neurologists/psychiatrists, patient representatives) input that has been collected through surveys and in a dedicated expert workshop. The SEBRA will be used to provide recommendations on future areas for excellent, innovative, and translational research comprising those for maximized cooperation, reduced overlap, and fragmentation.

Disclosure: No significant relationships.
Keywords: Brain research; Coordination; Shared European Brain Research Agenda; Funding

Clinical/Therapeutic

Diagnosing borderline personality disorder: A masterclass

W0044

To diagnose or not to diagnose your BPD patient

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Clinicians working in every field of psychiatry will likely encounter patients with borderline personality disorder (BPD) on a regular basis. Nevertheless, diagnostic assessment and disclosure in patients suspected to suffer from BPD can be difficult and even uncomfortable to many clinicians. In a survey among psychiatrists, 57% indicated they had failed to disclose a diagnosis of BPD at some point in their careers, citing diagnostic uncertainty and concerns about stigma as key issues.[1]This workshop will engage the audience in an intensive discussion of when and how to disclose a suspected diagnosis of BPD to a patient, and how to involve the patient in the diagnostic process. Dr. De Picker will demonstrate how BPD diagnostic disclosure can become a key intervention in every psychiatric setting by using a two-step process. The first step involves a review of the DSM-5 diagnostic criteria together with the patient. This is always followed by a narrative explanation using either the interpersonal hypersensitivity model or emotional vulnerability model as trait factor. With these two steps, diagnostic disclosure creates both an important validating experience for the patient and a not to be missed opportunity for psycho-education about the heritability, prognosis and treatability of borderline personality disorder which installs hope, trust and confidence. References: 1. Sisti D, Segal AG, Siegel AM, Johnson R, Gunderson J. Diagnosing, disclosing, and documenting borderline personality disorder: a survey of psychiatrists' practices. J Pers Disord 2016; 30: 848–56.

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Keywords: Borderline personality disorder; Diagnostic disclosure; DSM-5; Psychoeducation

W0045

The difficult differential diagnosis of BPD look-alikes

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The traits of Borderline Personality Disorder (BPD) and various other personality or mental disorders may overlap, causing diagnostic difficulties and pitfalls for psychiatrists early in their career. An online survey conducted among psychiatric trainees and young specialists in 2019 showed that only 63% of them think they are well prepared to diagnose BPD. Predispositions such as impulsivity or emotional instability, which commonly are present in BPD, may also be prevalent in such disorders as Antisocial Personality Disorder, Bipolar Disorder, in people misusing psychoactive substances, or in neurodevelopmental disorders such as ADHD. These symptoms can lead to considerable difficulties in global functioning and performing adequate social roles unless appropriate treatment is provided. Therefore, a proper differential diagnosis is crucial in good psychiatric management of people with BPD features. Dr. Gondek will present what BPD symptom domains may be shared with other mental and personality disorders and how to navigate the diagnostic process to set the correct diagnosis in often unobvious clinical presentations of BPD and its look-alikes.

Disclosure: No significant relationships.
Keywords: Borderline personality disorder; education in psychiatry; differential diagnosis; personality disorders

W0047

Adding dimension to the diagnostic process: Demonstration of the DSM-5 checklist and PID-5 personality trait assessment scale

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Borderline personality disorder (BPD) is very common, with an estimated community prevalence of 1-3%, rising to 25% in psychiatric inpatients. The aim of this talk is to address the challenges clinicians face when diagnosing borderline personality disorder. The new dimensional approach to the classification of personality disorders adopted by ICD-11 diverges from the classical categorical case definitions used in the ICD-10 and DSM-IV/DSM-5 diagnostic frameworks, thereby significantly altering the concept of personality disorders. While the DSM-5 checklist is a well-known and widely used diagnostic entity by now, with the introduction of Personality Inventory for DSM-5 (PID-5) a new assessment tool has emerged, providing the possibility of a more detailed description of personality functioning and traits. PID-5 is a 220-item self-rated personality trait assessment scale, assessing 25 personality trait facets and 5 main personality trait domains. This talk will focus on analyzing the difference between categorical and dimensional diagnostic

work-up, using a case presentation to demonstrate the diagnostic processes and their outcomes.

Disclosure: No significant relationships.
Keywords: PID-5; Borderline personality disorder; dimensional model; categorical model

W0048

Diagnostic dilemma's in the new world of ICD-11 personality disorders

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Personality disorders have ever been a troublesome group. From the early 90's ICD 10 tidied up the group. DSM-IV, IV-TR, aand then DSM 5, changed the style but not substance, leaving clinicians to grapple with thorny questions of multiple diagnoses, treatment and prognosis. International views on the utility of the diagnosis often depended upon the institution or the funding mechanism. Were fears of exclusion and stigma dominated or where there was no treatment, there was under-diagnosis, such as in the United Kingdom and the Republic of Ireland. Where a label was a ticket of entry to treatment and funding, diagnostic generosity prevailed, such as in Australia, New Zealand and the United States. Gender discrepancies disappeared with structured interviews, and interest grew in the category which seem to only include the most severe forms. For many years the DSM taskforce tried to shift the construct but shied away from the cliff edge; a bold new initiative did not materialise. It was left to the ICD-11 to generate a much more adventurous and positive view of how characterological traits shift under pressure, moving from something that may at first have helped patients to 'survive' to something that became maladaptive and harmful. With a court tested case Dr Wise will demonstrate the differences between ICD-10 and ICD-11 highlighting the more important differences: onset, course and severity descriptors. PD's are no longer lifelong impairments. Prepare for 'The shock of the new'!

Disclosure: No significant relationships.
Keywords: ICD-11; Personality Disorder; personality disorder

Educational

The "forgotten" psychiatric syndromes

W0050

Kleptomania as a neglected disorder in psychiatry

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Kleptomania is an impulse control disorder characterized by the irresistible urge to steal not for monetary gain. Since its conceptualization, this categorical diagnosis has been conflated with common beliefs regarding the social class and gender such as the idea that women are intrinsically fragile and that people in the middle class were unlikely to commit theft. Also, its use has been controversial in the medical and forensic fields. This presentation will provide a historical excursus through the definitions of the syndrome and summarize the available pharmacological and psychotherapeutic options for its treatment. Currently, there is a lack of systematic studies regarding the clinical characteristics of kleptomania and its treatment options for practical standardized approaches.

Disclosure: No significant relationships.
Keywords: Shoplifting; Stealing; Impulse control disorders; Kleptomania

W0054

The de Clérambault syndrome: More than just a delusional disorder?

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The de Clèrambault syndrome is a psychiatric condition characterized by the presence of a delusion in which the patient is convinced that another person has fallen in love with him or her. Patients usually believe that their lover is a person belonging to a higher social and economic class, or is already married, or even is imaginary or deceased person. In the majority of cases, the patients do not seek for psychiatric help, but usually is referred to the mental health care system due to behavioural consequences associated with the syndrome, including stalking behaviours (repetitive calling, unexpected visits or continuous attempts to send gifts or letters to the loved person). The name of the syndrome derives from the French psychiatrist Gaetan Gatian de Clerambault, who systematically described this syndrome in a series of patients. According to the modern classification systems, the syndrome is conceptualized as erotomanic subtype of the delusional disorder. However, the presence of delusions is not the only clinical feature of the syndrome. In fact, specific affective features are usually present, such as grandiosity, hypersexuality and promiscuity. Therefore, it has been argued that De Clèrambault syndrome should be considered as lying on the continuum of the spectrum of bipolar disorders. Those diagnostic uncertainties highlight the difficulties for clinicians to properly manage this syndrome and should represent a valid reason for rediscovering this almost neglected psychiatric syndrome.

Disclosure: No significant relationships.
Keywords: Delusion; psychosis; affective symptoms