La Mentalizzazione: Terreno Comune o Terreno Minato dei Trattamenti per il DBP?

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Mentalizzazione e DBP

- “C’era una volta, in un paese lontano, lontano…”
- Nel 1997 Wampold e colleghi pubblicarono una meta-analisi degli studi di efficacia delle psicoterapie *bona fide*; malgrado le controversie generate, questo studio mise in luce alcuni punti fermi, replicati da una meta-analisi successiva di Luborsky e coll. (2002):
- 1. esiste un’efficacia generale delle psicoterapie;
- 2. non esistono differenze significative nell’efficacia tra diverse tecniche psicoterapeutiche;
- Quindi…

3. “Everybody has won and all must have prizes”

Mentalizzazione e DBP

- Gli studi di Crits-Cristoph (per es., Crits-Christoph, 1997; Crits-Cristoph e coll., 2002) hanno fornito un quadro meno pessimistico, indicando la presenza di fattori “comuni” o “aspecifici” che spiegavano la variazione degli ES. In particolare, tre sono risultati particolarmente rilevanti (Messer e Wampold, 2002):

  1. Alleanza terapeutica
  2. Fedeltà del terapeuta al modello teorico-clinico
  3. Competenza del terapeuta

Mentalizzazione e DBP

- Quali evidenze d’efficacia delle psicoterapie per il DBP?

The Effectiveness of Psychodynamic Therapy and Cognitive Behavior Therapy in the Treatment of Personality Disorders: A Meta-Analysis

Falk Leichsenring, D.Sc.

Eric Leibing, D.Sc.

(Am J Psychiatry 2003; 160:1223–1232)

Fourteen studies of psychodynamic therapy (9, 10, 12, 13, 15–24) and 11 studies of cognitive behavior therapy (9, 10, 13, 14, 25–31) met the inclusion criteria (Table 1). Two further studies examined the effects of psychodynamic and cognitive behavior therapy combinations (35, 36).

TABLE 2. Features of Studies Included in a Meta-Analysis Examining the Effectiveness of Psychodynamic Therapy and Cognitive Behavior Therapy in the Treatment of Personality Disorders

Form of Therapy and Feature	Studies With Data	Mean	SD	Median	Range
Psychodynamic therapy (15 studies)[a]					
Length (weeks)	13	37.18	26.80	28	1.4–102
Number of sessions	6	23.17	11.63	22	12–40
Follow-up duration (weeks)	15	78.13	60.39	75	1–208
Global Adjustment Scale score	4	43.69	11.51	44	30–57
Study group size (personality disorder diagnoses only)	15	27.47	14.20	26	12–55
Cognitive behavior therapy (11 studies)					
Length (weeks)	8	16.36	16.63	11	1–52
Number of sessions	7	13.19	8.59	12	6–32
Follow-up duration (weeks)	10	12.50	17.82	2.5	1–52
Global Adjustment Scale score	1	37.73	7.53		
Study group size (personality disorder diagnoses only)	11	21.00	13.24	16	12–57

[a] The data of Wilberg et al. were treated as two studies.

TABLE 3. Outcome Measures From Studies Included in a Meta-Analysis Examining the Effectiveness of Psychodynamic Therapy and Cognitive Behavior Therapy in the Treatment of Personality Disorders

Form of Therapy and Outcome Measure	Number of Studies	Mean	SD	Median	Range
Psychodynamic therapy					
Attrition (%)	11	15.36	12.39	14	0 to 38
Improvement effect size					
Overall	15	1.46	0.73	1.29	0.34 to 2.70
Self-report measures	12	1.08	0.36	0.94	0.65 to 1.67
Observer-rated measures	12	1.79	1.07	1.90	0.34 to 4.02
Improvement effect size for specific measures of personality disorder pathology	6	1.56	0.76	1.65	0.50 to 2.40
Improvement effect size for control conditions					
Self-report measures	2	0.10	0.50	0.10	–0.26 to 0.45
Observer-rated measures	0				
Recovery (%)	3	59	22	40	30 to 72
Cognitive behavior therapy					
Attrition (%)	9	16.89	10.45	15	0 to 31
Improvement effect size					
Overall	10	1.00	0.48	0.99	0.34 to 2.13
Self-report measures	8	1.20	0.38	1.20	0.81 to 1.85
Observer-rated measures	8	0.87	0.71	0.70	0.19 to 2.40
Improvement effect size for control conditions					
Self-report measures	2	0.17	0.01	0.17	0.16 to 0.18
Observer-rated measures	3	0.51	0.39	0.40	0.19 to 0.95
Recovery (%)	1	47			

TABLE 4. Improvement Effect Sizes for the Most Frequently Used Outcome Measures From Studies Included in a Meta-Analysis Examining the Effectiveness of Psychodynamic Therapy and Cognitive Behavior Therapy in the Treatment of Personality Disorders

Form of Therapy and Subject Group	Beck Depression Inventory			SCL-90-R Global Severity Index			Health-Sickness Rating Scale or Global Adjustment Scale		
	Number of Studies	Effect Size		Number of Studies	Effect Size		Number of Studies	Effect Size	
		Mean	SD		Mean	SD		Mean	SD
Psychodynamic therapy									
Personality disorders	6	1.44	0.51	5	0.81	0.17	4	2.05	0.99
No personality disorder	2	2.39	0.54	2	1.39	0.04	2	2.52	1.47
Cognitive behavior therapy									
Personality disorders	3	1.49	0.28	2	1.37	0.41	1	1.36	
No personality disorder	1	2.04		1	1.40		0		

Conclusions: There is evidence that both psychodynamic therapy and cognitive behavior therapy are effective treatments of personality disorders. Since the number of studies that could be included in this meta-analysis was limited, the conclusions that can be drawn are only preliminary. Further studies are necessary that examine specific forms of psychotherapy for specific types of personality disorders and that use measures of core psychopathology. Both longer treatments and follow-up studies should be included.

Borderline personality disorder

Falk Leichsenring, Eric Leibing, Johannes Kruse, Antonia S New, Frank Leweke Lancet 2011; 377: 74–84

	Treatment	Comparison
Bateman and Fonagy[109]	Mentalisation-based treatment in a partial hospital setting	Treatment as usual
Bateman and Fonagy[118]	Mentalisation-based psychodynamic treatment	Structured clinical management
Blum et al[120]	Brief cognitive-behavioural therapy plus treatment as usual	Treatment as usual
Bohus et al[121]	Inpatient dialectical behaviour therapy	Treatment as usual
Clarkin et al[122]	Transference-focused therapy	Dialectical behaviour therapy as supportive therapy
Cottraux et al[123]	Cognitive-behavioural therapy	Client-centred therapy
Davidson et al[119]	Brief cognitive-behavioural therapy plus treatment as usual	Treatment as usual
Doering et al[132]	Transference-focused therapy	Community treatment by experienced therapists
Farrel et al[124]	Schema-focused therapy plus treatment as usual	Treatment as usual
Giesen-Bloo et al[125]	Schema-focused therapy	Transference-focused therapy
Gregory et al[126]	Dynamic deconstructive therapy	Treatment as usual
Harned et al[127]	Dialectical behaviour therapy	Community treatment by experts
Koons et al[114]	Dialectical behaviour therapy	Treatment as usual
Linehan et al[110]	Dialectical behaviour therapy	Treatment as usual
Linehan et al[112]	Dialectical behaviour therapy	Treatment as usual
Linehan et al[111]	Dialectical behaviour therapy	Comprehensive validation therapy plus a 12-step substance misuse programme
Linehan et al[128]	Dialectical behaviour therapy	Therapy by experts
McMain et al[129]	Dialectical behaviour therapy	Psychodynamically informed clinical management
Munroe-Blum et al[116]	Psychodynamic therapy	Interpersonal group therapy
Soler et al[130]	Dialectical behaviour therapy skills training	Standard group therapy
Tyrer et al[117]	Brief cognitive-behaviour therapy	Treatment as usual
Turner et al[115]	Dialectical behaviour therapy	Client-centred therapy
Verheul et al[131]	Dialectical behaviour therapy	Treatment as usual
Weinberg et al[133]	Brief cognitive-behavioural therapy plus treatment as usual	Treatment as usual

Table 2: **Randomised controlled trials of psychotherapy in patients with borderline personality disorder**

In summary, dialectical behaviour therapy and specific forms of psychodynamic psychotherapy seem to be superior to treatment as usual in some clinically relevant problems of borderline personality disorder. Adding brief cognitive behaviour therapy to treatment as usual seems to be superior to treatment as usual alone. According to follow-up studies, effects of psychotherapy are stable over time.[111,112,116,119,120,124,127,128,136–138] At present, there is no clear evidence that one specific form of psychotherapy is superior to another.[139] In several studies comparing specific forms of psychotherapy, however, power was not sufficient to detect possible differences.[111,116,122] In summary, there is evidence that psychotherapy is beneficial with respect to some clinically relevant problems of patients with borderline personality disorder. However, the available forms of psychotherapy do not yet lead to remission of borderline personality disorder for most patients (ie, no longer fulfilling the criteria of a diagnosis of borderline personality disorder). Thus, further research is needed.

Acta Psychiatr Scand 2011: 123: 327–338
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DOI: 10.1111/j.1600-0447.2010.01652.x

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ACTA PSYCHIATRICA SCANDINAVICA

Review

Treatment completion in psychotherapy for borderline personality disorder – a systematic review and meta-analysis

Barnicot K, Katsakou C, Marougka S, Priebe S. Treatment completion in psychotherapy for borderline personality disorder – a systematic review and meta-analysis.

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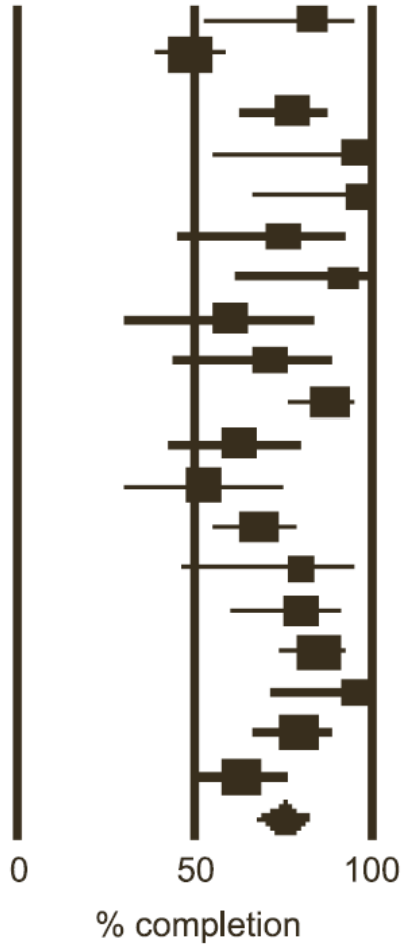
Table 2. Meta-analyses of completion rates in psychotherapy for borderline personality disorder – intervention length under 12 months

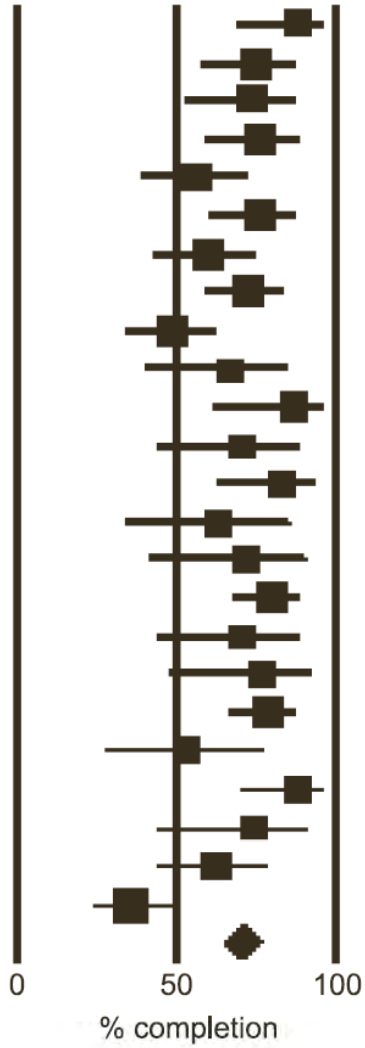
First author and date	Treatment	Sample initiating treatment (*M*)	Treatment completion (%)
Black 2008 (47)	STEPPS	12	83
Blum 2008 (42)	STEPPS	92	48
Bohus 2004 (49)	DBT	40	78
Brassington 2006 (50)	DBT	10	100
Farrell 2009 (41)	SFT	16	100
Fleischhaker 2006 (56)	DBT	12	75
Gratz 2006 (38)	ERGT	13	92
Harley 2007 (58)	DBT	10	60
Koons 2001 (33)	DBT	14	77
Kröger 2006 (61)	DBT	50	88
Linehan 2008 (62)	DBT	24	67
Nee 2005 (66)	DBT	17	53
Rüsch 2008 (68)	DBT	60	68
Schornstein 2008 (69)	DBT	10	80
Simpson 2004 (70)	DBT	25	80
Soler 2008 (71)	DBT	60	85
Stanley 2007 (72)	DBT	20	95
Van Wel 2009 (43)	STEPPS	45	80
Woodberry 2008 (74)	DBT	46	63
Overall estimate			75



DBT, dialectical behaviour therapy; ERGT, emotion regulation group therapy.

Table 3. Meta-analyses of completion rates in psychotherapy for borderline personality disorder – intervention length 12 months or longer

First author and date	Treatment	Sample initiating treatment (N)	Treatment completion (%)
Bateman 1999 (39)	MBT	25	88
Brown 2004 (51)	CBT	32	75
Clarkin 2001 (52)	TFP	23	74
Clarkin 2007 (44)	TFP	30	77
Clarkin 2007 (44)	DBT	30	57
Comtois 2007 (54)	DBT	38	76
Cottraux 2009 (55)	CBT	33	69
Giesen-Bloo 2006 (40)	SFT	45	73
Giesen-Bloo 2006 (40)	TFP	43	49
Gregory 2008 (37)	DDP	15	67
James 2008 (59)	DBT	16	88
Kennedy 2007 (60)	DBT	14	71
Linehan 1991 (30)	DBT	24	81
Linehan 1999 (31)	DBT	11	63
Linehan 2002 (34)	DBT	11	73
Linehan 2006 (36)	DBT	52	83
Lopez 2004 (63)	TFP	14	71
Low 2001 (64)	DBT	13	77
Nadort 2009 (65)	SFT	62	85
Nee 2005 (66)	DBT	13	54
Perseius 2007 (67)	DBT	27	89
Turner 2000 (32)	DBT	12	75
Verheul 2003 (35)	DBT	27	63
Zinkler 2007 (75)	DBT	50	36
Overall estimate			71



CBT, cognitive behaviour therapy; DBT, dialectical behaviour therapy; DDP, dynamic deconstructive psychotherapy; MBT, mentalisation-based therapy; TFP, transference-focused therapy.

Results: Forty-one studies were included, with completion rates ranging from 36% to 100% – a substantial between-study heterogeneity. Random effects meta-analyses yielded an overall completion rate of 75% (95% CI: 68–82%) for interventions of <12 months duration, and 71% (95% CI: 65–76%) for longer interventions. Egger's test for publication bias was significant for both analyses ($P \leq 0.01$). Study characteristics such as treatment model and treatment setting did not explain between-study heterogeneity. In individual studies, factors predicting dropout status included commitment to change, the therapeutic relationship and impulsivity, whilst sociodemographics were consistently non-predictive.
Conclusion: Borderline personality disorder should no longer be associated with high rates of dropout from treatment. However, the substantial variation in completion rates between studies remains unexplained. Research on the psychological processes involved in dropping out of treatment could further improve dropout rates.

Article

Systems Training for Emotional Predictability and Problem Solving (STEPPS) for Outpatients With Borderline Personality Disorder: A Randomized Controlled Trial and 1-Year Follow-Up

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Objective: Systems Training for Emotional Predictability and Problem Solving (STEPPS) is a 20-week manual-based group treatment program for outpatients with borderline personality disorder that combines cognitive behavioral elements and skills training with a systems component. The authors compared STEPPS plus treatment as usual with treatment as usual alone in a randomized controlled trial.

Method: Subjects with borderline personality disorder were randomly assigned to STEPPS plus treatment as usual or treatment as usual alone. Total score on the Zanarini Rating Scale for Borderline Personality Disorder was the primary outcome measure. Secondary outcomes included measures of global functioning, depression, impulsivity, and social functioning; suicide attempts and self-harm acts; and crisis utilization. Subjects were followed 1 year posttreatment. A linear mixed-effects model was used in the analysis.

Results: Data pertaining to 124 subjects (STEPPS plus treatment as usual [N=65]; treatment as usual alone [N=59]) were analyzed. Subjects assigned to STEPPS plus treatment as usual experienced greater improvement in the Zanarini Rating Scale for Borderline Personality Disorder total score and subscales assessing affective, cognitive, interpersonal, and impulsive domains. STEPPS plus treatment as usual also led to greater improvements in impulsivity, negative affectivity, mood, and global functioning. These differences yielded moderate to large effect sizes. There were no differences between groups for suicide attempts, self-harm acts, or hospitalizations. Most gains attributed to STEPPS were maintained during follow-up. Fewer STEPPS plus treatment as usual subjects had emergency department visits during treatment and follow-up. The discontinuation rate was high in both groups.

Conclusions: STEPPS, an adjunctive group treatment, can deliver clinically meaningful improvements in borderline personality disorder-related symptoms and behaviors, enhance global functioning, and relieve depression.

(Am J Psychiatry 2008; 165:468–478)

TABLE 3. Primary and Secondary Outcome Measures in Outpatients With Borderline Personality Disorder Randomly Assigned to STEPPS Plus Treatment as Usual or Treatment as Usual Alone

	Treatment Assignment								
	STEPPS Plus Treatment as Usual (N=65)		Treatment as Usual Alone (N=59)[a]		Analysis of Difference in Rate of Change				
Outcome Measure	Mean	SD/SE[b]	Mean	SD/SE[b]	F	df	p	Effect Size[c]	SE
Primary measure									
Zanarini Rating Scale for Borderline Personality Disorder (total score)					11.0	1, 89	0.001	0.84	0.25
Baseline	18.9	6.8	17.3	7.0					
Week 20	9.8	1.0	13.4	1.0					
Secondary measures									
Affective subscale[d]					7.6	1, 89	0.007	0.70	0.25
Baseline	10.8	2.7	10.1	2.8					
Week 20	3.9	0.4	4.9	0.4					
Cognitive subscale[d]					5.1	1, 89	0.027	0.51	0.23
Baseline	6.1	2.3	6.2	2.2					
Week 20	2.0	0.3	3.0	0.3					
Impulsivity subscale[d]					6.9	1, 89	0.010	0.65	0.25
Baseline	5.0	2.1	4.3	2.0					
Week 20	1.9	0.3	2.3	0.3					
Disturbed relationships subscale[d]					5.1	1, 88	0.026	0.61	0.27
Baseline	6.0	2.0	5.8	2.0					
Week 20	2.2	0.3	3.2	0.3					
CGI severity rating					14.1	1, 398	<0.001	0.75	0.20
Baseline	5.1	0.8	4.9	0.9					
Week 20	4.4	0.1	4.7	0.1					
CGI improvement rating					11.6	1, 277	<0.001	1.09	0.32
Baseline	3.8	1.0	4.0	1.1					
Week 20	2.7	0.2	3.8	0.2					
CGI patient self-rating					9.0	1, 254	0.003	0.90	0.30
Baseline	3.6	1.3	3.7	1.4					
Week 20	2.4	0.2	3.3	0.2					
Global Assessment Scale					12.1	1, 84	<0.001	0.65	0.19
Baseline	39.7	11.2	39.6	11.4					
Week 20	50.5	1.6	43.5	1.6					
Thoughts/feelings[e]					4.9	1, 379	0.027	0.51	0.23
Baseline	23.1	6.6	23.6	7.7					
Week 20	18.7	1.0	20.6	1.1					
Negative behaviors[e]					0.3	1, 375	0.578	0.12	0.22
Baseline	9.3	3.3	9.6	4.3					
Week 20	8.2	0.5	7.9	0.5					
Positive behaviors[e]					2.6	1, 368	0.110	0.41	0.26
Baseline	8.5	2.7	8.6	2.8					
Week 20	10.1	0.4	9.3	0.4					
Total score[e]					3.5	1, 364	0.063	0.47	0.25
Baseline	39.0	9.7	39.8	12.6					
Week 20	31.8	1.7	34.1	1.8					
Positive affectivity (PANAS)					0.6	1, 374	0.440	0.15	0.19
Baseline	21.6	9.3	22.3	7.9					
Week 20	23.4	1.1	22.4	1.1					
Negative affectivity (PANAS)					4.3	1, 376	0.038	0.43	0.21
Baseline	28.9	9.4	29.9	9.0					
Week 20	23.6	1.2	26.1	1.2					
Beck Depression Inventory					4.6	1, 377	0.033	0.50	0.23
Baseline	29.0	11.6	29.7	15.0					
Week 20	22.0	2.0	25.8	2.0					
Barratt Impulsiveness Scale					9.0	1, 80	0.004	0.54	0.18
Baseline	80.6	12.6	77.4	12.8					
Week 20	72.7	1.8	76.8	1.8					
Sympton Checklist-90-Revised Global Severity Index[f]					4.8	1, 78	0.031	0.44	0.20
Baseline	16.0	7.2	16.8	6.0					
Week 20	12.5	1.0	14.9	1.1					
Social Adjustment Scale total score[f]					3.5	1, 80	0.065	0.43	0.23
Baseline	27.8	5.0	28.2	5.0					
Week 20	24.6	0.8	26.3	0.8					

[a] Estimated mean and standard error from linear mixed-effects model adjusted for last assessment time and avoidant personality disorder. All subjects with postbaseline assessment contributed to the estimation of baseline and week 20 means.
[b] Standard deviation was used at baseline, and standard error was used at week 20.
[c] Effect size is estimated as the group difference in week 20 mean improvement divided by the pooled standard deviation at baseline.
[d] From the Zanarini Rating Scale for Borderline Personality Disorder.
[e] From the Borderline Evaluation of Severity Over Time scale.
[f] To facilitate the reporting of significant digits, we scaled this measure by multiplying item means by 10.

Article

Dialectical Behavior Therapy Compared With General Psychiatric Management for Borderline Personality Disorder: Clinical Outcomes and Functioning Over a 2-Year Follow-Up

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Robert J. Cardish, M.D.

Paul S. Links, M.D.

Objective: The authors conducted a 2-year prospective naturalistic follow-up study to evaluate posttreatment clinical outcomes in outpatients who were randomly selected to receive 1 year of either dialectical behavior therapy or general psychiatric management for borderline personality disorder.

Method: Patients were assessed by blind raters 6, 12, 18, and 24 months after treatment. The clinical effectiveness of treatment was assessed on measures of suicidal and nonsuicidal self-injurious behaviors, health care utilization, general symptom distress, depression, anger, quality of life, social adjustment, borderline psychopathology, and diagnostic status. The authors conducted between-group comparisons using generalized estimating equation, mixed-effects models, or chi-square statistics, depending on the distribution and nature of the data.

Results: Both treatment groups showed similar and statistically significant improvements on the majority of outcomes 2 years after discharge. The original effects of treatment did not diminish for any outcome domain, including suicidal and nonsuicidal self-injurious behaviors. Further improvements were seen on measures of depression, interpersonal functioning, and anger. However, even though two-thirds of the participants achieved diagnostic remission and significant increases in quality of life, 53% were neither employed nor in school, and 39% were receiving psychiatric disability support after 36 months.

Conclusions: One year of either dialectical behavior therapy or general psychiatric management was associated with long-lasting positive effects across a broad range of outcomes. Despite the benefits of these specific treatments, one important finding that replicates previous research is that participants continued to exhibit high levels of functional impairment. The effectiveness of adjunctive rehabilitation strategies to improve general functioning deserves additional study.

(Am J Psychiatry 2012; 169:650–661)

Mentalizzazione e DBP

- Dunque, anche per il DBP …

… oppure no?

Mentalizzazione e DBP

- Al di là dei fattori “aspecifici”, Bateman e Fonagy (2004) hanno ipotizzato l’esistenza di un tema comune sotteso ai diversi tipi di intervento per il DBP, che potrebbe rendere ragione della loro comune efficacia.
- Il tema in questione è rappresentato dalla focalizzazione della terapia sulle capacità di MENTALIZZAZIONE, ossia sulla implicita o esplicita interpretazione o percezione delle azioni proprie o altrui come intenzionali, ossia, mediate da processi o stati mentali (Bateman e Fonagy, 2004)

Mentalizzazione e DBP

- In quest'ottica, un aspetto chiave della relazione è il fatto che il terapeuta – o il milieu terapeutico – mentalizzi il paziente in modo tale da rinforzare la capacità di mentalizzazione del paziente stesso: l'aspetto cruciale della terapia del paziente BPD verrebbe così ad essere rappresentato dall'esperienze delle menti di altri esseri umani che hanno in mente la mente del paziente.

Mentalizzazione e DBP

- Da questo punto di vista, ciò ha un valore terapeutico non è tanto il contenuto esplicito dell'interpretazione o dell'intervento educativo, quanto il processo implicito che lo sottende.
- La mentalizzazione può essere sia implicita che esplicita. Quella implicita è una funzione procedurale inconscia e non riflessiva: per dirla con Baron-Cohen "per la maggior parte del tempo noi leggiamo la mente in modo automatico e largamente inconscio"

Mentalizzazione e DBP

- Bateman e Fonagy (2004) indicano 6 argomenti a favore della mentalizzazione come aspetto cardine di un processo terapeutico efficace:

1. la mentalizzazione implicita è il fondamento di ogni lavoro terapeutico: senza coinvolgimento sociale non può esserci psicoterapia e senza mentalizzazione implicita non può esserci coinvolgimento sociale;

Mentalizzazione e DBP

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Mentalizzazione e DBP

2. la psicoterapia attiva il sistema dell'attaccamento e come componente genera un'esperienza di base sicura; l'esperienza di essere compreso genera un'esperienza di di sicurezza che a sua volta facilita "l'esplorazione mentale" (ossia, l'esplorazione della mente dell'altro per trovarvi sé stesso);
3. i terapeuti – di tutti i pazienti, ma particolarmente di quelli con un'esperienza del proprio mondo mentale confusa e diffusa – costruiscono e ricostruiscono continuamente nella loro mente un'immagine della mente del paziente

Mentalizzazione e DBP

4. la mentalizzazione nelle terapie psicologiche è tipicamente un processo di attenzione condivisa, comune, in cui gli interessi del paziente e del terapeuta si incrociano nello stato mentale del paziente;
5. il contenuto esplicito degli interventi del terapeuta è mentalistico indipendentemente dall'orientamento teorico dello stesso, ossia, indipendentemente dal fatto che il terapeuta sia principalmente interessato a reazioni transferali, pensieri negativi automatici, ruoli reciproci o pensiero lineare.

Mentalizzazione e DBP

6. la natura diadica della terapia promuove intrinsecamente la capacità del paziente di generare prospettive multiple.

- Si può considerare la psicoterapia per il BPD come un processo integrativo in cui la mentalizzazione implicita e quella esplicita vengono sintetizzate in un atto di “ridescrizione rappresentativa” (Karmiloff-Smith, 1992), ossia attraverso un processo attraverso il quale ‘l’informazione implicita nella mente diventa conoscenza esplicita per la mente’ (p. 18).

Mentalizzazione e DBP

- Ipotesi affascinante… MA UN'IPOTESI!
- Che deve essere considerata alla luce di alcune questioni…

Mentalizzazione e DBP

- QUESTIONI DI EFFICACIA
- Avere evidenze empiriche sull'efficacia dei trattamenti per il DBP ha posto in luce anche il fatto che l'effetto sul funzionamento psicosociale non va di pari passo con l'effetto della remissione sintomatologica (vedi per es., Bateman e Fonagy, 2008; McMain e coll., 2012); quanto a questìultima, sembra esserci una riduzione dell'efficacia con l'aumentare del tempo di follow-up…

Journal of Consulting and Clinical Psychology
2010, Vol. 78, No. 6, 936–951

© 2010 American Psychological Association
0022-006X/10/$12.00 DOI: 10.1037/a0021015

Dialectical Behavior Therapy for Borderline Personality Disorder: A Meta-Analysis Using Mixed-Effects Modeling

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Objective: At present, the most frequently investigated psychosocial intervention for borderline personality disorder (BPD) is dialectical behavior therapy (DBT). We conducted a meta-analysis to examine the efficacy and long-term effectiveness of DBT. *Method:* Systematic bibliographic research was undertaken to find relevant literature from online databases (PubMed, PsycINFO, PsychSpider, Medline). We excluded studies in which patients with diagnoses other than BPD were treated, the treatment did not comprise all components specified in the DBT manual or in the suggestions for inpatient DBT programs, patients failed to be diagnosed according to the *Diagnostic and Statistical Manual of Mental Disorders*, and the intervention group comprised fewer than 10 patients. Using a mixed-effect hierarchical modeling approach, we calculated global effect sizes and effect sizes for suicidal and self-injurious behaviors. *Results:* Calculations of postintervention global effect sizes were based on 16 studies. Of these, 8 were randomized controlled trials (RCTs), and 8 were neither randomized nor controlled (nRCT). The dropout rate was 27.3% pre- to posttreatment. A moderate global effect and a moderate effect size for suicidal and self-injurious behaviors were found, when including a moderator for RCTs with borderline-specific treatments. There was no evidence for the influence of other moderators (e.g., quality of studies, setting, duration of intervention). A small impairment was shown from posttreatment to follow-up, including 5 RCTs only. *Conclusions:* Future research should compare DBT with other active borderline-specific treatments that have also demonstrated their efficacy using several long-term follow-up assessment points.

Mentalizzazione e DBP

- Come ha suggerito Bender (2011) è possibile che la generale, benchè ridotta, efficacia di molti interventi manualizzati sia legata alla ridotta durata di questi, che impedisce al gestione dei problemi complessi legati al DBP
- Il miglioramento di un sintomo o pochi sintomi diviene possibile a spese di una continua disfunzionalità generale

Mentalizzazione e DBP

- QUESTIONI LEGATE ALL'INTERVENTO
- L'idea che qualsiasi processo psicoterapeutico implichi l'uso di risorse mentalistiche è affascinante e – dal mio punto di vista – condivisibile
- Ma questo si può estendere a trattamenti quali STEPPS, basati su un approccio psicoeducazionale direttivo, cui si associano diari dell'intensità emotiva, monitoraggio dei sintomi DBP e dei filtri cognitivi espliciti? Personalmente, ho qualche dubbio…

Mentalizzazione e DBP

- Lascio la parola a D. Bender (2011):
- “The insistence on RCT as the gold standard for studying psychotherapy raises a number of other issues. I will mention just a few. Advocates of using the RCT approach to study psychotherapy would have us believe that in the name of good science, it is necessary to mimic the double-blind methodology employed in drug studies (2). However, it is impossible to be blind in a study of psychotherapy. It is interesting to note that in studies comparing manualized treatments, very often, the one most favored by the authors tends to come out looking better than the others”.

Mentalizzazione e DBP

- “Then, there is the issue of the treatment-as-usual control group. Most clinicians are not adequately trained to treat BPD. Thus, in many cases, using treatment-as-usual as the comparison group is like a race between someone who carboloaded the night before and a person who hasn’t eaten in 3 days”.

Mentalizzazione e DBP

- “… Contrived horse races between competing treatments that arbitrarily end should be replaced with better efforts to study what works for which kind of patient and why, and how long does it really take?”.
- Quest’ultima riflessione ci porta nel vivo di un’ulteriore questione che deve essere presa in esame prima di aderire entusiasticamente alla prospettiva della mentalizzazione…

Mentalizzazione e DBP

- QUESTIONI DI PROCESSO
- Gli studi disponibili, oltre che criticabili, riguardano sostanzialmente alcuni fattori di esito.
- Poco o nulla si sa dei fattori di processo che determinano l'efficacia dei singoli trattamenti manualizzati per il DBP.
- Si tratta di informazioni importanti, vista la natura multimodale di molti di questi trattamenti
- IN OGNI CASO, SE NON SAPPIAMO PERCHE' E COME FUNZIONA UN SINGOLO TRATTAMENTO, COME FACCIAMO A SOSTENERE CHE ESISTE UN SINGOLO ELEMENTO PROCESSUALE COMUNE A TUTTI? A RIGORE, SOLO LO STUDIO DI LEVY E COLL. (2006) HA MOSTRATO UN CAMBIAMENTO DELLA RF LEGATO ALL'EFFICACIA DI TFP NEI BPD IN UN RCT (meno male che ho esaurito le sigle…)

Mentalizzazione e DBP

QUESTIONI DI ASSESSMENT

Mentalization: Ontogeny, Assessment, and Application in the Treatment of Borderline Personality Disorder

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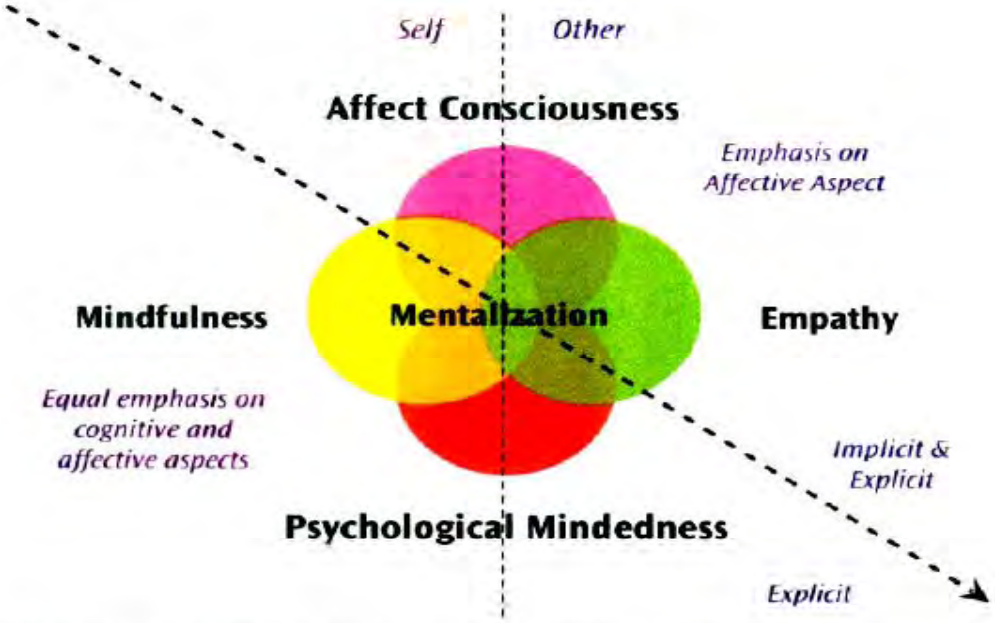
This article aims to review the development of the concept of mentalization, its applications in the understanding and treatment of borderline personality disorder, and the issue of its assessment. While conceptually derivative of theory of mind, Fonagy's concept of mentalization concerns more affectively and interpersonally complex understandings of oneself and others, reflecting abilities that enable an individual not only to navigate the social world effectively but also to develop an enriched, stable sense of self. The components of mentalization can be organized around self-/other-oriented, implicit/explicit, and cognitive/affective dimensions. Concepts of mindfulness, psychological mindedness, empathy, and affect consciousness are shown to partially overlap with mentalization within these three dimensions. Mentalization is assessed by the measure of reflective function, a scale to be used adjunctively on semistructured narrative interviews such as the Adult Attachment Interview. Its validity has not been fully tested, and its usage has been hampered by the time and expense it requires. Although the concept of mentalization is a useful heuristic that enables clinicians to adopt a coherent treatment approach, it may be too broad and multifaceted to be operationalized as a marker for specific forms of psychopathology such as borderline personality disorder. Research elucidating the relationship between reflective function, overlapping concepts, and features of borderline psychopathology is needed.

(Am J Psychiatry 2008; 165:1127–1135)

FIGURE 1. Mentalization Map: Dimensional Features and Conceptual Overlaps[a]



[a] This Venn diagram maps the conceptual overlaps between mentalization and four related concepts including mindfulness, psychological mindedness, empathy, and affect consciousness, which are represented by the four circles. The lines which bifurcate the diagram according to its three dimensions (i.e., self-/other-oriented, implicit/explicit, and cognitive/affective) are dashed to illustrate the permeable and nonabsolute nature of these divisions. In the self/other dimension, mindfulness focuses more on mental states within oneself, while empathy is primarily understood in terms of one's imagination of mental states within others. Both affect consciousness and psychological mindedness concern both sides of the self and other distinction. While mindfulness and psychological mindedness emphasize both cognitive and affective aspects of mental states and function explicitly, affect consciousness and empathy relate more primarily to affective mental contents and function both explicity and implicity. Mentalization lies at the intersection of these concepts but the boundaries between them are not distinctly drawn.

Mentalizzazione e DBP

- QUESTIONI DI TECNICA

Curr Psychiatry Rep (2011) 13:60–68
DOI 10.1007/s11920-010-0167-x

Common Factors in Empirically Supported Treatments of Borderline Personality Disorder

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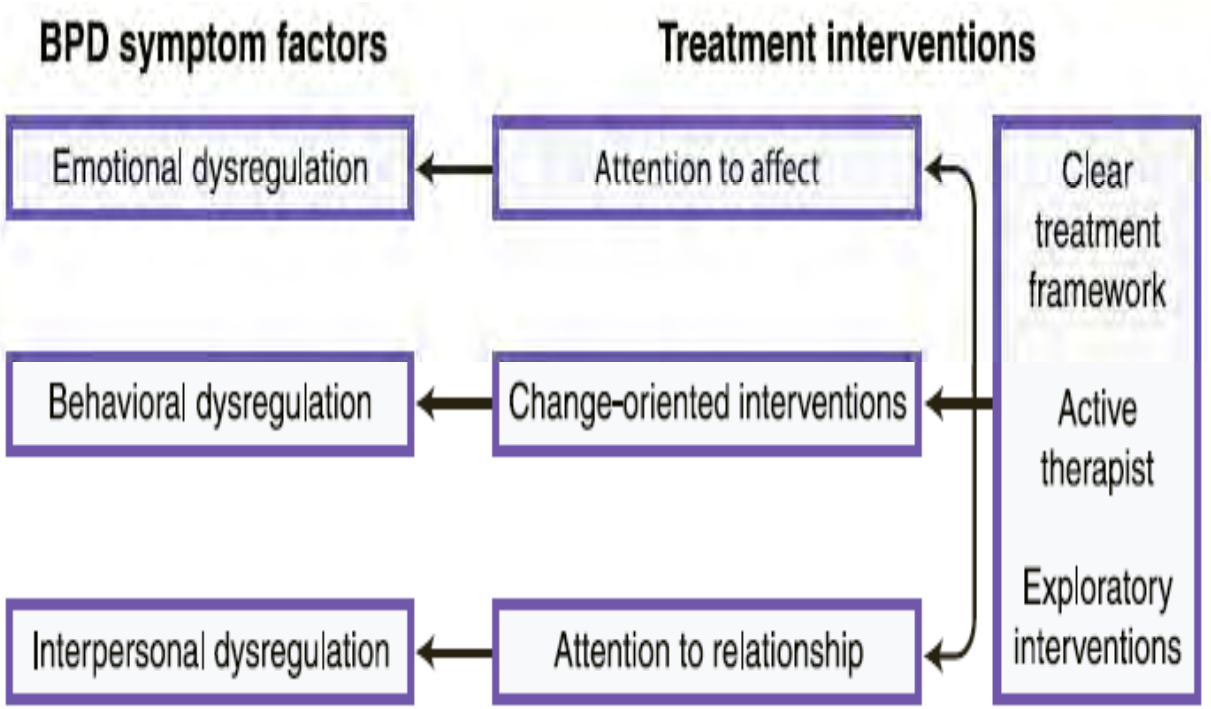
Table 1 Ratings for interventions in empirically supported treatments for BPD

Intervention	DBT	MBT	SFT	TFP	GPM	STEPPS
Multimodal treatment	3	3	0	0	2	2
Clear treatment framework	3	3	2	3	3	3
Explicit treatment targets	3	1	2	2	2	2
Attention to affect	3	3	3	3	3	3
Focus on treatment relationship	3	3	3	3	3	0
Active therapist	3	3	3	3	3	0
Interpretations	−2	−2	0	3	Uncertain	0
Exploratory interventions	3	3	3	3	3	0
Supportive interventions	3	2	3	1	3	3
Change -oriented interventions	3	2	3	3	3	3
Support for therapists	3	3	0	0	3	0
Attention to functioning	3	1	0	3	3	2

Ratings are as follows: −2—contraindicated intervention, 0—intervention absent in the manual, 1—moderately present intervention 2—distinctly present intervention, 3—important intervention

DBT dialectical behavior therapy; *GPM* general psychiatric management; *MBT* mentalization-based psychotherapy; *SFT* schema-focused psychotherapy; *STEPPS* systems training for emotional predictability and problem solving; *TFP* transference-focused psychotherapy

Fig. 1 Possible relationship of treatment interventions to borderline personality disorder (*BPD*) psychopathology



Mentalizzazione e DBP

- In altre parole, si tratta di elementi – per es., attenzione agli affetti, attenzione alla relazione, ruolo attivo del terapeuta, interventi esplicativi – più collegati alla ri-strutturazione delle esperienze d'attaccamento e degli IWM che alla funzione mentalistica *sensu strictu*.
- L'attaccamento è un fattore connesso alla funzione mentalistica, ma oltre a non essere il solo, non coincide con la mentalizzazione

Mentalizzazione e DBP

- In sintesi, la mentalizzazione come fattore specifico comune agli interventi manualizzati con prove di efficacia per il DBP è un'ipotesi affascinante, ma non supportata da evidenze
- Vi sono questioni di efficacia, di metodo, legate all'intervento, di assessment, di tecnica, ecc. che devono essere risolte
- Oltre all'utilizzo di tecniche alternative agli RCT per gli studi di outcome, sarebbe opportuno iniziare ad approfondire gli elementi di processo

GRAZIE PER L’ATTENZIONE!