it can be assumed that the treatment of patients with severe impairment of personality functioning also involves longer treatment durations, which can be measured in years rather than months. It can also be assumed that a higher frequency of sessions than once a week can support a positive outcome.

3.5	Consensus-based statement	New
Expert consensus	Patients with severe impairment of personality functioning usually require longer and sufficiently high-frequency psychotherapeutic treatment.	
	Literature: cf. S3 Guideline Borderline Personality Disorder; NICE, 2009; Kool et al. 2018; Bruijniks et al. 2020; Bone et al. 2021; Woll and Schönbrodt 2020; Shefler et al. 2023	
	Consensus strength: 100%	

4.2.4 Key question 2: Do patients with severe impairment of personality functioning who receive online interventions without continuous personal medical-therapeutic support have a worse outcome than those who receive an unspecified control condition?

In the LL-SBPF, online interventions without continuous personal medical-therapeutic support are understood as interventions that are carried out purely computer-based without the involvement of a human being.

Internet-based interventions are often developed to facilitate access to therapy (Griffiths and Christensen 2006; Spek et al. 2007). These can help if easily accessible services or sufficient therapists are not available, or if they have to care for a large number of patients (e.g. Backhaus et al. 2012; Ahern et al. 2018; Spek et al. 2007).

The authors assume that patients with severe impairment of personality functioning often experience internal and external barriers to accessing therapeutic services and that a direct approach is necessary (see also chapter 4.2.8). This can increase motivation for therapy and enable learning through personal contact. If there is no therapeutic counterpart, as can be the case with online interventions, these experiences are not possible and a poorer outcome can be expected than if a therapist is involved. (cf. Simon et al. 2022; Cuijpers et al. 2019).

Evidence:

The studies on the evidence and the evaluation of the outcomes are presented in the long version of the LL-SBPF.

Conclusion of the evidence for online interventions for patients with SBPF:

4.1	Evidence-based statement	New
	The data situation does not allow a clear recommendation for or against online interventions without continuous personal medical-therapeutic support for patients with severe impairment of personality functioning.	
Quality of the evidence:	Systematic literature research; two randomised controlled trials, one cluster-randomised controlled trial:	
Psychosocial functioning: ⊕⊖⊖⊖ Health anxiety: ⊕⊕⊖⊖⊖ Symptom severity of the depression: ⊕⊕⊖⊖ Frequency of suicidal behaviour: ⊕⊖⊖⊖⊖ Health-related quality of life: ⊕⊕⊖⊖⊖	Hedman et al. (2016) Hedman et al. (2016) Adu et al. (2023) Rodante et al. (2022) Adu et al. (2023)	
	Consensus strength: 96%	

Due to the low quality of the evidence, the small number of studies and the lack of certainty of the results, an online intervention without continuous personal medical-therapeutic support cannot be recommended, but no recommendation against it can be made either. A decision must be made on a case-by-case basis, taking into account individual circumstances and preferences.

4.2.5 Key question 3: Do patients with severe impairment of personality functioning who receive coordinated outpatient and inpatient care have a better outcome than those who receive an unspecified control condition?

The coordination of inpatient, day-clinic, outpatient and outreach treatments enables flexible and customised care for patients and should therefore be further promoted, as the Government Commission for Modern and Needs-based Hospital Care describes in its eighth statement. It identifies sector boundaries as a key cause of reduced quality and efficiency and recognises that the mental health disciplines have relevant potential for improvement (Government commission for modern and needs-based hospital care 29/09/2023). Coordinated care is aimed for in the German healthcare system with "complex care" (KSVPsych-RL, G-BA 2021). This implies intensive coordination and cooperation between the practitioners involved. If practitioners join forces across sectors and professional groups, this enables an exchange regarding diagnostics, indications and treatment planning. This allows an overall treatment plan to be drawn up and, above all, ensures the continuity of relationships. For example, a patient can have a fixed contact person who coordinates treatment, takes care of organisational tasks and supports patients in attending treatment appointments (see KBV 2024). Overall, this should make it easier for patients to live independently and stably, avoid inpatient stays and minimise relationship breakdowns. This is particularly important for patients with severe impairment of personality functioning, as their limited ability to establish and maintain contact and serious deficits in emotion regulation make it difficult to find a place in therapy, especially in the strained situation of outpatient psychotherapeutic psychiatric care (Bundespsychotherapeutenkammer (Federal Chamber of Psychotherapists 2018Goldner et al. 2011). Patients with severe impairment of personality functioning often give up quickly in frustration (e.g. after the first or second call to the doctor or psychotherapist) (Bridler et al. 2013). In some cases, up to 50 calls are necessary before treatment can begin (Wietersheim et al. 2021)), or treatment that has begun is discontinued, which usually leads to increased demoralisation (Benecke et al. 2018). According to experts, if inpatient and outpatient care can be successfully coordinated, inpatient stays can be avoided if patients are unable to find follow-up outpatient treatment. In their distress, patients then often turn to inpatient facilities.

Evidence:
The relevant studies and the assessment of outcomes are presented in the long version of the LL-SBPF.

Conclusion of the evidence for coordinated outpatient and inpatient care for patients with severe impairment of personality functioning:

5.1	Evidence-based statement	New
	The available data do not allow a clear recommendation for or against coordinated outpatient and inpatient care for patients with severe impairment of personality functioning.	

Quality of the evidence:	Systematic literature research; a quasi-experimental longitudinal study:
Psychosocial level of functioning: ⊕⊖⊖⊖	Müller et al. (2016)
Subjective quality of life: ⊕⊖⊖⊖⊖	Müller et al. (2016)
Change in the symptoms: ⊕⊖⊖⊖	Müller et al. (2016)
Treatment adherence: ⊕⊖⊖⊖	Müller et al. (2016)
Frequency of inpatient treatment: ⊕⊖⊖⊖	Müller et al. (2016)
	Consensus strength: 92%

The quality of the evidence and the ambiguous direction of the results alone do not allow for a clear recommendation, but clinical experience clearly points in the direction that patients benefit from coordinated outpatient and inpatient care. It is therefore recommended that patients with severe impairment of personality functioning be offered coordinated outpatient and inpatient care.

5.2	Consensus-based recommendation	New
Expert consensus	If patients with severe impairment of personality functioning receive both outpatient and inpatient care, this care should be coordinated, taking into account the wishes of the patient and, if applicable, their relatives.	
	Consensus strength: 100%	

4.2.6 Key question 4: Do patients with severe impairment of personality functioning who live in "special forms of housing" under one roof have a better outcome than those who receive an unspecified control condition?

In this chapter, the usual terminology of clients is used.. This addresses the fact that this area of care is relevant for a very heterogeneous clientele.

For clients with complex treatment needs, there can be various forms of support that affect the client's living environment. These include inpatient and outpatient support services. There is a lack of precise terminology, which makes comparison of studies (Richter and Hoffmann 2017) and a precise description of different forms of housing difficult. There is also a lack of high-quality studies that analyse the effectiveness of different forms of support (Chilvers et al. 2002, 2006; Speck et al. 2013). Accordingly, the criterion of "special form of housing" was deliberately kept open in the LL-SBPF, which is defined here as a continuum from inpatient residential facilities, long labelled as "homes" and now as "special forms of housing", to outpatient support services in the person's own home (Dehn et al. 2021). The degree of support in the living situation and the degree to which therapeutic services are provided varies. On the one hand, it can be accommodation for clients who would otherwise become homeless, and on the other hand, it can be an intensively social-therapeutically supported therapeutic residential group. Roughly speaking, three forms can be distinguished in Germany: Outpatient assisted living, inpatient

assisted living and assisted living in families (S3 guideline Psychosocial therapies for severe mental illnesses).
On an empirical level, according to Richter and Hoffmann (2017) there are no differences between inpatient and outpatient forms of housing in terms of social and health parameters. Separating one's own home from support services appears to be an ideal that should be maintained or achieved through the interventions (Tabol et al. 2010). An independent form of housing is generally favoured (Richter and Jäger 2021). We are not aware of any studies that examine different forms of housing for clients with severe impairment of personality functioning.
In principle, the social participation of clients with severe impairment of personality functioning is promoted through self-determined, outpatient living close to home, as described, for example, in the S3 guideline Psychosocial therapies for severe mental illnesses (Chapter 10.3, p. 134ff). Only if this is not possible should supported housing be considered, or if clients have a preference for it. The LL-SBPF refers to this special situation. Reasons why self-determined living is not possible may be, for example, a lack of structure in everyday life because clients are unable to do so due to the impairments of personality functioning. A therapeutically managed living environment can promote development in terms of social therapy, as new relationship experiences can be made, self-images can be permanently tested, interactions can receive feedback and interactional functions can be promoted (practising in the community). By living together permanently, an intensive space for exchange can be created. However, the aim should always be to return to a self-determined form of living, as supported forms of living often involve moving away from home and a loss of independence (S3 guideline Psychosocial therapies for severe mental illnesses).

Evidence:
The evidence studies and the assessment of outcomes are presented in the long version of the LL-SBPF.

Conclusion of the evidence for "special forms of housing" for clients with SBPF:

6.1	Evidence-based statement	New
	The available data do not allow a clear recommendation for or against accommodation in a "special form of housing" under one roof for clients with severe impairment of personality functioning.	
Quality of the evidence:	Systematic literature research; two publications from a prospective cohort study:	
Social functioning level: ⊕⊖⊖⊖ Admission to a psychiatric hospital: ⊕⊖⊖⊖⊖ Psychopathological symptom severity: ⊕⊖⊖⊖ Quality of life: ⊕⊖⊖⊖⊖	Dehn et al. (2021) Dehn et al. (2022)	
	Consensus strength: 92%	

Note: A special vote is proposed in the DGPPN statement (see Chapter 3.2 in the guideline report).

Due to the low quality of the evidence, the small number of studies and the lack of certainty of the results, accommodation in a "special form of housing" under one roof cannot be recommended, but neither can a recommendation against it be made. A decision must be made on a case-by-case basis, taking into account individual circumstances and preferences.
If a form of supported living is necessary, it should:

- Enable the greatest possible self-determination for clients
- Promote self-determined living for clients
- Provide therapeutic concepts and qualified staff for clients with severe impairment of personality functioning
- Maintain a connection to the community.

4.2.7 Key question 5: Do patients with severe impairment of personality functioning who receive outpatient coordinated care have a better outcome than those who receive an unspecified control condition?

Legislation requires coordinated care, particularly in outpatient care. Therefore, the "Directive on cross-professional, coordinated and structured care, especially for severely mentally ill insured persons with complex psychiatric or psychotherapeutic treatment needs (KSVPsych-RL)" was adopted in 2021 (G-BA 2021). This states that there is insufficient "cross-professional, coordinated and structured care, particularly for seriously mentally ill insured persons with complex psychiatric or psychotherapeutic treatment needs".
Well-coordinated care is characterised by the fact that patients with severe impairment of personality functioning have a contact person who:

- has sufficient training in mental disorders,
- is networked across sectors,
- can arrange appointments and initiate further services and assistance,
- can motivate patients to attend appointments,
- can establish and maintain regular (up to weekly) contact with patients,
- integrates the relevant environment if necessary,
- if necessary and with the patient's consent, visits them in their home environment.

Coordination can be carried out by the treating persons themselves or delegated to appropriately qualified personnel. The qualifying description of what constitutes coordinated care is stated in the KSVPsych-RL. It also names professional groups who can provide this coordinated care or to whom tasks can be delegated. However, since not all relevant professional groups, such as general practitioners, are named, only the qualifying description was chosen here. In addition, the directive is often not implemented due to a lack of monetary incentives.

Evidence:
The evidence studies and the assessment of outcomes are presented in the long version of the LL-SBPF.

7.1	Evidence-based recommendation	New
Degree of recommendation: **0**	To improve the quality of mental health, patients with severe impairment of personality functioning can be offered coordinated outpatient care.	
Quality of the evidence:	Systematic literature research; a meta-analysis:	

Mental quality of life: ⊕⊕⊖⊖⊖	Lim et al. (2022)
	Consensus strength: 100%

7.2	Evidence-based recommendation	New
Degree of recommendation: **B**	To improve psychosocial functioning, patients with severe impairment of personality functioning should be offered coordinated outpatient care.	
Quality of the evidence:	Systematic literature research; a Cochrane Review:	
Psychosocial functioning st: ⊕⊕⊕⊖ Psychosocial functioning mt: ⊕⊕⊖⊖ Psychosocial functioning according to ⊕⊕⊕⊖	Dieterich et al. (2017) Dieterich et al. (2017) Dieterich et al. (2017)	
	Consensus strength: 100%	

The quality of the evidence for psychosocial functioning was assessed according to time periods, st - short term, mt - medium term, lt - long term

7.3	Evidence-based recommendation	New
Degree of recommendation: **0**	To reduce unemployment, patients with severe impairment of personality functioning can be offered coordinated outpatient care.	
Quality of the evidence:	Systematic literature research; a Cochrane Review:	
Employment status mt: ⊕⊕⊖⊖ Employment status lt: ⊕⊕⊖⊖	Dieterich et al. (2017) Dieterich et al. (2017)	
	Consensus strength: 100%	

The quality of the evidence was analysed for the employment status according to mt - medium term, lt - long term

Note: A special vote is proposed in the DGPPN statement (see Chapter 3.2 in the guideline report).

Conclusion of the evidence for outpatient coordinated care for patients with severe impairment of personality functioning:

Evidence and clinical experience suggest that patients with severe impairment of personality functioning benefit from coordinated outpatient care and this should be recommended.

7.4	Evidence-based recommendation	New
Degree of recommendation: **B**	If multi-professional outpatient treatment is required, this should be coordinated by a person involved in this treatment.	

Quality of the evidence:	Systematic literature research; a meta-analysis and a Cochrane Review:
Mental quality of life: ⊕⊕⊖⊖ Functioning st: ⊕⊕⊕⊖ Functioning mt: ⊕⊕⊖⊖ Functioning lt ⊕⊕⊕⊖ Employment status mt: ⊕⊕⊖⊖ Employment status according to ⊕⊕⊖⊖	Lim et al. (2022) Dieterich et al. (2017) Dieterich et al. (2017) Dieterich et al. (2017) Dieterich et al. (2017) Dieterich et al. (2017)
	Consensus strength: 96%

The quality of the evidence was assessed for the functional capacity according to time periods, st - short term, mt - medium term, lt - long term, the acquisition status according to mt - medium term, lt - long term.

4.2.8 Key question 9: Do patients with severe impairment of personality functioning who have a fixed reference mental health care professional have a better outcome than those who do not?

This chapter deals with the role of the therapeutic relationship in patients with severe impairment of personality functions.

The term therapeutic relationship refers to "the feelings and attitudes that therapist and patient have towards each other and the way in which these are expressed" (Norcross and Lambert 2018, p. 304). It is therefore not a question of individual techniques or interventions, but rather the way in which being with each other takes shape and requires fundamental therapeutic skills and attitudes. Treatment methods and the therapeutic relationship inform and shape each other. In other words, treatment methods are relational acts (Safran and Muran 2000).

A systematic search of meta-analyses was used as the basis for nine further recommendations. The basis of for the search terms for this were primarily based on the the results of the American Psychological Association's Task Force on Evidence-based Relationships and Responsiveness (Norcross & Lambert, 2011; Norcross & Lambert, 2018). The exact search strategy can be found in the guideline report. A total of 17 meta-analyses were included.

4.2.8.1 Relevance and impact of the therapeutic relationship and relationship continuity

The therapeutic relationship and the working alliance between patient and practitioner contribute significantly to the effectiveness of psychotherapeutic and psychosocial measures (Gelso et al. 2018; Norcross and Lambert 2018). Up to 8% of the therapy outcome is attributable to the therapeutic relationship (Barkham et al. 2017).

8.1	Evidence-based statement	New
	A sustainable therapeutic relationship across all phases of the disease contributes significantly to the success of treatment in acute and maintenance therapy.	
Quality of the evidence:	Systematic literature research; three meta-analyses, one meta-synthesis, two systematic reviews:	

Guideline adaptation Relevance from the patient's perspective: ⊕⊕⊕⊕ Relevance from a clinician's perspective: ⊕⊕⊕⊖ Result of the psychotherapy: ⊕⊕⊕⊖ Change in psychiatric symptoms: ⊕⊕⊕⊖	Literature: Gelso et al. (2018); Loughlin et al. (2020); Haw et al. (2023); Troup et al. (2022); Flückiger et al. (2018); Bourke et al. (2021) Comparable guideline recommendation: S3 guideline on the diagnosis and treatment of bipolar disorders [Statement 7, p. 91]. The sentence "and prophylactic therapy" was changed to "and maintenance therapy". Further reading: Barkham et al. (2017); Norcross and Lambert (2018)
	Consensus strength: 100%

Various meta-analyses (Flückiger et al. 2018; Bourke et al. 2021; Browne et al. 2021; Howard et al. 2022) show: If the therapeutic alliance is strong and alliance disorders are well managed (Eubanks et al. 2018), the outcome of psychotherapy is slightly to moderately better. The therapeutic alliance encompasses the holistic co-operative aspects of the therapist-patient relationship. The connection with therapeutic success is well documented. In a meta-analysis of 295 studies with over 30,000 participants (Flückiger et al. 2018) the effect size was $d = 0.58$.

8.2	Evidence-based recommendation	New
Degree of recommendation: **A**	As part of the diagnosis and treatment of patients with severe impairment of personality functioning, a sustainable therapeutic relationship should be established. For people with severe impairment of personality functioning, this should be seen as the basis for all further therapy steps, and depending on the severity of the impairment of personality functioning, even as a treatment goal.	
Quality of the evidence:	Systematic literature research; four meta-analyses, one systematic review:	
Guideline adaptation Result of the psychotherapy: ⊕⊕⊕⊖ Change in psychiatric symptoms: ⊕⊕⊕⊖ Change in psychotic symptoms: ⊕⊕⊖⊖ Change in PTSD symptoms: ⊕⊕⊕⊖ Relevance trusting and long-term relationship: ⊕⊕⊕⊕	Formulation originally based on: S3 Guideline on the Diagnosis and Treatment of Eating Disorders [there Expert Consensus, recommendation 3, p.59; "psychotherapy" changed to "therapy". Added as basis of therapy and as therapy goal]. Subsequently de novo research of meta-analyses. new literature: Flückiger et al. (2018); Bourke et al. (2021); Browne et al. (2021); Howard et al. (2022); Haw et al. (2023)	
	Consensus strength: 100%	

It is beneficial for the course of therapy if **positive expectations** are encouraged. However, it must be borne in mind that these expectations should not be so high that they are very difficult to achieve, as this could lead to demotivation and demoralisation. If patients idealise the therapy or the therapist, this can also lead to avoidance of working on problematic behaviour and thought patterns. Instead, a mildly positive expectation is the best way to work therapeutically.

The relationship expectations that patients have are not only related to the real relationship experienced in the here and now (see next section), but also to the experiences that patients have had with previous attachment figures. Their expectations therefore cannot simply be changed. However, therapists should take care not to promote idealisation and to be actively available to help.

8.3	Evidence-based recommendation	New
Degree of recommendation: **B**	A mildly positive relationship expectation should be established in order to improve the success of the therapy.	
Quality of the evidence:	Systematic literature research; a meta-analysis:	
Result of the psychotherapy: ⊕⊖⊖⊖	Literature: Constantino et al. (2018)	
	Consensus strength: 100%	

Note: A special vote is proposed in the DGPPN statement (see Chapter 3.2 in the guideline report).

If the therapeutic relationship is characterised by positive regard, the outcome of psychotherapy is slightly better (Farber et al. 2018). This effect was particularly strong in individual therapy, in outpatient settings and in anxious and depressed patients. For patients with severe impairment of personality functioning, the specific relationship skills consist of being able to perceive changes appreciatively and communicate appropriately despite their interactional difficulties.

8.4	Evidence-based recommendation	New
Degree of recommendation: **B**	The therapist should recognise even seemingly small changes in patients with severe impairment of personality functioning and value them as a success of the therapy process and the relationship.	
Quality of the evidence:	Systematic literature research; a meta-analysis:	
Result of the psychotherapy: ⊕⊖⊖⊖	Literature: Farber et al. (2018)	
	Consensus strength: 100%	

4.2.8.2 Relationship skills of practitioners

4.2.8.2.1 General relationship skills

Patients attribute a close therapeutic relationship as a crucial part of recovery by improving agency, interaction and sense of identity (Loughlin et al. 2020). When the therapeutic relationship is characterised by **empathy,** the outcome of psychotherapy is moderately better, as a meta-analysis showed (Elliott et al. 2018). Empathy includes resonant reactions, understanding and the experience of being understood. Another important skill is the ability to establish and maintain a **real relationship.** Working through **relationship breakdowns** contributes significantly to the success of therapy (Eubanks et al. 2018). This is particularly relevant for patients with severe impairment of personality functioning, as relationship breakdowns can occur more frequently due to their impairments.

8.5	Evidence-based recommendation	New
Degree of recommendation: **B**	Practitioners should be able to support the development of patients with severe impairment of personality functioning appropriately: ▪ Be present (in contact with oneself and patients) ▪ Be able to enter into a relationship ▪ Be emotionally available ▪ Be therapeutically active ▪ Reflect on their expectations of the success of the therapy and their own effectiveness	
Quality of the evidence:	Systematic literature research; four meta-analyses, one systematic review:	
Result of the psychotherapy: ⊕⊖⊖⊖ Type of relationship design: ⊕⊕⊕⊕	Literature: Elliott et al. (2018); Flückiger et al. (2018); Tryon et al. (2018); Loughlin et al. (2020); Eubanks et al. (2018)	
	Consensus strength: 100%	

Selective self-opening by therapists can strengthen the therapeutic relationship, improve psychological functioning and promote insight, but should be used with caution as it is not always helpful (Hill et al. 2018). Boundary violations should be avoided and sometimes therapeutic abstinence is necessary. Successful countertransference management, in which therapists regulate and utilise their emotional responses to patients, is a strong predictor of therapeutic success (Hayes et al. 2018). Unregulated countertransference can have a negative impact, for example through avoidance of certain topics or over-involvement.

8.6	Evidence-based recommendation	New
Degree of recommendation: **B**	Therapists should be aware of the polarity of self-opening on the one hand and abstinence on the other and be able to organise this flexibly.	
Quality of the evidence:	Systematic literature research; a meta-analysis, a qualitative meta-analysis:	
Result of the psychotherapy: ⊕⊖⊖⊖	Literature: Hayes et al. (2018); Hill et al. (2018)	
	Consensus strength: 95%	

The socio-cultural context, consisting of role expectations, ethnic norms and religious affiliation, shapes how patients enter into relationships. Successful therapy does not require a match between patient and therapist in terms of cultural characteristics. Patient preference and the therapist's ability to familiarise themselves with the patient's socio-cultural background are crucial. This includes understanding the specific disease model and adapting the therapeutic offer. Therapists should consciously deal with their possible prejudices, use the patient's language, ask about cultural customs and regularly encourage a feedback process.

8.7	Evidence-based recommendation	New
Degree of recommendation: **B**	The therapist should be able to engage with the "culture" (language, behaviour, values) of the patient with severe impairment of personality functioning and treat them with appreciation and acceptance.	

Quality of the evidence:	Systematic literature research; a systematic review:
Type of relationship design: ⊕⊕⊕⊕	Literature: Loughlin et al. (2020)
	Consensus strength: 100%

4.2.8.2.2 Special relationship skills for long-term relationships

Long-term therapeutic relationships can promote positive effects such as trust and professional competence, but can also be stressful (Tryon et al. 2018). Consensus on goals between therapist and patient improves the therapy outcome and should be developed in a participatory manner. Shared decision making strengthens the therapeutic relationship and communication (Stovell et al. 2016).

8.8	Evidence-based recommendation	New
Degree of recommendation: **B**	The therapist should regularly enquire about the patient's tasks and goals, reach a participatory consensus and orientate themselves on the current consensus.	
Quality of the evidence:	Systematic literature research; two meta-analyses:	
Result of the psychotherapy: ⊕⊖⊖⊖ Strengthening the therapeutic relationship: ⊕⊕⊕⊖	Literature: Tryon et al. (2018) Literature: Stovell et al. (2016)	
	Consensus strength: 100%	

4.2.8.2.3 Challenges in shaping relationships

From the perspective of professionals, the therapeutic relationship is crucial for the success of patient treatment (Troup et al. 2022). Challenges for therapists are often negative feelings, burnout and the feeling of being too close. Regular **supervision and intervision** and specific training can reduce negative attitudes towards patients and improve the relationship. Establishing a sustainable therapeutic relationship takes **time and expertise**. Specialities in working with patients with severe impairment of personality functioning require a special **qualification**. Thorough **self-awareness** can be helpful.

8.9	Evidence-based recommendation	New
Degree of recommendation: **A**	Therapists of patients with severe impairment of personality functioning should pay attention to their ability to work and regularly reflect on the therapeutic relationship and their own behaviour: ▪ Regular supervision or intervision should be used to reflect on whether the therapeutic relationship is serving the patient's development. ▪ When treating people with severe impairment of personality functioning, therapists should pay attention to the limits of their resilience. This applies to both external stress factors and personal dispositions.	

	▪ Maintaining professional boundaries is a particular challenge for patients with severe impairment of personality functioning. Therefore, professional closeness and distance should be regularly reflected upon and, if necessary, supervision or intervision should be sought. ▪ Therapists should have sufficient time resources and competences to work on the establishment of attachment, therapy motivation, the coordination of therapy goals and strategies, as well as on self-regulation and overcoming ruptures in the relationship by the therapist.
Quality of the evidence:	Systematic literature research; a meta-synthesis:
Challenges in shaping relationships: ⊕⊕⊕⊕ The need for supervision: ⊕⊕⊕⊕	Literature: Troup et al. (2022)
	Consensus strength: 100%

8.10	Consensus-based recommendation	New
Expert consensus	Training and further education of therapists and members of treatment teams for patients with severe impairment of personality functioning should include at least case-based self-awareness.	
	Consensus strength: 100%	

4.2.8.2.4 Special relationship skills for outreach work

Outreach work offers many opportunities that have so far been little utilised in a psychotherapeutic context. Outreach work requires specific relationship skills, which are related, among other things, to entering the patient's private space. This can lead to embarrassment for those affected and create resistance to change (Aggett et al. 2015).

8.11	Consensus-based recommendation	New
Expert consensus	In outreach work, the therapist should be aware that they are entering the private sphere of other people and should therefore adopt a respectful, interested and open attitude towards the system. The therapist should be aware of the system's ambivalence between change and non-change, be able to perceive the possible shame that prevails in the system and therefore only give impulses for change when the relationship is sustainable.	
	Literature: Aggett et al. (2015)	
	Consensus strength: 100%	

4.2.8.3 Importance of continuity and duration

When therapists work **continuously** with patients, this results in better quality of life and treatment satisfaction (Ådnanes et al. 2019) and often also a more sustainable therapeutic relationship (Klingemann et al. 2020; Schultz et al. 2012).

The role of **treatment coordination** for patients with severe impairment of personality functioning should not be carried out by uninvolved persons, for example employees of health insurance companies, but by persons who are in direct treatment contact with the patients, as otherwise the important function of the therapeutic relationship cannot be effective.

8.12	Evidence-based recommendation	Modified Status 2019
Degree of recommendation: **B**	For patients with severe impairment of personality functioning, approaches to **relationship-orientated** treatment coordination should be expanded and then offered. In this context, the aspect of **commitment** and the need-based offer of follow-up help is of particular importance.	
Guideline adoption Evidence level: **2-** SIGN	Guideline adaptation: S3 Guideline on the Diagnosis and Treatment of Bipolar Disorders [Recommendation Care 3, p. 390] "Case management" changed to "treatment coordination". "Provision of help" changed to "offer of help" to emphasise the aspect of empowerment. Added: by persons in contact with treatment). new, relevant literature: Schöttle et al. 2018	
	Consensus strength: 100%	

8.13	Consensus-based recommendation	New
Expert consensus	Relationship-orientated case management should be offered by people who themselves are in regular **contact with** those affected.	
	Consensus strength: 96%	

Sometimes it takes longer periods of time for therapy to be successful. A German study (Nolte et al. 2016) showed that symptoms can improve both in the medium and long term. It is important for therapists and patients to agree on the length and frequency of therapy sessions. Outreach support should be considered on a case-by-case basis, as it can be perceived as intrusive, especially for complex traumatised patients.

8.14	Evidence-based recommendation	Modified Status (2019)
Degree of recommendation: **A**	People with severe impairment of personality functioning should have the opportunity to receive outreach treatment in their familiar living environment, even over a longer period of time and beyond acute phases of illness.	
Guideline adaptation Evidence level: **Ia** Oxford	Guideline adaptation: S3 Guideline Schizophrenia [Recommendation 151, p. 227, there also Guideline Adaptation of Psychosocial Therapies→ there Recommendation No. 12, page 38 and page 124] new literature: Nolte et al. (2016)	
	Consensus strength: 96%	

Long-term courses of treatment can place special demands on the therapeutic relationship and relationship skills.

4.2.8.4 Characteristics of structures or organisations that promote the therapeutic relationship

The quality of the therapeutic relationship is strongly influenced by social and organisational conditions. Patients with severe impairment of personality functioning often experience relationship breakdowns due to system-related factors such as flat share cancellations or discharges. These patients often drop out of clinical trials, which weakens the evidence base, but their care remains complex. Due to their disorder, they rarely receive therapy and place demands on the system through repeated inpatient stays. Access to psychiatric and psychotherapeutic care is difficult, especially in the outpatient sector, which is problematic for these patients and can exacerbate their symptoms. Structures that enable a continuous therapeutic relationship, such as fixed **reference therapists,** are important.

8.15	Consensus-based recommendation	New
Expert consensus	Concepts of clinics, outpatient treatment facilities and participation programmes should: ▪ Take into account the frequent comorbidities of patients with severe impairment of personality functioning (often: substance-related disorders) in order to improve therapeutic continuity; ▪ Anticipate and take into account the specific interactional difficulties of patients with severe impairment of personality functioning in order to ensure the maintenance of the therapeutic relationship within a coordinated treatment structure, even in and after crisis phases (e.g. finding a balance between limiting and tolerating; systematic work on breaks in the relationship; follow-up work). ▪ Offer people with severe impairment of personality functioning **a permanent reference therapist** who coordinates and networks therapeutic measures and support services in order to avoid disruptions, gaps, duplication or ineffective or harmful interventions. This applies to both individual and team-based treatment. ▪ In the case of integrated, team-based treatment, have **one or only a few reference therapists.** The therapist in charge of the case must be known to the patient as such and, if possible, be familiar with them. ▪ Determine together with the patient who will lead the case.	
	Consensus strength: 100%	

4.2.8.5 Relationship work with relatives

Relatives (family members, partners, children and close carers) play an important role in the treatment of people with severe impairment of personality functioning. They can contribute to the development and maintenance of severe impairment of personality functioning, but can also be an important resource in recovery. If relatives have a negative attitude towards therapy, this can trigger conflicts of loyalty. Involving relatives in treatment, with appreciation of their behaviour, can bring about more lasting changes in behaviour than working with individuals alone

8.16	Consensus-based recommendation	New
Expert consensus	If desired by the affected person, relatives should be included in the therapy process. If relatives are included in the therapy, the therapist should: ▪ Treat the different, possibly even conflicting concerns of all those involved with appreciation, without allowing themselves to be instrumentalised for one concern, ▪ Promote taking back responsibility for change in the system, ▪ Treat the system's previous attempts at solutions with respect, ▪ Appreciate even seemingly small changes in the system of the patient's relatives (e.g. in the family) as a success.	
	For further recommendations regarding the involvement of relatives, see recommendations 67 and 68 of the S3 Guideline Schizophrenia	
	Consensus strength: 100%	

4.3 Key questions and recommendations without a systematic literature review

4.3.1 Key question 6: Do patients with severe impairment of personality functioning who receive outpatient monitoring have a better outcome than those who receive an unspecified control condition?

4.3.1.1 System interventions

4.3.1.1.1 Early intervention and early detection

Mental illnesses in adulthood that lead to significant social impairments often have their origins in adolescence and young adulthood (cf. Giertz et al. 2021; Giertz et al. 2022; Kessler et al. 2005; Kim-Cohen et al. 2003). Secondary consequences of illness such as dropping out of school and addiction problems often contribute to a poorer outcome and long-term dependence on psychiatric services (cf. Giertz et al. 2021). Compared to physical illnesses, mental illnesses lead to poorer educational and occupational outcomes and increase the risk of unemployment in adulthood (Hale et al. 2015). Early interventions can reduce the risk of chronicity and secondary consequences (see Correll et al. 2018; Karow et al. 2013; Lambert et al. 2019).

4.3.1.1.2 Community psychiatric treatment/care

In Germany, care for people with severe impairment of personality functioning is provided in the inpatient and outpatient sector and falls under various social codes (SGB). The federal states, local authorities and numerous service providers are responsible, whereby care is divided into medical (SGB V) and rehabilitative and participation care (SGB IX). For older people with care needs, long-term care insurance offers compensatory benefits. People with severe impairment of personality functioning often require protracted psychiatric help and complex services from specialists in various therapeutic fields. The ICD-11 classification focuses on functional impairments in everyday life, which makes it necessary to link and coordinate various support services. The initial diagnosis and treatment planning is often carried out by GPs, supported by specialists and psychotherapists. Outpatient interventions such as home psychiatric nursing, occupational therapy and sociotherapy are particularly important. Psychiatric home nursing care aims to stabilise patients and promote their independence in everyday life. Access to care

is particularly difficult for people with low levels of personal functioning, which tends to exacerbate the symptoms. It is important to consider the specific interactional problems of these patients and to develop appropriate structures and concepts to enable a sustainable therapeutic relationship.

9.1	Consensus-based recommendation	New
Expert consensus	Outpatient psychiatric care can be offered as help in times of crisis, as medium and long-term support for functional limitations, to establish/promote self-management and disease management and to promote individual recovery processes. As the need for help does not depend on the diagnosis, outpatient psychiatric care can be offered for all diagnosis groups.	
Guideline adaptation	Literature: S3 Guideline Psychosocial Therapies for Severe Mental Illnesses See also Jacobi et al. (2021); Herpertz et al. (2022); G-BA (2023, 8,9); S3 Guideline Borderline Personality Disorder (p. 84)	
	Consensus strength: 96%	

4.3.1.1.3 Professional participation

4.3.1.1.3.1 Mental disorders and work

Severe mental disorders are often accompanied by considerable negative consequences for the professional situation of those affected, such as dropping out of education and training programmes, job losses and early retirement (Reker and Eikelmann 2004). Many sufferers remain completely excluded from the labour market, although most of them wish to work. Studies show an above-average unemployment rate among people with mental illness, particularly schizophrenia. The Federal Government's "Participation report on the situation of people with disabilities" (BMAS 2013) shows that 50% of employable people with chronic mental disorders do not work, 21% work in sheltered workshops for disabled people (WfbM) and 15% use support services such as day centres. Support for the transition to the general labour market is limited. People with mental disorders are less integrated and earn less than those with somatic illnesses (Richter et al. 2006). In 2021, almost 42% of early retirements were due to mental illnesses (DRV 2022). Early rehabilitation is important, as many days of absence due to illness make professional (re)integration more difficult. Unemployment has negative consequences such as loss of daily structure, social isolation and financial difficulties. Work improves the mental health, quality of life and autonomy of those affected, especially in the primary labour market. Measures to promote professional participation are therefore essential.

4.3.1.1.3.2 Approaches to vocational rehabilitation

The terms "work rehabilitation" and "vocational rehabilitation" refer here to psychosocial interventions to improve the work and employment situation of people with mental disorders (Reker and Eikelmann 2004). The right to occupational participation has been enshrined in law in Germany since 2009. There are two main methods: pre-vocational training and supported employment (SE). Pre-vocational training prepares those affected for the labour market with vocational preparation measures. Supported employment places those affected directly on the labour market and provides them with long-term support. In Germany, programmes based on

the "first-train-then-place" approach (pre-vocational training) dominate, but there is a trend towards the integration of SE elements.
The S3 guideline Psychosocial therapies for severe mental illnesses emphasises early and person-centred vocational rehabilitation in coordination with various service providers. Measures should take into account the aptitude and inclination of those affected and be available close to their place of residence. However, SE approaches are not suitable for all those affected. There is a need for further research into these rehabilitation measures in Germany.

9.2	Evidence-based recommendation	Modified status 2018
Degree of recommendation: **A**	People with severe impairment of personality functioning who wish to work in the general labour market should be offered programmes as part of the promotion of vocational participation with the aim of rapid placement directly in a job in the general labour market and the necessary support (supported employment).	
Guideline adaptation **Quality of evidence:** ⊕⊕⊕⊖ (downgraded due to indirectness)	S3 Guideline Psychosocial Therapies for Severe Mental Illness (Recommendation 18, p. 192)	
	Consensus strength: 100%	

9.3	Evidence-based recommendation	Modified status 2018
Degree of recommendation: **B**	People with severe impairment of personality functioning should also be offered programmes that follow the "train first, place later" principle. These are particularly important for the subgroup of severely mentally ill people without a preference for immediate employment on the general labour market. The aim is to place them on the general labour market with support.	
Guideline adoption **Quality of the evidence:** ⊕⊕⊖⊖ (downgraded due to indirectness)	S3 Guideline Psychosocial Therapies for Severe Mental Illness (Recommendation 19, p. 192)	
	Consensus strength: 100%	

9.4	Evidence-based recommendation	Modified status 2018
Degree of recommendation: **B**	The effectiveness of approaches based on the principles of supported employment can be increased by accompanying training interventions. These should therefore be offered depending on individual needs.	

Guideline adaptation **Quality of the evidence:** ⊕⊕⊕⊖ (downgraded due to indirectness)	S3 guideline Psychosocial Therapies for Severe Mental Illness (Recommendation 20, p. 192)
	Consensus strength: 100%

9.5	Consensus-based recommendation	New
Expert consensus	The promotion of occupational participation for people with severe impairment of personality functioning should be aimed at preventing job loss. This requires the early involvement of appropriate services and assistance when mental illness occurs. The availability of completed training is of enormous importance for people with severe impairment of personality functioning as a basis for participation in working life. Regular school, academic, in-company and special training programmes should therefore be available close to home and with appropriate accompanying support services. People with severe impairment of personality functioning should be given early access to tailored vocational training and rehabilitation programmes to promote their vocational participation, taking into account their right to choose.	
Guideline adaptation	S3 Guideline Psychosocial Therapies for Severe Mental Illnesses	
	Consensus strength: 96%	

4.3.1.2 Individual interventions

4.3.1.2.1 Psychoeducation

Psychoeducation can be integrated into both inpatient and outpatient treatment contexts and is a component of most psychotherapeutic procedures. Psychoeducation involves informing patients and their relatives about the illness, its causes, course and treatment options and is also carried out by non-medical professionals such as carers and social workers. There are simple and detailed forms of psychoeducation. Simple psychoeducation is limited in time and adapted to the patient's needs, can take place in an individual or group setting and comprises up to ten sessions. Detailed and interactive psychoeducation, such as for bipolar disorders, includes information about the disorder, self-observation, promotion of a stable everyday structure, reduction of stress and recognition of early symptoms.
Psychoeducation does not replace psychotherapy, but can be used as part of psychotherapeutic procedures and sensitise people to psychotherapy. Despite the lack of specific studies on psychoeducation for people with severe impairment of personality functioning, it is assumed that psychoeducation can contribute to coping with everyday problems and counteract stigmatisation and the consequences of the illness.

9.6	Consensus-based recommendation	New
Expert consensus	People with severe impairment of personality functioning and their relatives should be offered detailed, structured and interactive psy-	

	choeducation. This can be offered individually or in groups. The duration, content and structure should be adapted to the emotional and communicative needs and their individual preferences.
	Literature: S3 Guideline Diagnostics and Therapy of Bipolar Disorders; S3 Guideline Psychosocial Therapies for Severe Mental Illnesses
	Consensus strength: 100%

4.3.1.2.2 Trialogue

"Trialogue" describes the equal cooperation of patients, relatives and professionals in different treatment contexts (S3 guideline on the diagnosis and treatment of bipolar disorders (p. 27ff)). The characteristics and effects of this collaboration are characterised by the following aspects, among others:

- Patients are "experts in their own affairs".
- Relatives are included. They can play an important role in coping with everyday life and preventing relapses.
- Individual and family resources can be utilised.
- It can lead to more responsibility.
- It can bring about active self-determination and an improvement in self-management skills.
- An open, trusting and successful cooperation between patients, relatives and professionals can develop.
- Common interests and treatment goals can be pursued.
- Shared skills can be used in a three-way exchange.

This can have a positive effect on the course of the disease. The S3 guideline on the diagnosis and treatment of bipolar disorders emphasises the importance of trialogue forums, training courses and conferences as a mediation platform and for anti-stigma work. Well-coordinated and continuous care by reference therapists is recommended in order to promote trust and respect and support trialogue.

The S3 guideline Psychosocial therapies for severe mental illness (p. 200) emphasises the importance of trialogical cooperation for the provision of information and relationship work in the support system. It promotes open, trusting cooperation and has an impact on the representation of the interests of patients and their relatives in public and in politics, the promotion of quality and the further development of care structures.

9.7	Consensus-based recommendation	New
Expert consensus	Trialogue cooperation between patients with severe impairment of personality functioning, their relatives and professionals should be offered. The trialogue aspect should be taken into account in professional training and seminars, e.g. through the direct participation of those affected and their relatives. Trialogue forums should be offered to patients with severe impairment of personality functioning and their relatives.	
	Literature: S3 Guideline Diagnostics and Therapy of Bipolar Disorders; S3 Guideline Psychosocial Therapies for Severe Mental Illnesses	
	Consensus strength: 100%	

4.3.1.2.3 Further psychosocial therapies

Art therapies [1]

The specialist areas of art therapies include art, music, dance and theatre therapy. These therapies utilise artistic media in diagnostics and therapy and are applied in various contexts such as clinical, rehabilitative, outpatient and educational settings. They are based on psychotherapeutic models and other scientific concepts. Art therapies are person-centred and promote self-actualisation, self-efficacy and personal responsibility in patients. They correspond to psychotherapeutic approaches in many effective factors, such as the quality of the therapeutic relationship and the activation of resources. A key feature is the creation of an artistic product that can be reflected on within the therapeutic relationship. Contraindications are acute psychotic phases and a lack of willingness to actively participate.

Occupational therapy

Occupational therapy is a client-centred health profession that promotes health and well-being through activity. It supports people whose ability to act is restricted in carrying out activities in their personal environment. The goals of occupational therapy are self-determined participation in social life and a satisfactory quality of life. This is achieved through occupational therapy interventions such as practising specific activities, environmental adaptation and counselling, etc. Occupational therapy is a recognised, legally established remedy and a scientifically based form of therapy. It uses various methods to promote skills and build up activity.

Exercise and sports therapies

The effects of sport and exercise on severe impairment of personality functioning can be differentiated by physiological and psychological explanations. The release of endorphins and other neurotransmitters can improve mood and well-being. Sport and exercise can also increase self-esteem and self-confidence and help to break negative thought patterns. Sports can promote social integration and interaction. However, it is important to note that sports and exercise therapy should not be seen as the main therapy, but as part of a wider treatment plan that also includes psychotherapeutic interventions. The exact application should be under the guidance of qualified professionals.

9.8	Consensus-based recommendation	New
Expert consensus	Art therapies should be offered to patients with severe impairment of personality functioning as part of an overall treatment plan in both inpatient and outpatient settings. Occupational therapy should be offered to people with severe impairment of personality functioning as part of an overall treatment plan in both inpatient and outpatient settings and should be orientated towards individual needs and preferences. Sports and exercise therapy should be offered to people with severe impairment of personality functioning as part of an overall treatment plan and based on the individual needs and preferences of patients in both outpatient and inpatient settings.	

[1] Art therapies are comprehensively recognised in the German Society for Psychiatry and Psychotherapy, Psychosomatics and Neurology (DGPPN) e.V. 2018 described. The explanations here are based on chapter 11.3.1 of the German Society for Psychiatry and Psychotherapy, Psychosomatics and Neurology (DGPPN) e.V. 2018 (p. 254ff) back.

Guideline adaptation	Literature: S3 Guideline Psychosocial Therapies for Severe Mental Illnesses See also: Lindström et al. 2012Ercan Doğu et al. 2021; Mashimo et al. 2020; Wasmuth et al. 2021; Ikiugu et al. 2017
	Consensus strength: 100%

4.3.1.2.4 Health-promoting interventions

The S3 guideline Psychosocial therapies for severe mental illness (p. 311ff) emphasises the importance of health-promoting interventions, particularly in relation to diet and exercise. People with severe impairment of personality functioning often have comorbidities. For example, , according to a study by Greggersen et al. (2011), women with borderline personality disorder in particular have an increased risk of cardiovascular disease compared to women who do not suffer from a borderline personality disorder. Not only pharmacological interventions are recommended for this, but also, for example, lifestyle modifications (e.g. S3 guideline on general practitioner risk counselling for cardiovascular prevention (p. 37)).

9.9	Consensus-based recommendation	New
Expert consensus	People with severe impairment of personality functioning should be counselled on their somatic health and disease risks and offered health-promoting interventions tailored to them.	
	Consensus strength: 96%	

4.3.2 Key question 7: Is psychotherapy with a treatment contract more effective for patients with severe impairment of personality functioning than without a treatment contract?

4.3.2.1 Use of treatment contracts

While intentions or agreements are usually verbal agreements between therapist and patient, treatment contracts are usually written agreements. General treatment contracts are used in therapy for the organisation of framework conditions (appearance in therapy, general rules of conduct, etc.). In terms of patient rights, numerous explanations (e.g. desired and possible undesired effects of treatment) must be communicated to the patient when starting outpatient psychotherapy in the sense of guideline psychotherapy. "The therapist should document all information provided in the patient file. The information should be confirmed in writing by the patient with a list of the topics discussed, if the treatment contract has not already been recorded in writing anyway" (Faber and Haarstrick 2021, p. 111). More specific contracts concern therapeutic content and topics, e.g. suicide risk (life or anti-suicide contracts), therapy-damaging behaviour, self-harm, behavioural excesses (addictive behaviour, eating behaviour, etc.) and the development of functional behaviour such as planning activities or overcoming procrastination (Fehm and Helbig-Lang 2020; Siegl and Wendler 2019).

A contract is unilateral if the patient commits to certain actions independently of the involvement of other persons. Bilateral contracts concern reciprocal agreements with other persons (e.g. partnership, therapeutic relationship).

10.1	Consensus-based recommendation	New
Expert consensus	Patients with severe impairment of personality functioning should be offered a specific treatment contract in the context of psychotherapy.	
	Consensus strength: 100%	

Justification of the recommendation/specification

Treatment, therapy and behavioural contracts in verbal and/or written form can be used without contraindications if they are used prudently (precisely defined, well embedded, closely monitored, adapted to the patient and the problem as well as the goals) and ensure a good balance between consideration of the patient's autonomy and therapeutic support by the therapist. Where possible, the patient's care system or trusted persons should be involved according to the principle of participatory decision-making. Ideally, the contracts should also be available in plain language. Even though specific studies on the effectiveness of contracts are lacking, there are clear indications that contracts are effective and helpful in establishing stable changes. Experience to date suggests that behavioural, therapy and treatment contracts can contribute to person-centred and patient-oriented treatment and care. Prior to the contract meeting, the patient's ability to enter into a contract must be assessed and/or suitable framework conditions for the patient's active participation in the contract meeting must be established (e.g. sufficient time, involvement of a trusted person, interpreter).

In behavioural therapy, both general treatment contracts and specific behavioural contracts are frequently used and their use is explicitly described in the literature (Siegl and Wendler 2019). Epstein and Wing (1979) and Kirschenbaum and Flanery (1983) report in overview articles on the successful use of contract management for numerous comorbid problems such as addiction, eating disorders or depression. For eating disorders Solanto et al. (1994) found behavioural contracts to be effective in changing behaviour. In the treatment of substance dependence, an increase in compliance and a reduction in relapse rates were achieved through contract management (Calsyn et al. 1994). A Cochrane review of 30 studies found significantly better results for at least one outcome measure in half of the studies with behavioural contract conditions (Bosch-Capblanch et al. 2007). However, behavioural contracts have rarely been evaluated as stand-alone interventions as they are usually part of more complex programmes and there is still a lack of good quality studies explicitly investigating contracts.

In principle, psychodynamic psychotherapy does not require specific written treatment contracts to be concluded in addition to verbal agreements between therapist and patient. This is certainly due to the fact that analytical therapy in particular aims to offer an opening space in a very clear setting for the "realisation of unconscious neurotic psychodynamics and integration of 'split-off' personality parts to eliminate or change intrapsychic and interpersonal conflict fields" (Faber and Haarstrick 2021, p. 45). In the context of modified analytical therapy methods and especially in the context of depth psychology-based psychotherapy, an explicitly consensual formulation of therapy goals and content - often in the form of treatment contracts - is common practice due to the specific goal/focus. On the one hand, treatment contracts refer to general and specific content (e.g. focus when working on changing symptoms and complaints, intrapsychic attitudes, attitudes and feelings, interpersonal behaviour and experiences, see e.g. Boll-Klatt et al. 2021, p. 543). It should be particularly emphasised that the majority of manualised and evidence-based psychodynamic developments explicitly intend specific treatment contracts. For example, in the manualised procedures for the treatment of personality disorders and in Supportive-Expressive Therapy, which is fundamental to most disorder-specific manuals

(Luborsky and Crits-Christoph 1990Albani et al. 2008), the understanding of the problem and objectives is defined and written down in the course of defining the central relationship conflict issue.
In systemic therapy, the "clarification of the assignment", which ideally results in a "contract", always plays a central role. Such contracts are usually only recorded in writing if there are different goals and mandates (cf. Schweitzer and Schlippe 2015, p. 180) and conflicts of interest are to be expected, which is often the case with BPD, eating disorders and addiction, for example. The authors are not aware of any studies that have investigated a connection between the treatment contract/contract in systemic therapy and its effectiveness.

The handling of treatment contracts in manualised procedures for the treatment of personality disorders, special contracts (e.g. for anti-suicide contracts) and open research questions are described in the long version of the guideline.

4.3.3 Key question 8: When should patients with severe impairment of personality functioning be admitted as (partial) inpatients?

This chapter deals with the indications for (partial) hospitalisation of patients with severe impairment of personality functioning.
For this question, reference was made to related national and international guidelines, recommendations, meta-analyses and reviews as well as literature known to the authors. The following statements and recommendations are based on a thorough review of the aforementioned literature.

4.3.3.1 (Partial) inpatient admission

4.3.3.1.1 General information on (partial) inpatient admission

Germany has around 40,000 inpatient psychotherapeutic treatment places, which treat around 450,000 patients a year, a third of whom are in rehabilitation centres. The main difference between hospital and rehabilitation treatment lies in the therapy goal: curative therapy vs. averting incapacity to work. According to SGB V, insured persons are entitled to necessary medical treatment, including psychotherapeutic treatment. Full inpatient treatment is required if partial inpatient or outpatient treatment is not sufficient. At present, no evidence-based statements or recommendations can be derived from the literature for specific indications for (partial) inpatient treatment for the treatment of the heterogeneous core symptoms of severe impairment of personality functioning. There are different indications and contraindications between and within the specialisms. For example, a comorbid addiction disorder is an indication for inpatient addiction treatment, but a contraindication for inpatient psychosomatic treatment. The treatment goals must match the inpatient options available at the clinic.

4.3.3.1.2 General indication criteria for (partial) inpatient treatment

Regardless of the diagnosis according to ICD-10/ICD-11 or HiTOP spectra, there are general indications for (partial) inpatient treatment that also apply to people with severe impairment of personality functioning. These include emergency indications such as acute danger to self or others, as well as situations in which outpatient therapy is not sufficient to ensure multidisciplinary and close-meshed care or to prevent decompensation. Serious psychosocial factors such as family conflicts, domestic violence or the threat of losing one's job or home can also make

inpatient treatment necessary. The indication for inpatient treatment for patients with severe impairment of personality functioning results from the assessment and linking of the interaction between the clinical picture, personality functions, psychosocial circumstances, treatment goals and the reality of care. Patients should be admitted to somatic clinics if the treatment of somatic comorbidity is the main focus. The recommendation is based on safety aspects and good clinical practice and is orientated towards other guidelines mentioned.

11.1	Consensus-based recommendation	New
Expert consensus	If severe impairment of personality functioning is present, inpatient or day-care treatment may be appropriate for diagnostic and/or therapeutic reasons. The principle of outpatient treatment before partial inpatient treatment before full inpatient treatment should be followed while maintaining participatory decision-making. When determining the indication for hospital treatment, it should be carefully examined together whether the desired therapeutic goals are in line with the respective treatment options of the institution. Hospitalisation should be carried out in accordance with the indications listed Table 6 or in an emergency.	
	Literature: S3 Guideline National Care Guideline Unipolar Depression; S3-Guideline Schizophrenia; S3 Guideline Obsessive-Compulsive Disorder; S3-Guideline Diagnostics and Therapy of Bipolar Disorders; S3-Guideline Borderline Personality Disorder; S3 Guideline Psychosocial Therapies for Severe Mental Illnesses; S3-Guideline Diagnostics and Treatment of Eating Disorders; S3-Guideline Functional Body Complaints; S2k Guideline Emergency Psychiatry; S3-Guideline Posttraumatic Stress Disorders	
	Consensus strength: 100%	

Table 6: Indications for inpatient treatment

Emergency indication[1]
▪ Acute danger to self or others
▪ Stupor, catatonia and other syndromes and disorders relevant to emergency psychiatry
Check briefings
▪ If medical care is required after a suicide attempt
▪ If a sufficiently reliable assessment of the continued existence of suicidal behaviour is not possible
▪ If the establishment of a sustainable therapeutic relationship is not successful and the person remains suicidal despite initial treatment
▪ In case of resistance to therapy despite guideline-compliant outpatient therapy
▪ In cases of severe psychopathology that cannot be adequately treated on an outpatient basis
▪ In the event of temporary inability to provide nutrition and/or care due to illness

- In the event of a high risk of (further) chronification despite guideline-compliant outpatient therapy
- In the case of such serious illnesses that outpatient treatment options are not sufficient
- In the event of imminent isolation due to illness, neglect and other serious psychosocial factors
- In the case of external circumstances that severely hinder the success of therapy (e.g. domestic violence or maintaining abstinence in the case of severe addiction and the resulting necessary change of environment) or
- In the case that the patient's life circumstances are pathogenetically significant for the development and maintenance of the disorder
- If the therapy goals within the framework of an overall treatment plan can only be achieved with the resources of the hospital
- In the case of comorbid addictions, if abstinence cannot be ensured on an outpatient basis or in the case of unclear somatic comorbidities
- If diagnostic clarification is required, especially for psychosomatic and somato-psychological clinical pictures
- To build up adequate motivation for therapy and to develop a psychosocial understanding of the illness
- If a comorbid somatic illness is present

[1] If there is no indication of an emergency and the patient is not willing to be admitted as an inpatient and is unable to agree, the patient may or must be admitted as an inpatient against their will

4.3.3.1.3 Specific indication criteria for (partial) inpatient treatment

The central treatment element for patients with severe impairment of personality functioning is psychotherapy. A meta-analysis concludes that inpatient psychotherapy is effective (Doering et al. 2023; Liebherz and Rabung 2013). The greatest effects were found in psychological symptom burden and general well-being, the least in the area of social communication. These findings are independent of the basic psychotherapeutic orientation. Group psychotherapeutic approaches can increase the success of treatment (Kösters et al. 2006). In future, the concept of severe impairment of personality functioning could help to characterise populations that are not reached by the traditional medical care system.

11.2	Consensus-based recommendation	New
Expert consensus	For the inpatient admission of patients with severe impairment of personality functioning and disorders from the somatoform spectrum, mixed symptoms from the internalising and externalising spectrum and the spectrum of thought disorders according to HiTOP, the same criteria should also be taken into account as described in the corresponding guidelines: ▪ Somatoform spectrum: S3 Guideline Functional Body Complaints, Version 2.0 from 18/07/2018 [Recommendation 21 (p. 182f)] ▪ Mixed pictures from the internalising and externalising spectrum: S3 Guideline Borderline Personality DisorderVersion 2.0 from 14 November 2022 [Recommendation 32.2, 32.3 & 33 (p. 82)]	

	▪ Mental disorders: S3 Guideline SchizophreniaVersion 2.0 of 15 March 2019 [Recommendation 156 (p. 233); 157 (p. 234); 155 (p. 233); 152 (p. 230); 153 (p. 230); 150 (p. 227); 151 (p. 227)] and S3 Guideline Psychosocial Therapies for Severe Mental Illnesses version 2.0 from 02/10/2018 [p. 365ff]
	Consensus strength: 87%

4.3.3.1.4 (Partial) inpatient rehabilitation

Medical rehabilitation is based on the biopsychosocial model and ICF, not primarily on categorical diagnoses. The aim is to improve participation in social life, particularly in the family and at work, not to cure the illness. The indication for psychosomatic or psychiatric rehabilitation is when participation is jeopardised or impaired and there is a threat of loss of independent living.

According to SGB IX, there is an indication for inpatient or all-day outpatient rehabilitation if the therapy goals include consolidating the success of treatment, treating the consequences of illness, improving the handling of chronic illnesses or regaining the ability to work. Prerequisites are a proven need for rehabilitation (significantly jeopardised or reduced earning capacity), the ability to undergo rehabilitation following adequate acute treatment and a positive rehabilitation prognosis. It is often difficult to return to work after a long period of incapacity for work, especially if the daily structure has been lost and symptoms of illness threaten independent living. Medical rehabilitation can improve social participation here. Patients who strictly refuse to be unable to work can also benefit from rehabilitation in order to avoid decompensation and even suicidal behaviour.

11.3	Consensus-based recommendation	New
Expert consensus	Patients with severe impairment of personality functioning should be recommended (partial) inpatient rehabilitation if they are capable of rehabilitation (motivation/motivability, resilience) and have a positive rehabilitation prognosis if one or more of the following criteria are met: ▪ (Imminent) significant risk or reduction in earning capacity ▪ (Impending) loss of the ability to lead a self-determined and independent life, ▪ (Impending) impairment of participation or increase in impairment of participation Exclusion criteria are: ▪ Acute danger to self or others ▪ Insufficient resilience for rehabilitation treatment, e.g. due to a pronounced inability to control themselves ▪ Primarily substance-related addiction disorders (possibly with indication for qualified withdrawal treatment) ▪ Pronounced cognitive impairments (e.g. dementia) ▪ Severe acute somatic diseasesPronounced psychopathology, e.g. delusional symptoms	
	Cf. Literature: S3 Guideline National Care Guideline Unipolar Depression (Recommendation 13-1, p.193)	
	Consensus strength: 94.4%	

In inpatient psychosomatic or psychiatric rehabilitation centres, patients receive psychotherapeutic services, psychosocial interventions such as occupational therapy or art therapies as well as sports and exercise therapies, supplemented by clinical social work and psychoeducational measures.
The treatment goals of acute and rehabilitation treatments differ fundamentally, although both are based on multimodal, multiprofessional approaches in an interdisciplinary team:

- Acute treatments (outpatient or inpatient) focus on curative therapy, i.e. healing and alleviation, based on the cause and development of the disease.
- Medical rehabilitation treatments aim to prevent, reduce, improve or avoid impairments caused by functional disorders. The aim is successful rehabilitation in terms of participation in social life, particularly in family, work and career.

In the future, outpatient and outreach rehabilitation programmes could also be a good alternative, although there is still a need for further research.

4.3.3.1.5 Problematic aspects of (partial) inpatient treatment

Partial and full inpatient treatment is only one component in the complex care of patients with severe impairment of personality functioning, which requires many players in the healthcare system. This makes it possible to fulfil a wide range of care needs, but also poses the challenge of efficient collaboration across treatment settings and care sectors. Good coordination is important both across the healthcare system and in individual cases. Integrated treatment plans and structured forms of care such as case management can help to avoid uncoordinated and fragmented care. The role of (partial) inpatient treatment should be developed together with those affected as part of participatory decision-making in order to overcome problematic interfaces during admission and discharge and to ensure continuity of care.

11.4	Consensus-based recommendation	New
Expert consensus	In order to ensure continuous care for patients with severe impairment of personality functioning, the measures listed in Table 7 should be implemented in good time before discharge from (partial) inpatient treatment as part of inter-professional discharge management. All stakeholders and professions involved in the care of patients with severe impairment of personality functioning should familiarise themselves with the respective regional care options.	
Guideline adaptation	Literature: S3 Guideline National Care Guideline Unipolar Depression (Recommendation 14-5, p.208; 14-1 p.201), S3 Guideline on the Diagnosis and Treatment of Bipolar Disorders, S3 Guideline Borderline Personality Disorder	
	Consensus strength: 100%	

Table 7: Measures on discharge of patients with severe impairment of personality functioning from (partial) inpatient treatment

The table can be found in the long version of the guideline

Appropriate structural and treatment quality is central to the (partial) inpatient treatment of patients with severe impairment of personality functioning. However, studies show that there is a

lack of the necessary structural quality in routine care, particularly in terms of staffing and training (Bohus et al. 2016Klein et al. 2016; Mehl et al. 2016; Berger et al. 2015; Schnell et al. 2016; Wiegand et al. 2020). This can lead to deterioration and chronicity.
If (partial) inpatient treatment is considered as a curative measure, it should take place in facilities with specific treatment programmes that offer a clear structure, treatment focus and discharge orientation in order to counteract hospitalisation risks and tendencies to abdicate responsibility.
There is a great need for research into the effects, side effects and long-term effects of (partial) inpatient treatment as well as concepts for the outpatientisation of these treatments. It is important to research how the advantages of intensive, multimodal therapeutic programmes can be maintained and how disadvantages such as high costs and the breakdown of therapeutic relationships can be avoided. Innovative concepts such as inpatient-equivalent treatments are necessary in order to overcome sector boundaries and utilise resources more efficiently.

4.3.4 Key question 10: Do patients with severe impairment of personality functioning who receive long-term/continuous care from General Practitioners have a better outcome than those who do not receive consultations?

The majority of people with mental disorders, including those with severe impairment of personality functioning, are treated by general practitioners (Linden et al. 1996; Linden 2001; Wittchen 2000; Linden 2004; Linden et al. 2000; Wittchen and Jacobi 2001; Dittmann et al. 1997; Wittchen et al. 1999). Conversely, many patients undergoing general practitioner treatment have mental disorders (Linden et al. (Linden et al. 1996; Wittchen and Jacobi 2001; Jacobi et al. 2014). Many people with severe mental illnesses receive long-term or permanent treatment predominantly from GPs (Linden et al. 1996; Linden et al. 2016; Heuft et al. 2014; Herzog et al. 2012). GP care is characterised by long-term, continuous support that covers all aspects of health and illness. Therefore, the importance of this care for the outcome of patients with severe impairment of personality functioning is significant.

12.1	Consensus-based recommendation	New
Expert consensus	Patients with severe impairment of personality functioning should be recommended continuous long-term monitoring by a general practitioner. The treatment of patients with severe impairment of personality functioning should be carried out cooperatively with the involvement of long-term support from the GP. The conscious, reliable, active and structuring organisation of the patient-physician relationship and patient-treatment team relationship is a decisive factor in the long-term care of patients with severe impairment of personality functioning. This should be addressed in GP research, further education and training.	
	Consensus strength: 100%	

All German care guidelines that deal with the care of severe mental disorders associated with severe impairment of personality functioning emphasise the importance of GP involvement in early detection and coordination and the importance of interdisciplinary and interprofessional

cooperation and coordination across settings (see Table 8; Linden et al. 2016; Muschalla and Linden 2019). This is all the more urgent the more severe the existing disorders are. Looking at the mortality of people with severe mental illnesses in Germany, their significantly shortened lifespan, in line with international data, is primarily due to their increased somatic disease and mortality risks, which emphasises the importance of interdisciplinary cooperation (Schneider et al. 2019; Basu et al. 2019).
In this context, it must be critically assessed that newly established care models such as complex outpatient care in accordance with the KSVPsych-RL (G-BA 2021) do not include GPs at all.

Table 8: Topic-relevant German guidelines:

The table can be found in the long version of the guideline

12.2	Consensus-based recommendation	New
Expert consensus	The continuous observation of patients and their interaction with the entire GP practice team provides a basis for recognising severe impairment of personality functioning. Complaints, problems, interpersonal conflicts and dysfunctional relationships can then be further explored in dialogue and, if necessary, a differential diagnosis can be initiated. For the successful management of acute crises in particular (suicidal crises, psychotic crises, relationship crises, crises in the context of acute traumatisation, etc.), knowledge of local support services and active networking and (e.g. case-related) exchange between local and regional service providers is helpful and relieving.	
	Consensus strength: 100%	

GP care is characterised by low-threshold access, a wide variety of almost unlimited and unselected reasons for seeking advice and, ideally, long-term continuity as part of long-term support. Diagnostics is also a sometimes lengthy longitudinal process and is characterised by a mixture of structured and experienced anamnesis, which also includes settings such as home visits. In psychosomatic primary care, it is possible to work together longitudinally and in a focussed manner in more regular, planned contacts lasting around 15 minutes (Reddemann et al. 2022; Reddemann 2023).
Complex structured interviews are generally not practicable in the GP care setting. In addition, the clinical validity of structured interviews that are valuable in a research context is not necessarily given (Linden and Muschalla 2012). The presence of an impairment caused by severe impairment of personality functioning will therefore initially be indicated by other criteria, as listed in Table 9.

Table 9: Possible indications of relevant impairments of personality functioning in the GP setting that make a more detailed clarification worth considering:

- Number of diagnoses? Also with regard to comorbid somatic diseases? Chronic pain?
- Frequent visits to the GP practice? Constant life-time events?
- History of many "critical life events"?
- Repeated relationship problems and breakdowns, including with doctors? E.g. number of previous practitioners and cancelled treatments? Which practitioners do patients return to after all?

- Repeated problems with keeping appointments, following medical recommendations, combined with annoying or back-biting interactions with the practice team?
- Observation of strong own emotional reactions to the interaction behaviour of patients?

For diagnostic categorisation in the GP practice, the criteria of the abbreviated "Level of Personality Functioning Scale" (Hummelen et al. 2021) are helpful. A more precise categorisation is usually carried out with specialists. Early indications of limitations in personality functioning are important for treatment planning. Long-term therapeutic relationships are also important in the GP setting. Further research is needed, as the implementation in GP practices may be different to that in psychotherapeutic practices (Reddemann et al. 2022). The practice team must recognise patients' structural deficits and take responsibility for the framework, course of the conversation and conflict management. Techniques such as mirroring, mentalising and careful confrontation help to facilitate healing relationship experiences. Slow developments in the relationship are reflected upon and appreciated. Knowledge of the local care situation and one's own network require personal commitment. GPs can prescribe outpatient psychiatric nursing care for up to six weeks in crises. Sociotherapy requires GPs to have an additional qualification in psychotherapy.

Table 10: Umbrella organisations and nationwide aid services for help in acute crises

The table can be found in the long version of the guideline

4.3.5 Key question 12: Are there indications for psychopharmacological therapy in severe impairment of personality functioning and if so, which ones?

No literature search was conducted for this question, but reference was made to neighbouring national and international guidelines. The following statements and recommendations are based on a thorough review of whether conclusions on the drug treatment of people with severe impairment of personality functioning can be derived from the literature research and the recommendations of these guidelines. Furthermore, it was discussed whether the recommendations could be transferred into a dimensional model based on the 2 axes severe impairment of personality functioning and HiTOP.

The following guidelines were analysed:
- S3 Guideline Borderline Personality Disorder
- S3 Guideline Schizophrenia
- S3 Guideline National Care Guideline Unipolar Depression
- S3 Guideline on the Diagnosis and Treatment of Bipolar Disorders
- S3 Guideline Post-traumatic stress disorders
- S3 Guideline Functional Body Complaints
- S3 Guideline on the Diagnosis and Treatment of Eating Disorders
- S3 Guideline Attention Deficit/Hyperactivity Disorder

In principle, no medication recommendations can be derived from these guidelines in relation to a possible disorder of personality functions (and possibly in addition to the primary disorder according to ICD-10 to which the source guideline refers).

Attempts to translate the guideline recommendations based on categorical diagnostic concepts into a dimensional model based on the two axes SBPF and HiTOP currently harbour the risk of extending indications that are not covered by evidence.

5 Open research questions

See long version of the guideline

6 Evidence tables

See long version of the guideline

7 Bibliography

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