PATIENT MANAGEMENT IN AN ITALIAN CENTRE FOR THE ASSESSMENT AND TREATMENT OF PERSONALITY DISORDER. MENTALIZATION-BASED TREATMENT FOR BORDERLINE PERSONALITY DISORDER PATIENTS: A FOLLOW-UP STUDY

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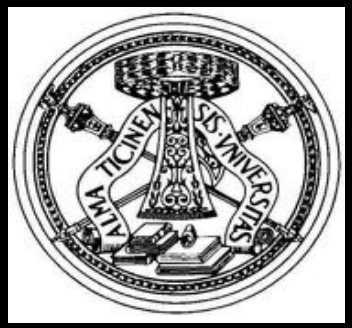


* Centre for the Assessment and Treatment of Personality Disorder, University of Pavia, Italy

CIRDIP

- University Clinical and Research Service

- Public Clinical Health Service: Unit of the Department of Mental Health of Pavia

La presa in cura presso l'Unità Operativa

Il Servizio offre la possibilità di un trattamento ambulatoriale ai pazienti in cui sia stata posta per la prima volta o confermata la diagnosi di Disturbo Borderline della Personalità. La presa in carico psicoterapeutica comprende una seduta settimanale individuale e una seduta settimanale di terapia di gruppo secondo l'orientamento MBT (Mentalization Based Treatment). Parallelamente viene offerto un servizio di supporto psico-educazionale ai familiari. Il contratto di cura prevede un trattamento della durata di un anno, al termine del quale una valutazione complessiva dell'andamento clinico del paziente orienterà sulle proposte terapeutiche successive.
Il Centro di Ricerca dell' Università di Pavia (CIRDiP) opererà in collaborazione con l'Unità Operativa dell'Azienda Ospedaliera per promuovere attività di ricerca epidemiologica e clinica, nonché per proporre forme di trattamento sperimentali. Il CIRDiP sarà la sede di coordinamento dei vari interventi

Come Contattarci

Si possono rivolgere direttamente all'unità operativa tramite contatto telefonico oppure via e- mail:

- il paziente stesso o i suoi famigliari
- lo specialista Psichiatra che ha in cura il paziente presso i Servizi Territoriali
- il Neuropsichiatra Infantile o il Neurologo che richiede una consulenza
- il Medico di medicina generale
- Psicologi e Psicoterapeuti che operino privatamente o in istituzioni

Non nascendo come struttura volta all'urgenza, ma all'approfondimento diagnostico e al trattamento, l'interessato verrà contattato secondo la priorità acquisita in una lista di attesa .
E richiesta l'impegnativa regionale del medico di medicina generale.

Informazioni pratiche :

Sede : Ambulatorio presso il padiglione Forlanini del IRCCS Policlinico S.Matteo di Pavia

Giorni e orari:
Lunedì dalle 9.00 alle 13.00
Martedì dalle 9.00 alle 13.00
Mercoledì dalle 8.30 alle 20.00
Venerdì dalle 9.00 alle 13.30

Contatti:
Per richiesta di prima visita : Segreteria 0382 987246

Per altre comunicazioni : Ambulatorio 0382 432635
chiamate negli orari di apertura

email : cirdip@ospedale.pavia.it
edgardo.caverzasi@unipv.it
sito web:

AO

UNIVERSITÀ DEGLI STUDI DI PAVIA

FACOLTÀ DI MEDICINA E CHIRURGIA

Unità Operativa Semplice per la diagnosi e la cura dei Disturbi della Personalità

Responsabile: Prof. Edgardo Caverzasi

CIRDIP

Collaborazione tra l'Azienda Ospedaliera della Provincia di Pavia e l'Università degli Studi di Pavia, Centro di Ricerca sui Disturbi di Personalità del Dipartimento di Scienze Sanitarie Applicate e Psicocomportamentali, direttore Prof. Francesco

TARGETS

- To optimize diagnostic process: definition of a qualified assessment
- To formulate therapeutic projects for each patient : psychotherapy in combination with standard psychiatric treatment (psychopharmacological and social support)
- MBT training
- MBT treatment for Borderline (4 group sessions of pre-treatment activities enhancing explicit mantalization, weekly individual and group sessions, case psychopathology discussion and treatment supervision)
- Family support group
- Training

MBT TRAINING

- Anna Freud Centre Courses
- Two –day intensive seminar for treatment supervision and model consistency led by two English MBT colleagues, once a year
- Usual training : case discussion and role playing, once a week
- Connection: MBT groups in Udine and Savona (Italy)
- University of Genève

WHY MBT

- Co-existence of two issues:
- How to train psychiatric students to deal with severe PDs
- The high value of a manualized structured model in a psychodynamic tradition

- In our challenging clinical encounters and by our observations on psychopathology organization of Borderline we have defined a structured assessment.
- It is a complex tool, able to inform us about the diagnostic profile of each patient , and somehow useful to anticipate and integrate some aspects of his/her behaviour.
- **The psychopathological assessment framework can be seen as a tripartite model**

- A) History, an accurate anamnesis
- B) Diagnostic tools
- C) Written final clinical report to discuss with the patient

PATIENT HYSTORY

- The first component is the patient history, meaning not only a throughout and detailed anamnesis, but also an investigation of the process profile as expressed by the patient, or rather of his/her priority, the modality with which he/she talks about it, his/her attitude toward others and the contingency of the evaluation. Special attention is paid to the patient's object relations and to the relation between object investment and narcissistic investment. The anamnesis represents pattern of a possible transformation from a formless and distressing chaos to a more liner and thinkable story. Moreover, in a medium-long term, it represents an operative model, a hallmark on which the patient can construct other stories, while at the same time developing an in-depth introspection.

The importance of the irrelevant

- Experience have taught us that the stories which stress the patient out the most guide our attention to the symptom and to the perceived core of suffering, and **hence**represent a **story** which the patient knows all too well. In fact, inflexible stories, perceived as dry, hyper-rationalised, two-dimensional, detached, impersonal or stereotyped, are not rare.On the other hand, stories might be fabricated, refined patchworks of previous psychotherapeutic experience, which are more stringent than the patient's authentic experience. These are the cases
- **in which one needs to mindfully pay attention to "the irrelevant"**
- **In a few words, it means to linger over precise and non invasive questions on annotations , ironic nuances, meaningful use of adjectives which refer to neglected and distant scenery. Although this selective attention is initially acknowledged by the patient with some doubts, it is the element through which the conclusive written reports find an inter-subjective depth. Thus, what seems irrelevant actually hides something, which in the final report is paradoxically unknown but at the same time also pleasantly familiar.**

Assessment tools

- The second part of the assessment is composed of a list of table tests, interviews and scales.

Assessment

- Structured Clinical Interview for DSM-IV (SCID-I and SCID-II)
- Hamilton Depression Scale (HAM-D)
- Hamilton Anxiety Scale (HAM-A)
- Zanarini Rating Scale (ZN)
- Shedler-Westen Assessment Procedure-200 (SWAP-200)
- Social Adaptation Self-evaluation Scale (SASS)
- Dissociative Experiences Scale (DES)
- Global Assessment of Fuctioning (GAF)
- Symptom Check-list 90 (SCL-90)

Reflective Function

Fonagy's Reflective Function Manual (version 5.0) for the Adult Attachment Interview

The final and the most significant part is the review of the written conclusive clinical report

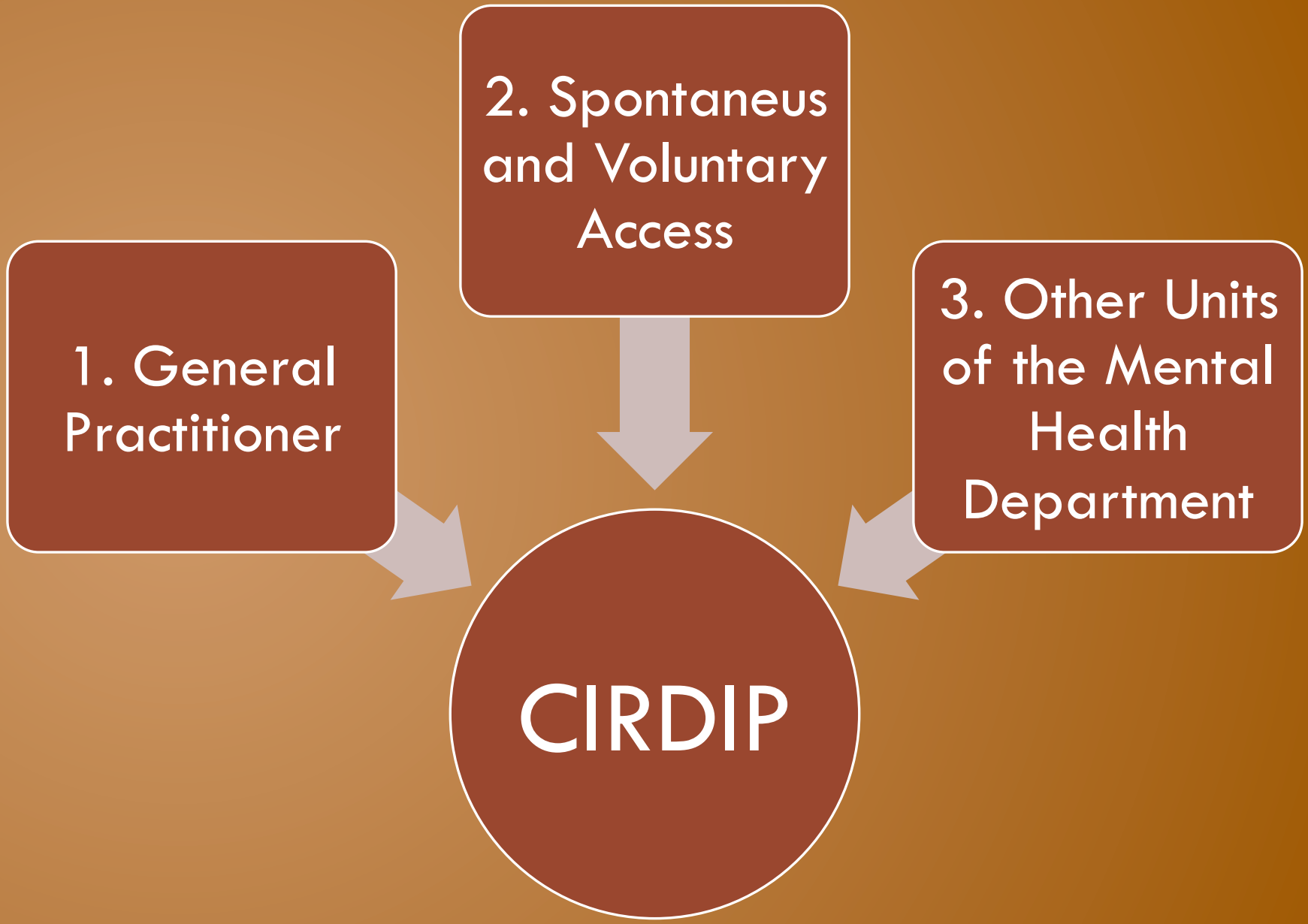
- A moment in which the patient is invited to a rereading, open to whatever free, vital and eventually polemic intervention into a history, which is far from being concluded and definitively inclusive.
- We see it important therefore to explicitly introduce, already at the assessment phase, the importance of an element, which we define as anti-narrative.
- All that is told and summarised in the psychopathologic clinical report serves to negatively highlight all that has been temporarily left at the edges of the narration, all that was left unobserved or misunderstood.

An introduction to mentalization concepts

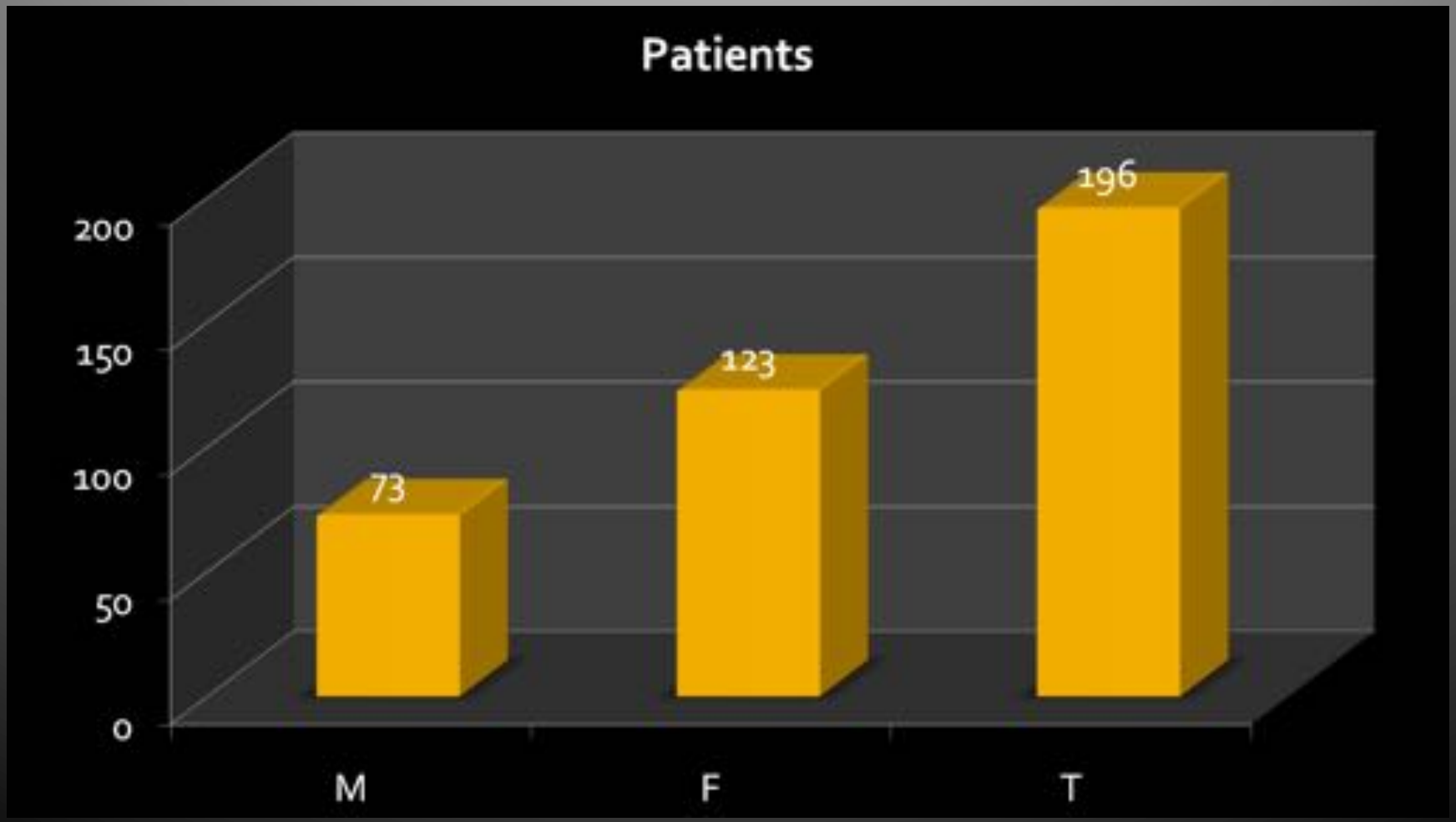
- In the jointed physician-patient attempts to understand the nature of his/her suffering, we tend to emphasize the fact that through a varied perspective some aspects of the same, previously latent, phenomenon occur. This elaboration represents the first step to mentalization, which sees both the clinical “editor” and the patient as simultaneously active.
- This dialectic of confrontation represents the first exercise of reflective capacities. The patient, despite **his/her** emotional tension and the **unpredictable** revival of intolerable emotional and autobiographic issues, remains, within the frame of the interview, in contact with **his/her** experience and with the investment required to rethink about it.

Conclusion

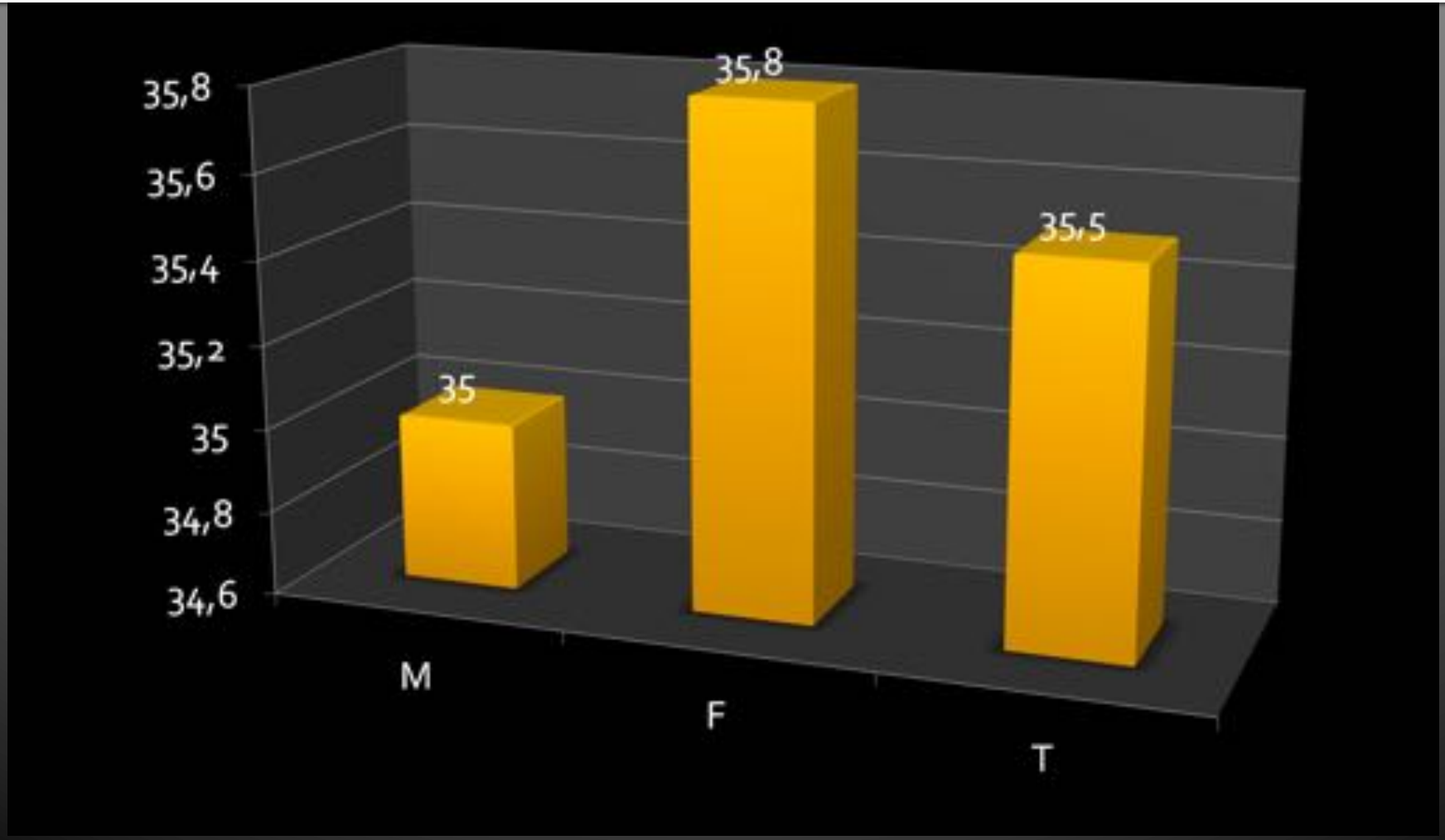
- The work done in the first interviews can therefore represent the simple model for an eventual further psychotherapeutic work, in which we continuously try to isolate and share elements from a magmatic mass of emotions, and to describe them in terms of intentionality.


1. General Practitioner
2. Spontaneus and Voluntary Access
3. Other Units of the Mental Health Department
CIRDIP

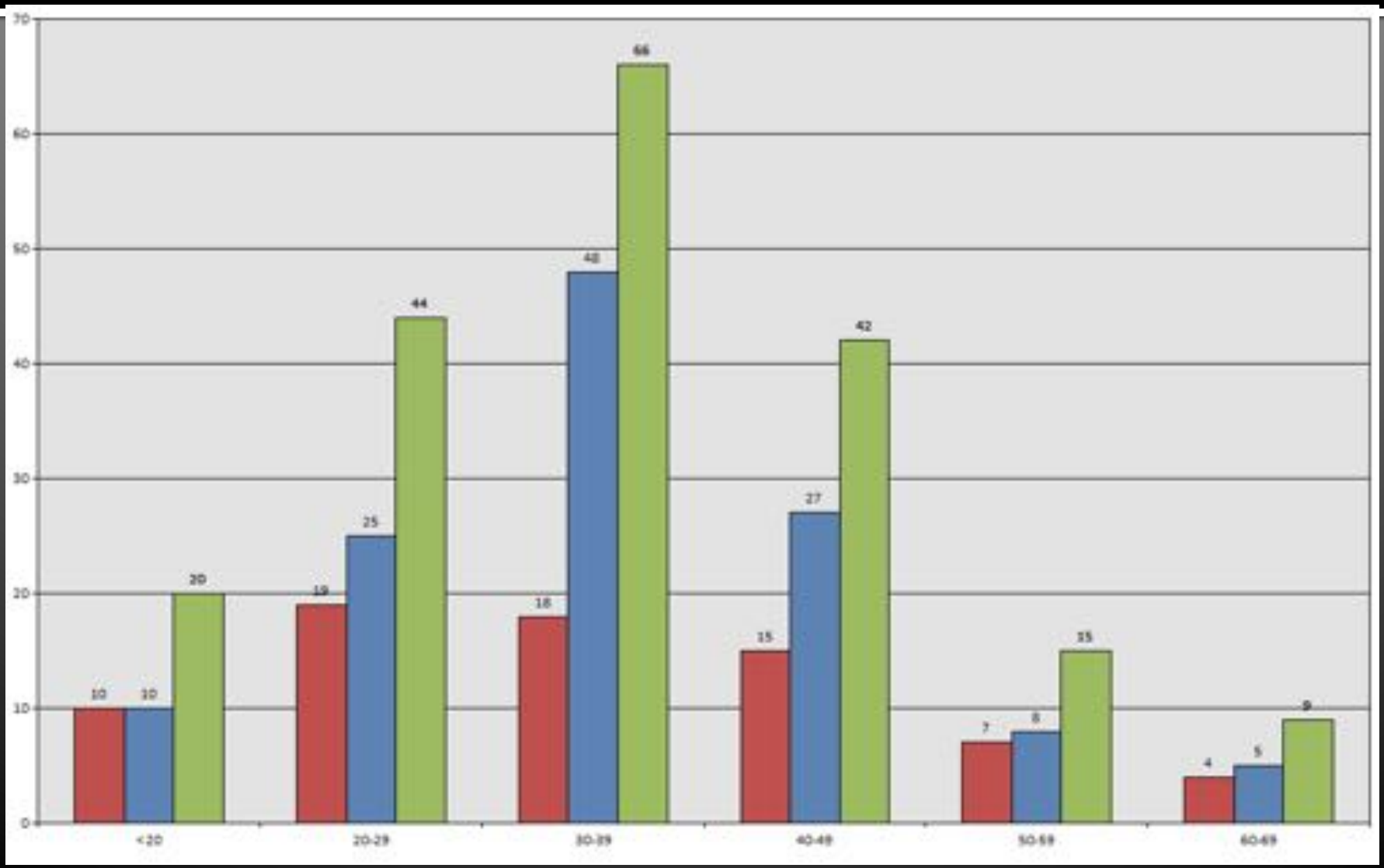
Total Sample (3/2010-3/2012)



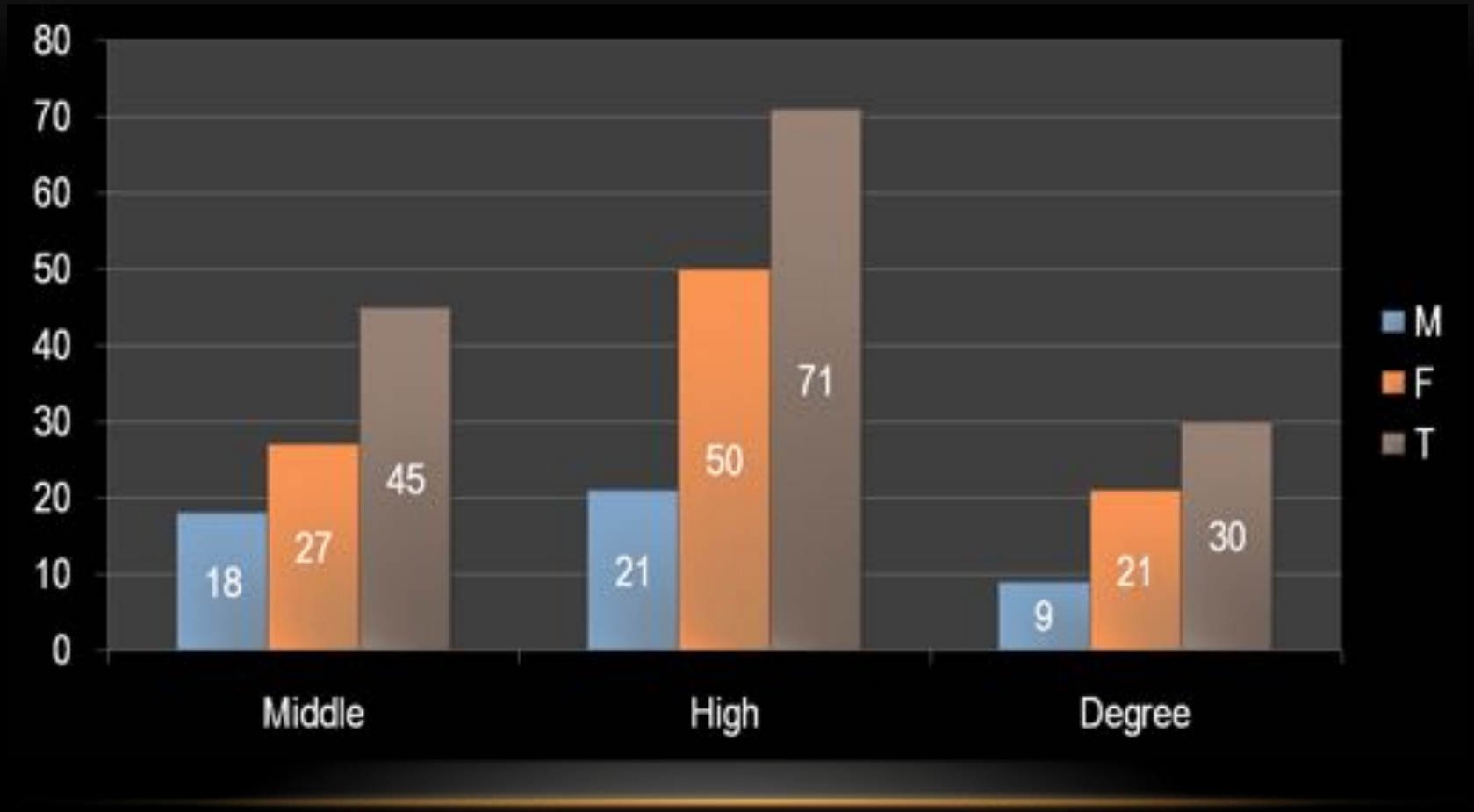
Sex and Mean Age



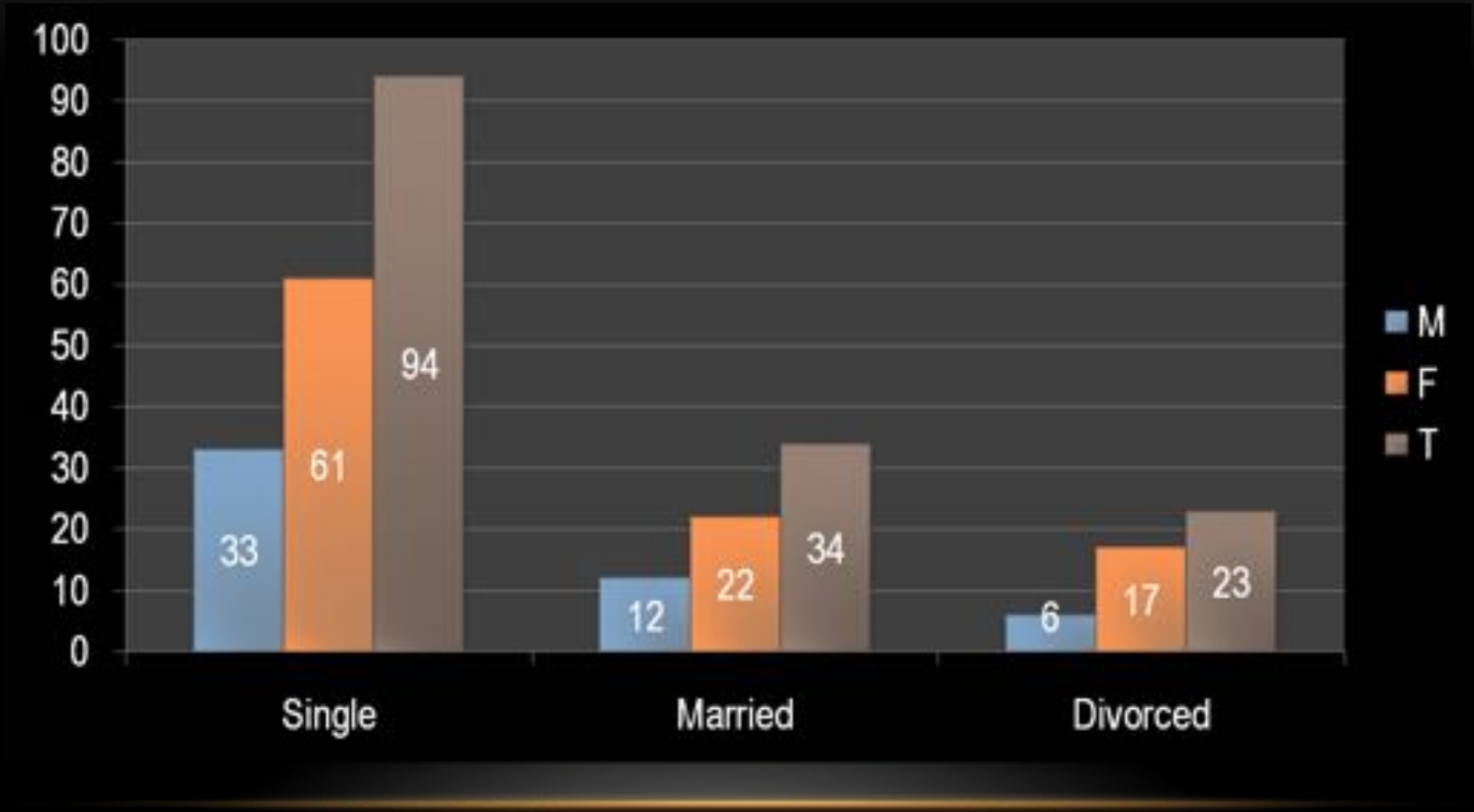
Age Class and Sex



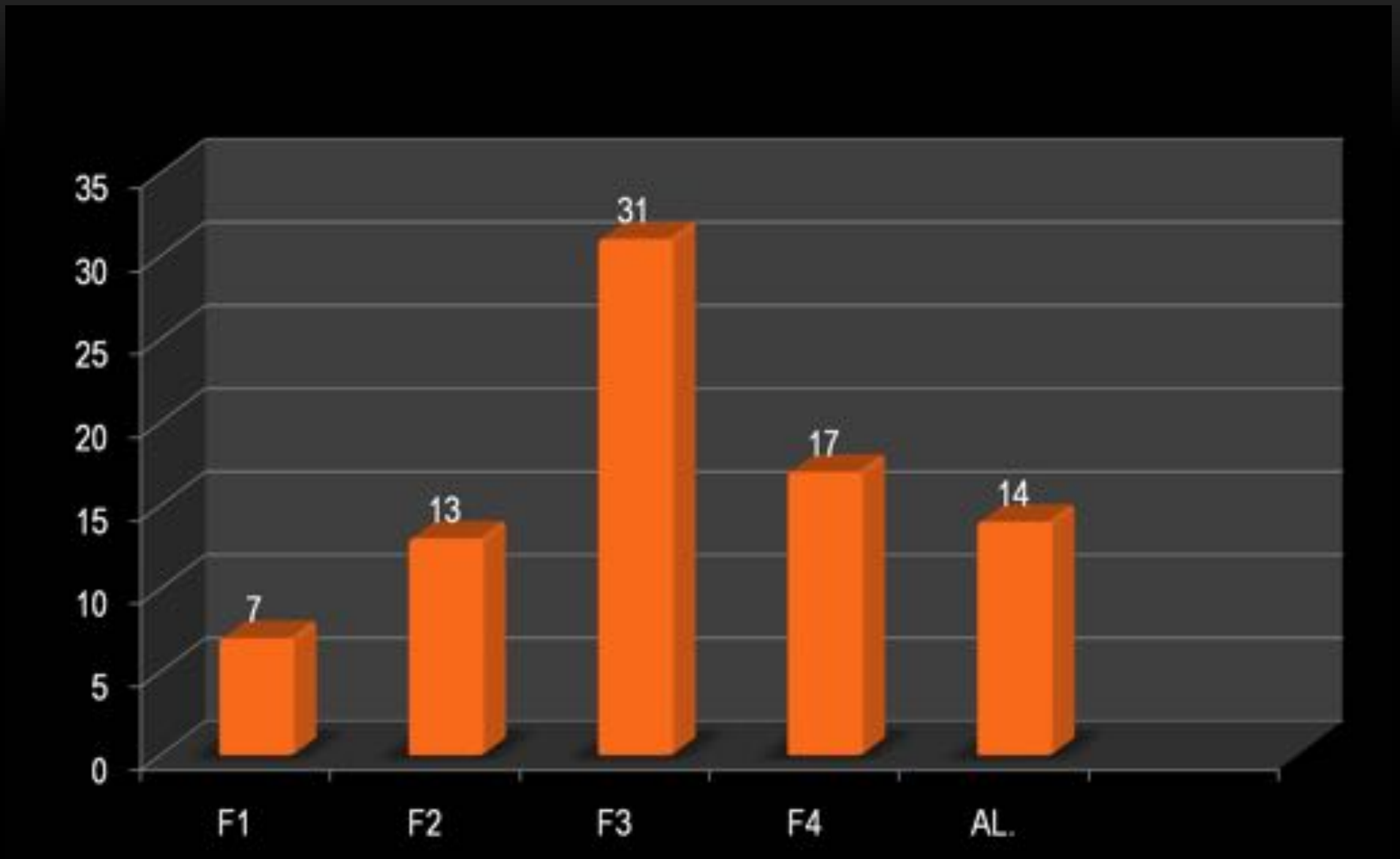
SEX AND SCHOOLING



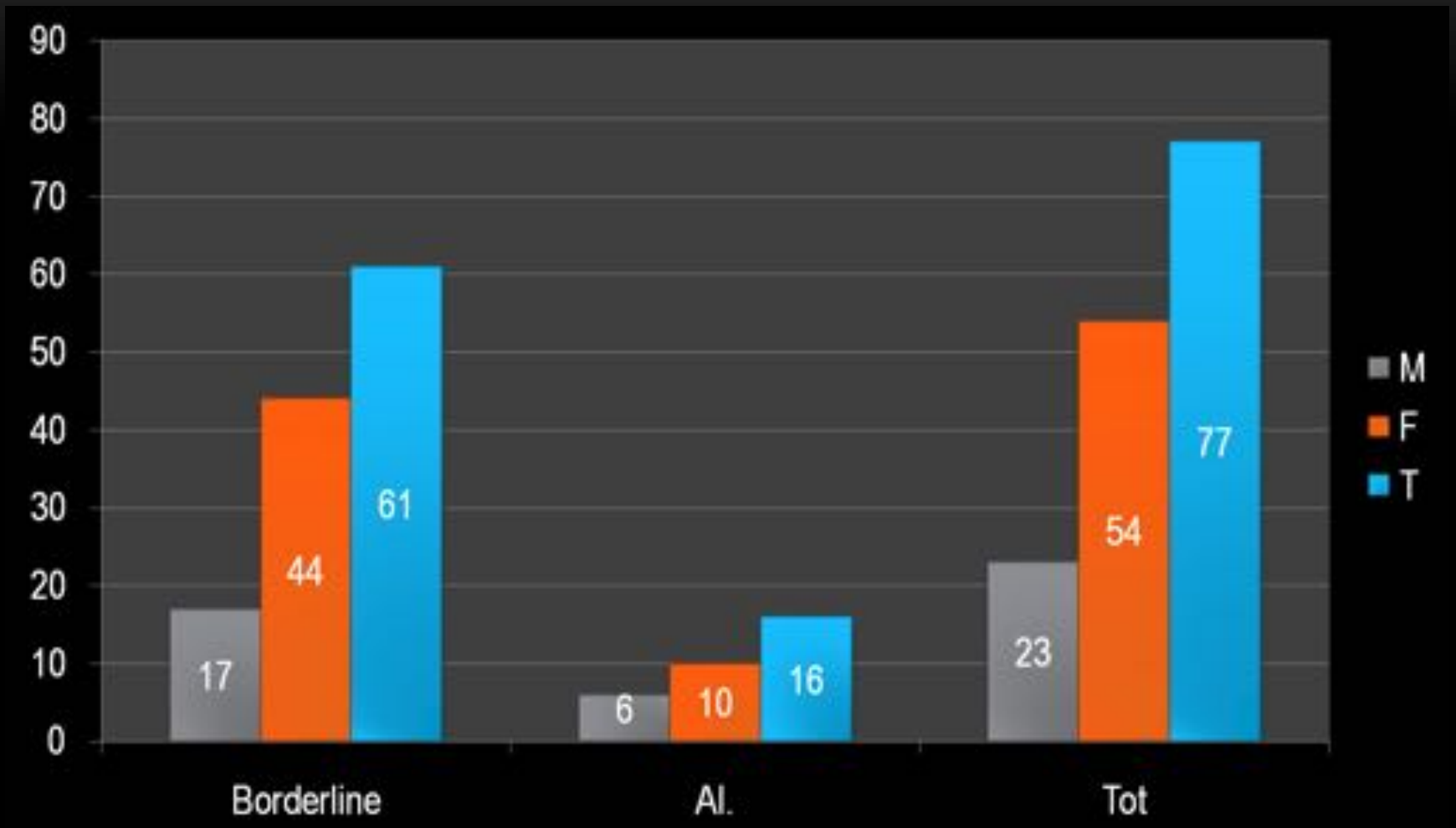
SEX AND MARITAL STATUS



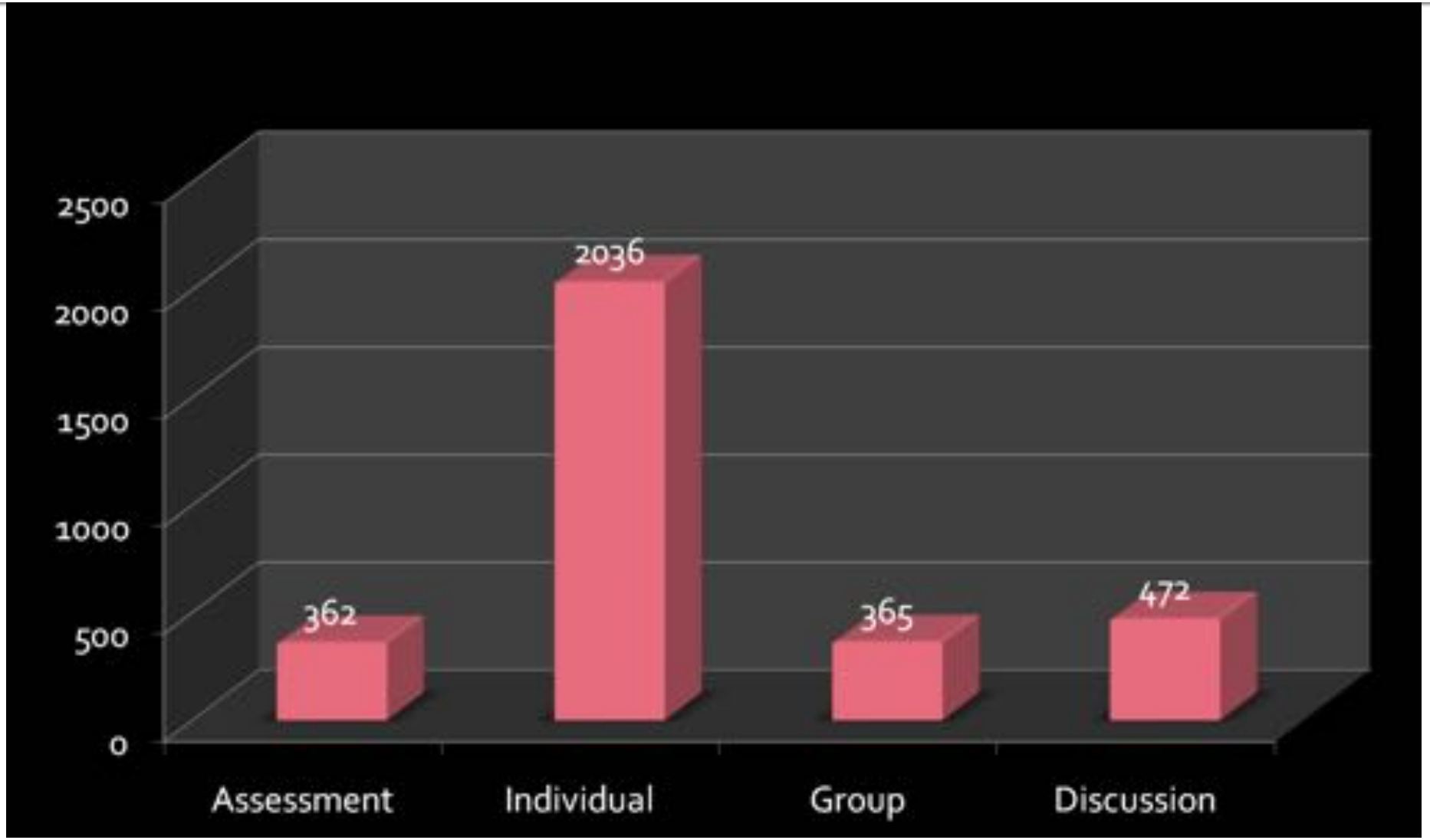
DIAGNOSIS: AXIS I (ICD-10)



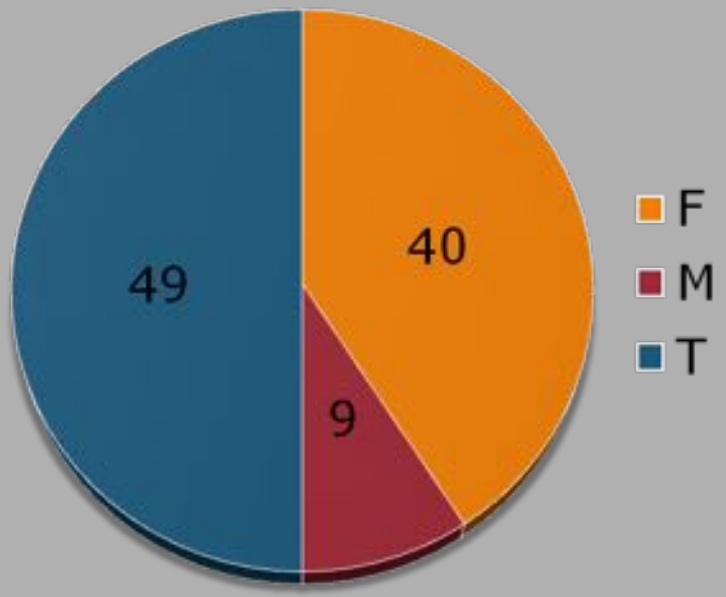
DIAGNOSIS: AXISII (DSM-IV)

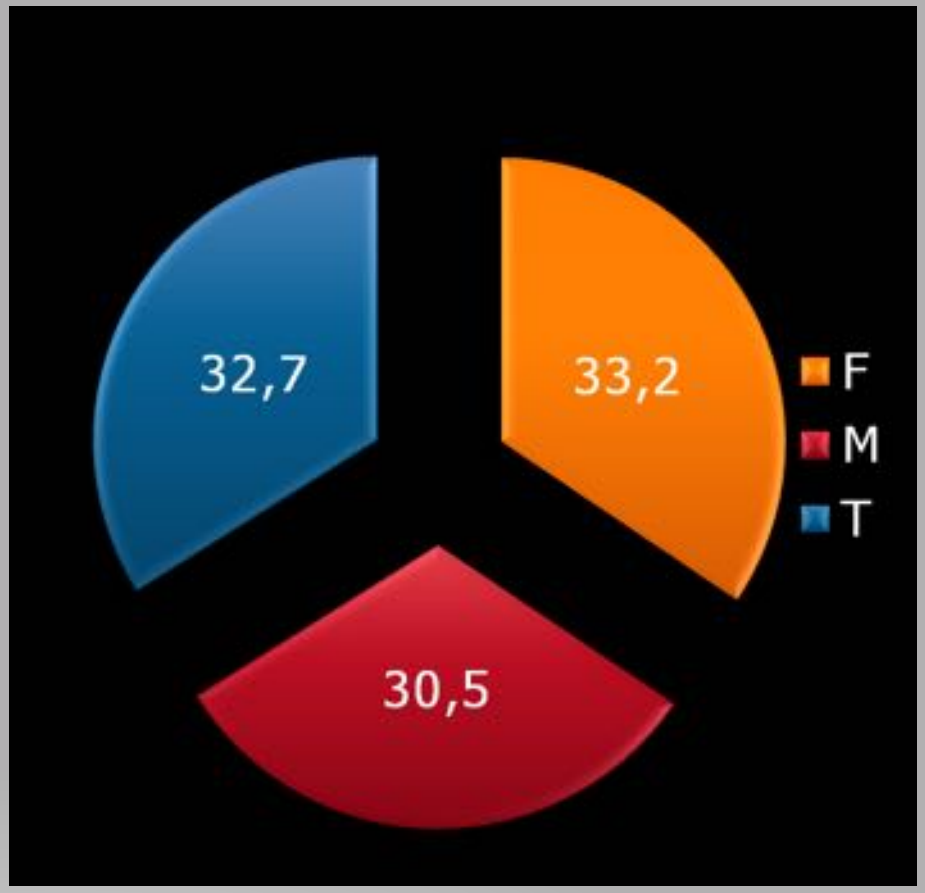


Activity (3/2010-3/2012)



FOLLOW-UP



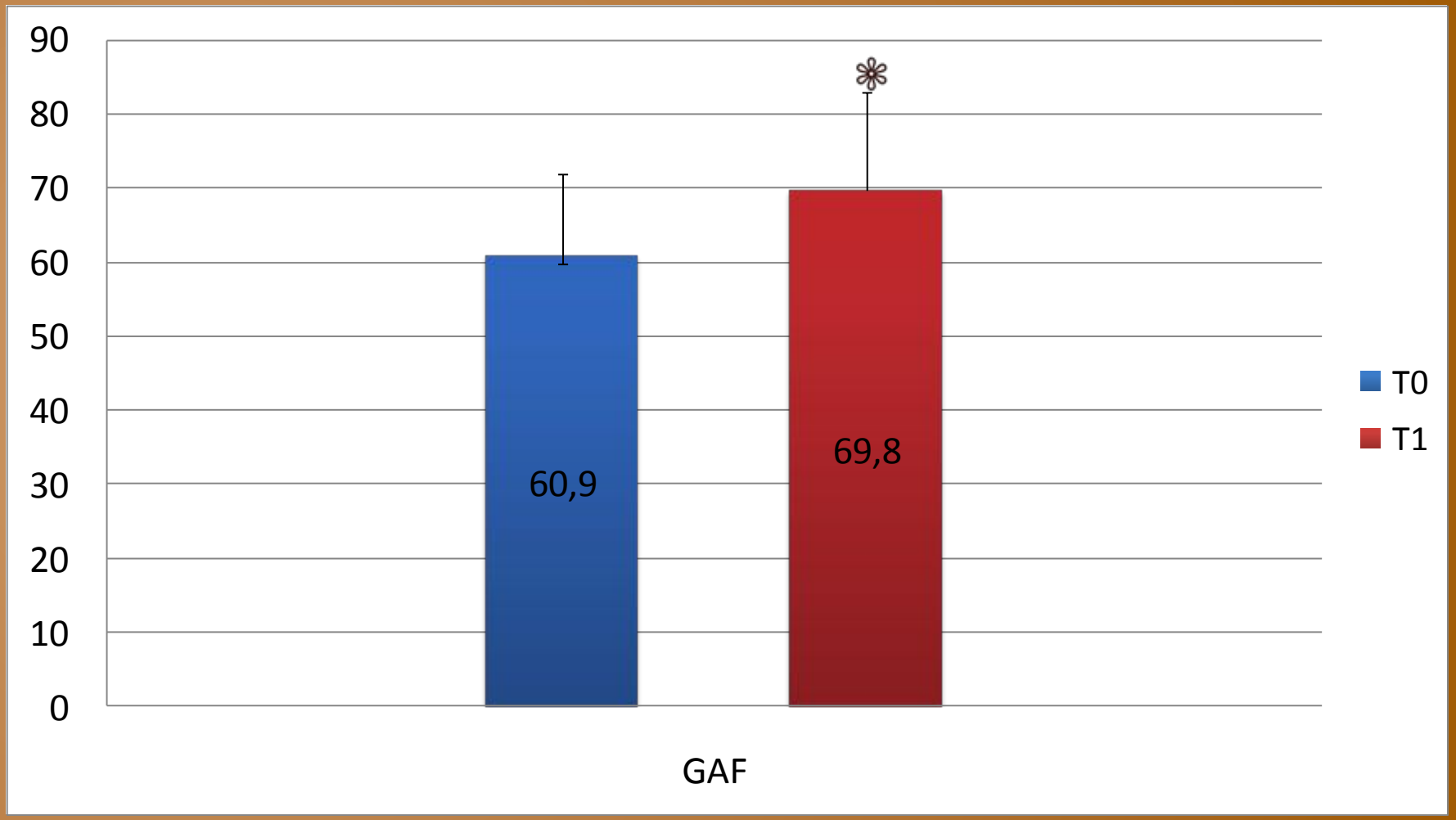


PATIENTS

MEAN AGE

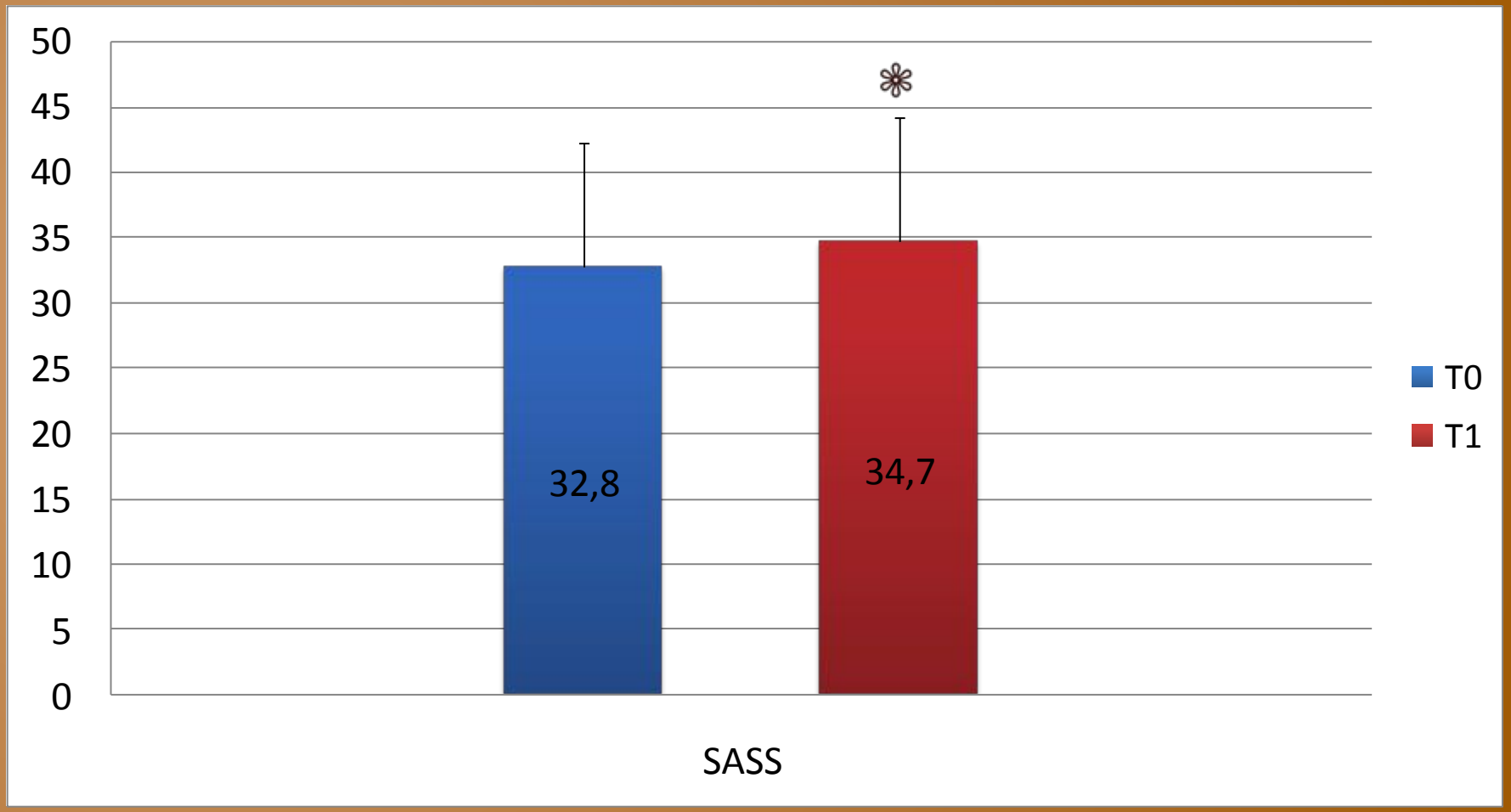
MBT TREATMENT SAMPLE

Global Assessment of Functioning (GAF): differences between T0 and T1



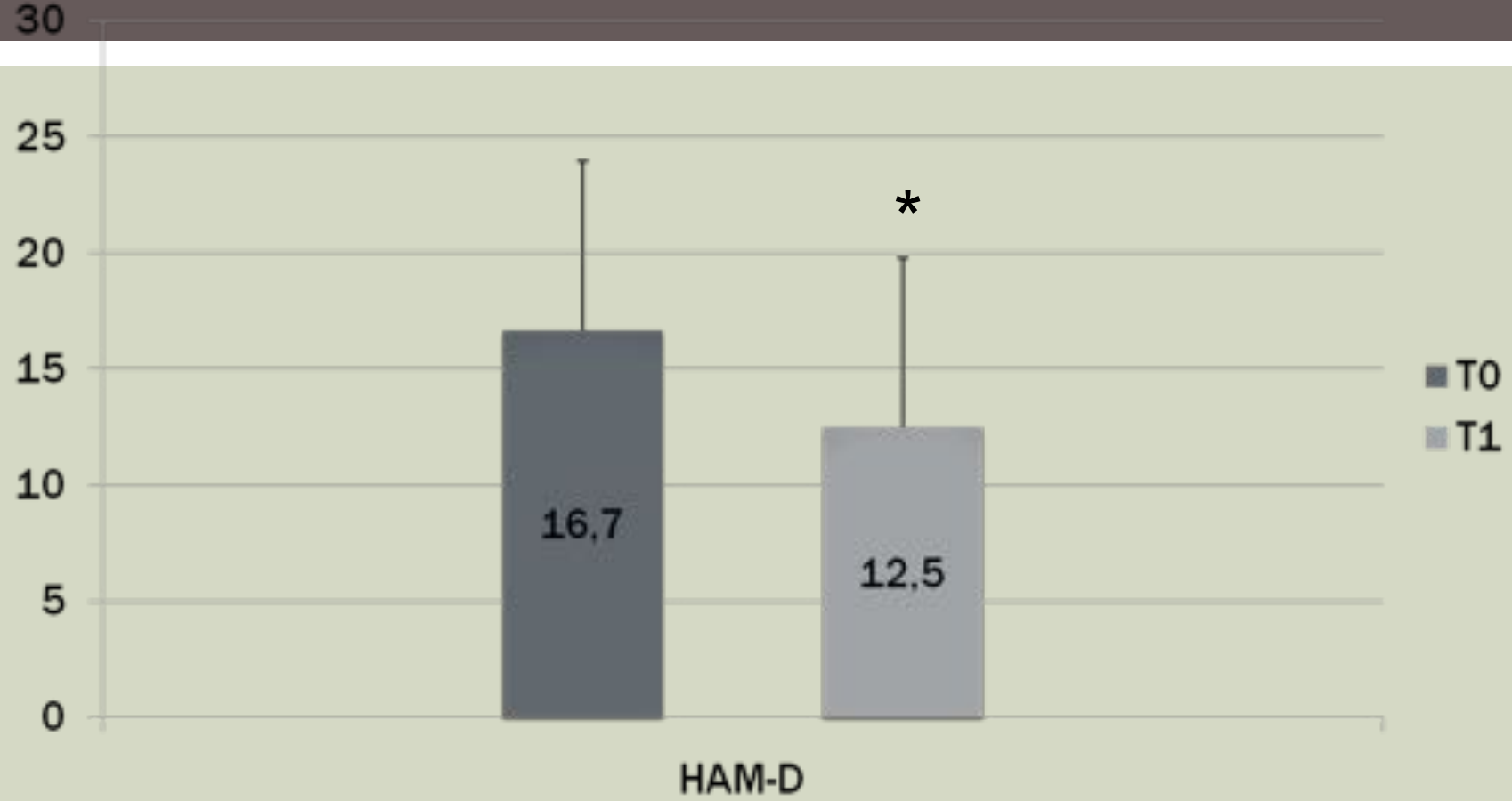
* Significant change from baseline ($p<0.05$)

Social Adaptation Self-Evaluation Scale (SASS): changes from T0



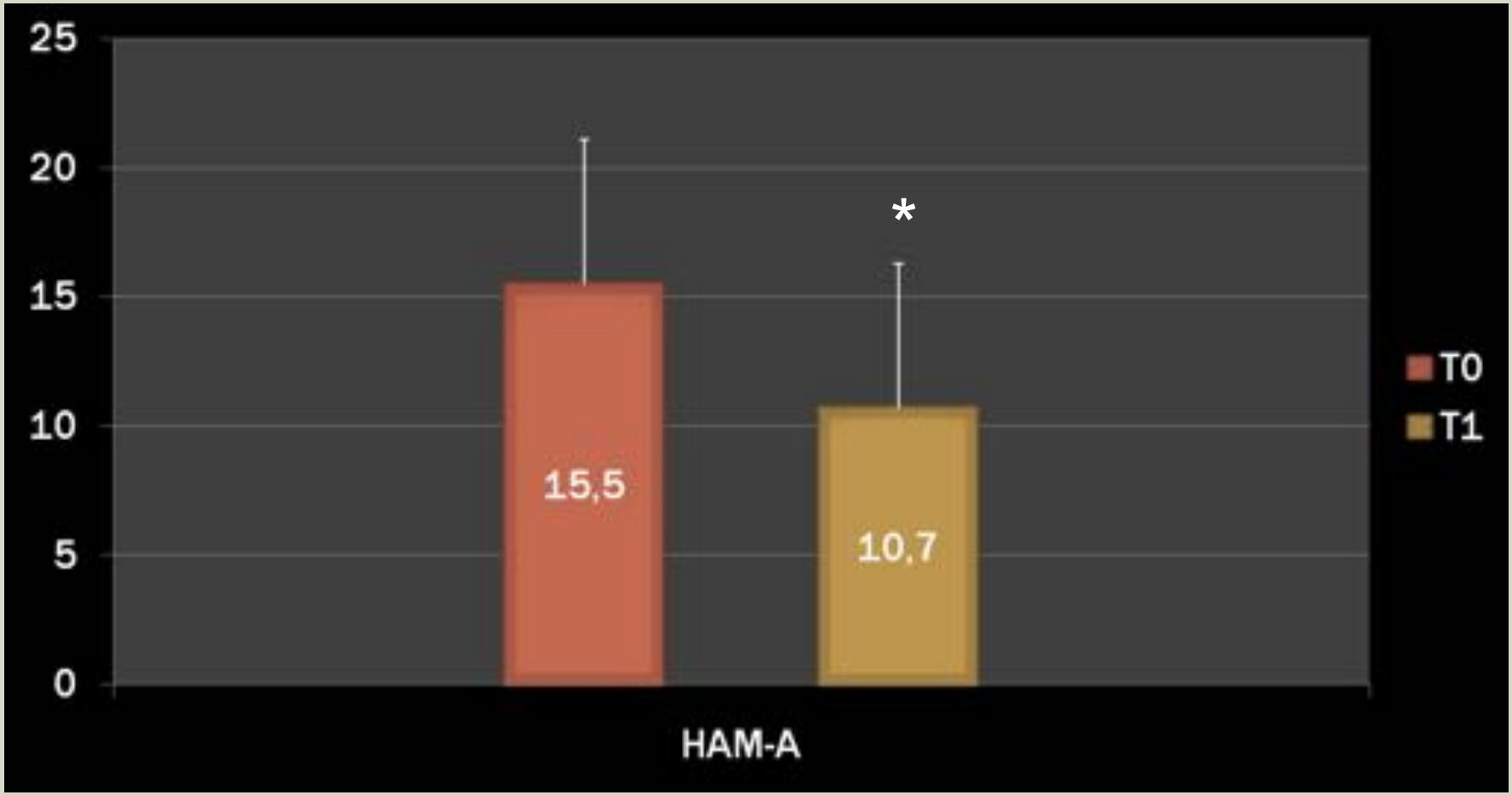
* Significant change from baseline ($p<0.05$)

HAMILTON DEPRESSION (HAM-D): CHANGES FROM BASELINE



* Significant change from baseline ($p<0.05$)

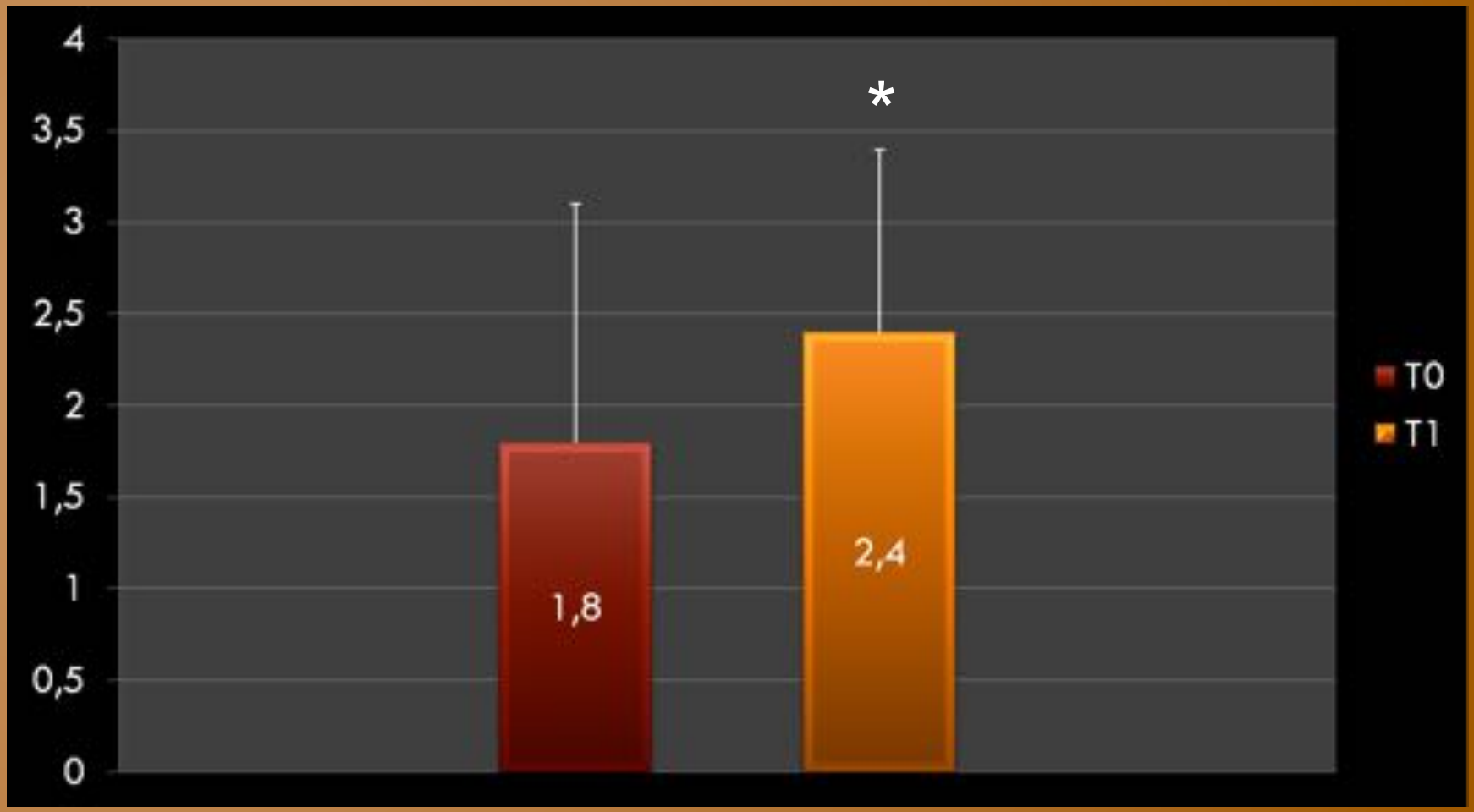
HAMILTON ANXIETY (HAM-A): DIFFERENCES BETWEEN T0 AND T1



* Significant change from baseline ($p<0.05$)

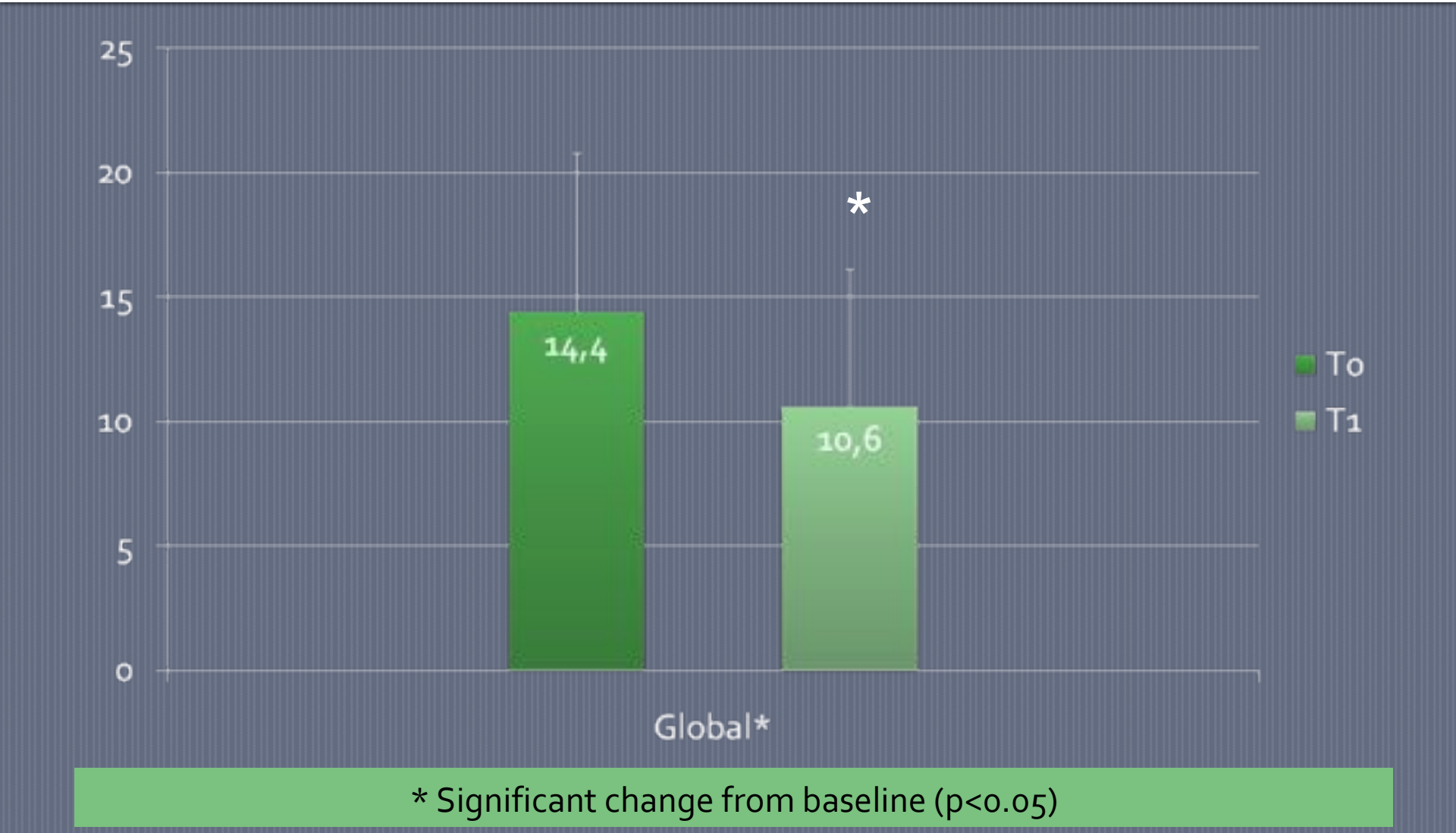
Changes from baseline in Reflective Function† among study group

† Reflective function was assessed using the Adult Attachment Interview according to Fonagy's Reflective Function Manual



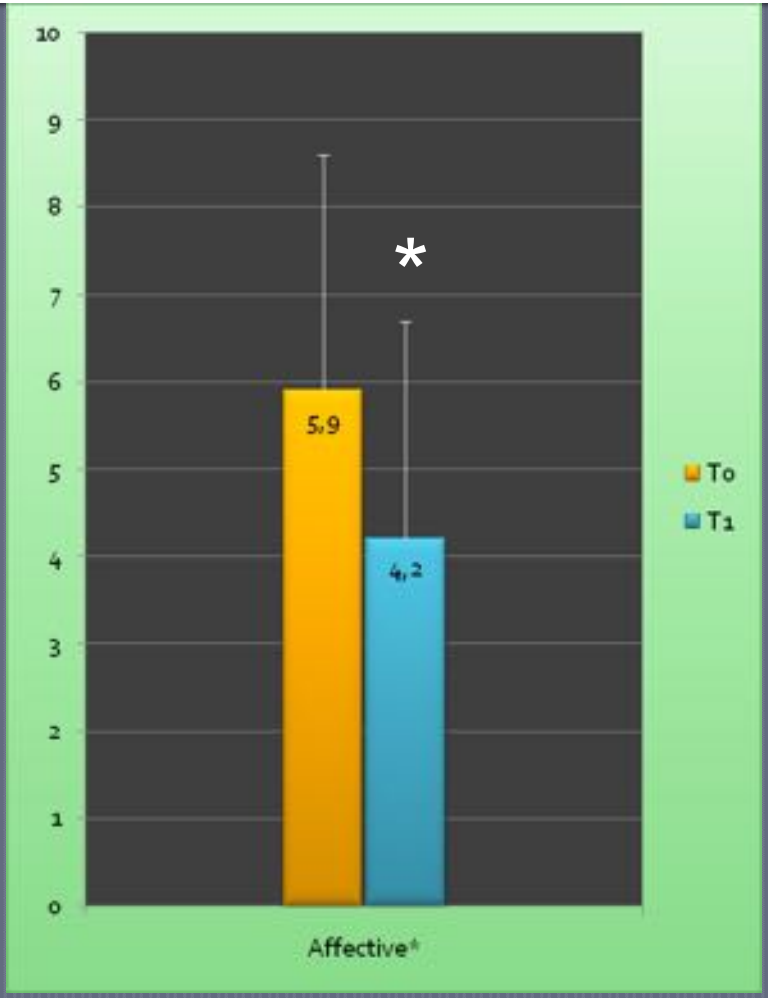
* Significant change from baseline ($p<0.05$)

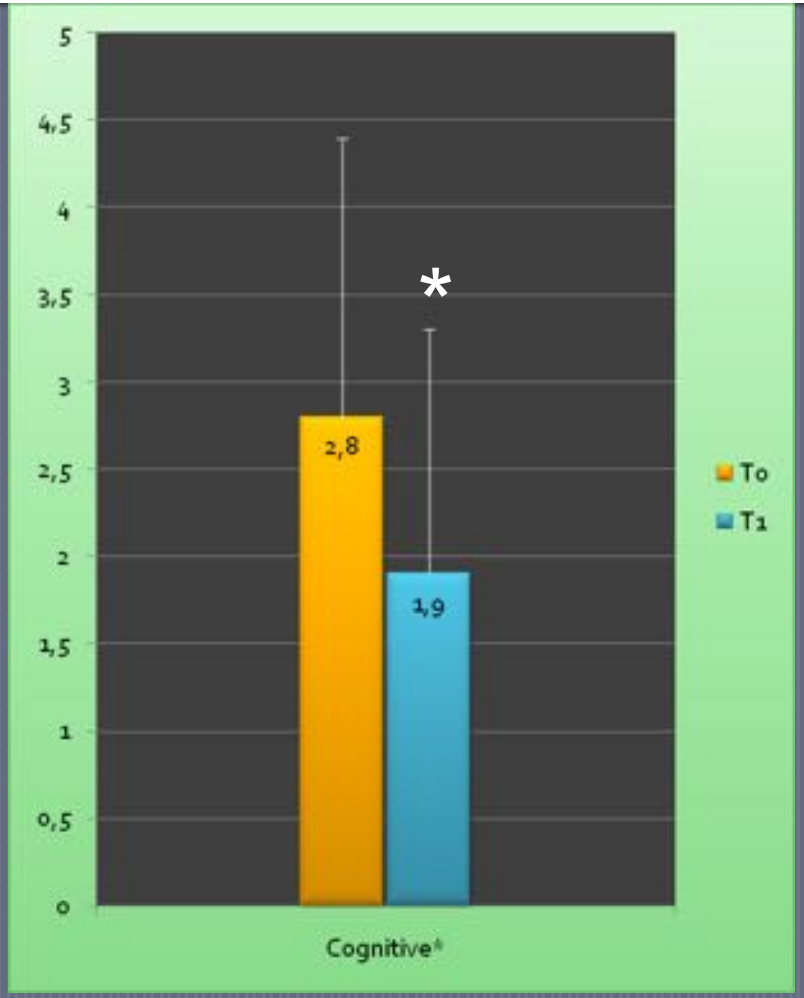
Changes between To and T1 in Zanarini total score



* Significant change from baseline ($p<0.05$)

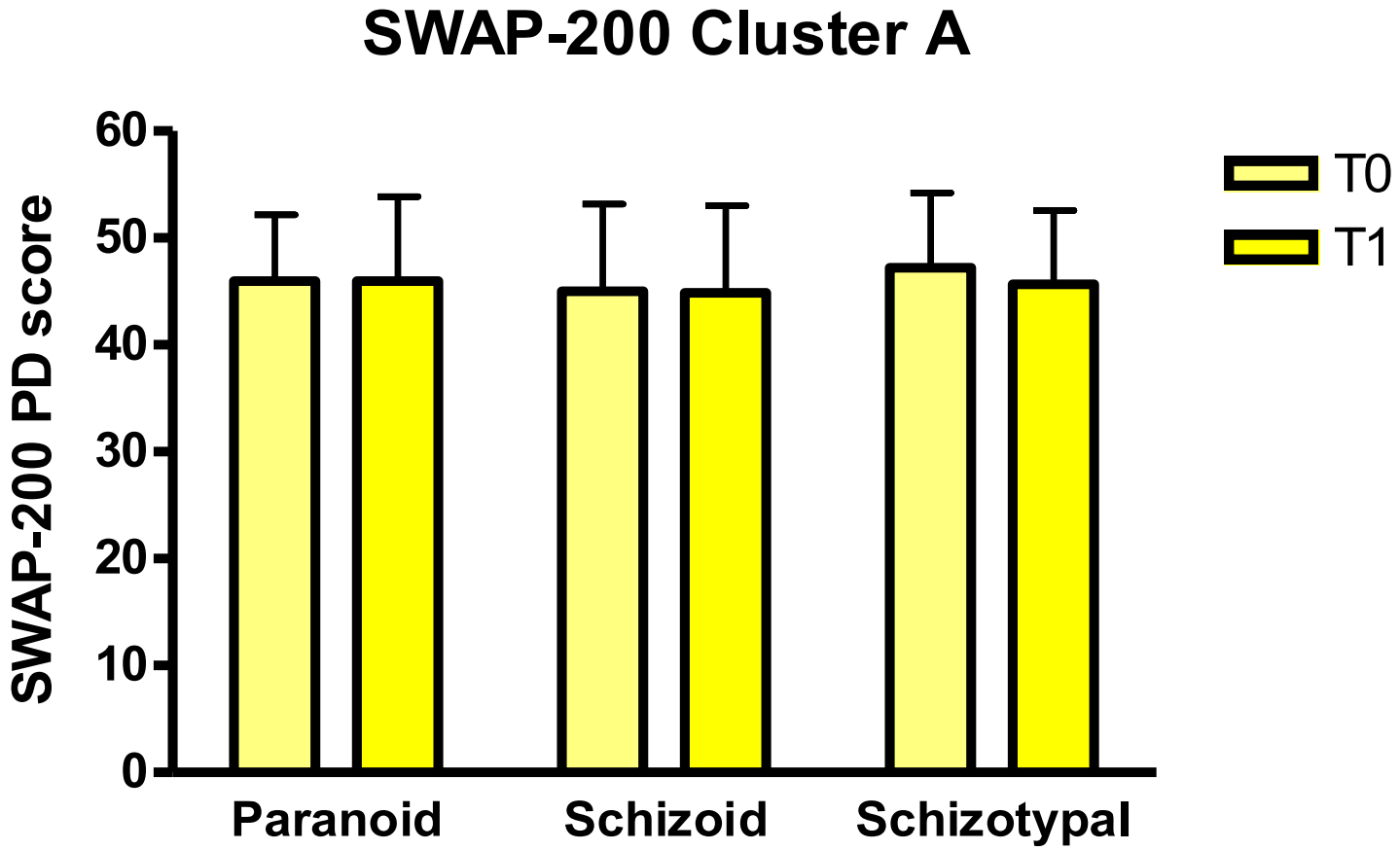
Changes between To and T1 in Zanarini Affective and Cognitive subscales





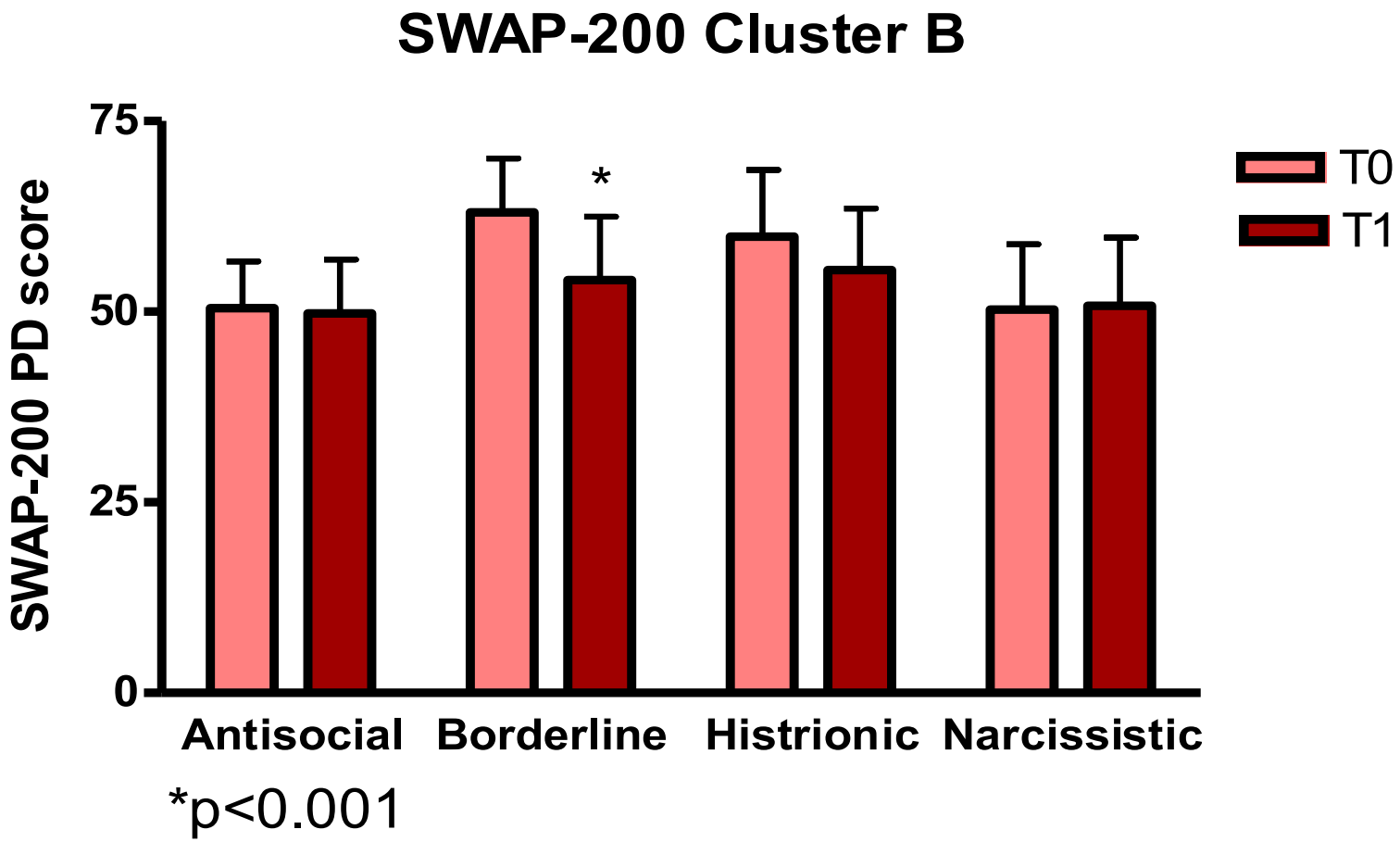
* Significant change from baseline ($p<0.05$)

Changes from baseline in SWAP-200 PD scores for cluster A personality types



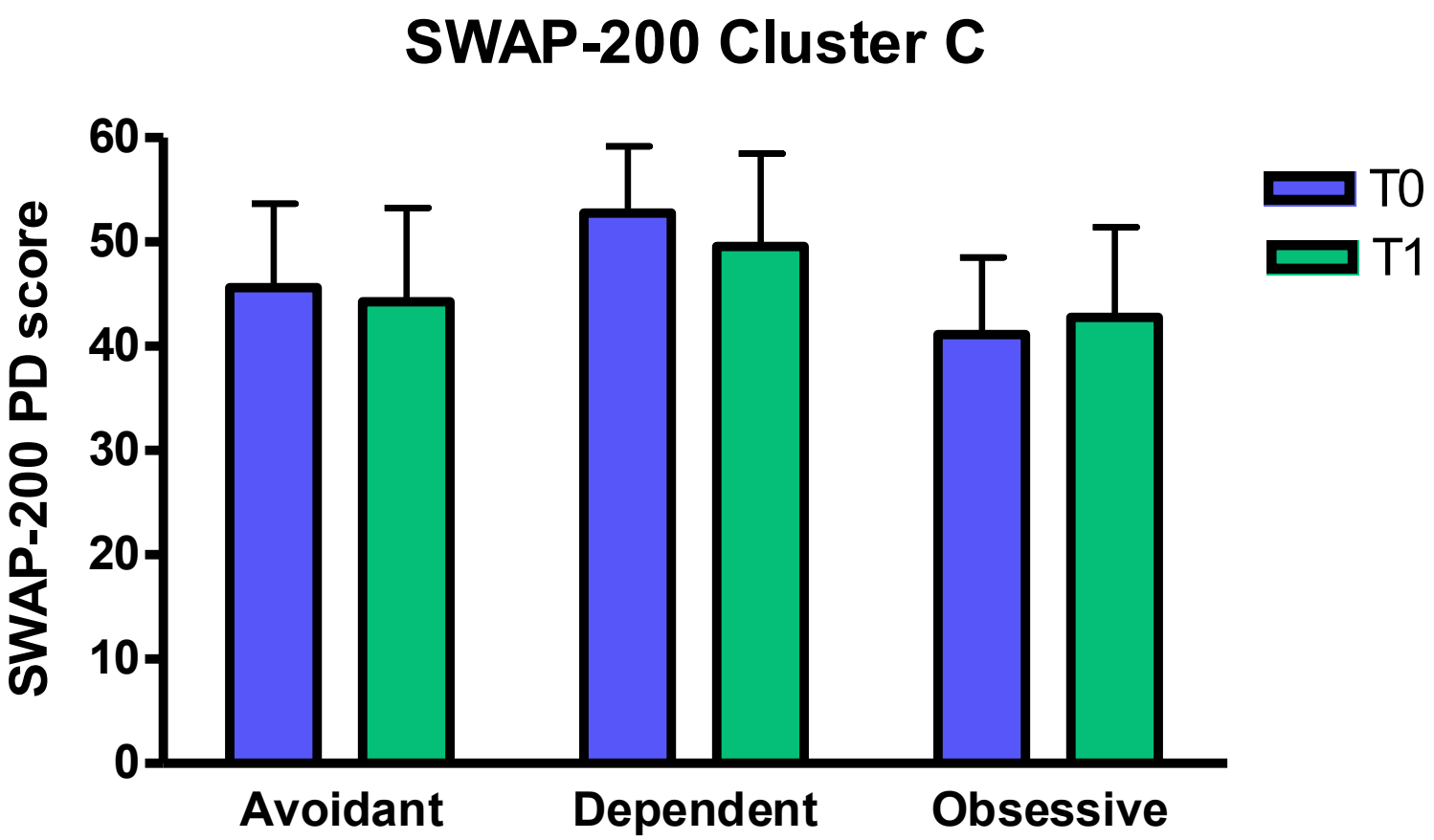
* No significant differences from baseline

Changes from baseline in SWAP-200 PD scores for cluster B personality types



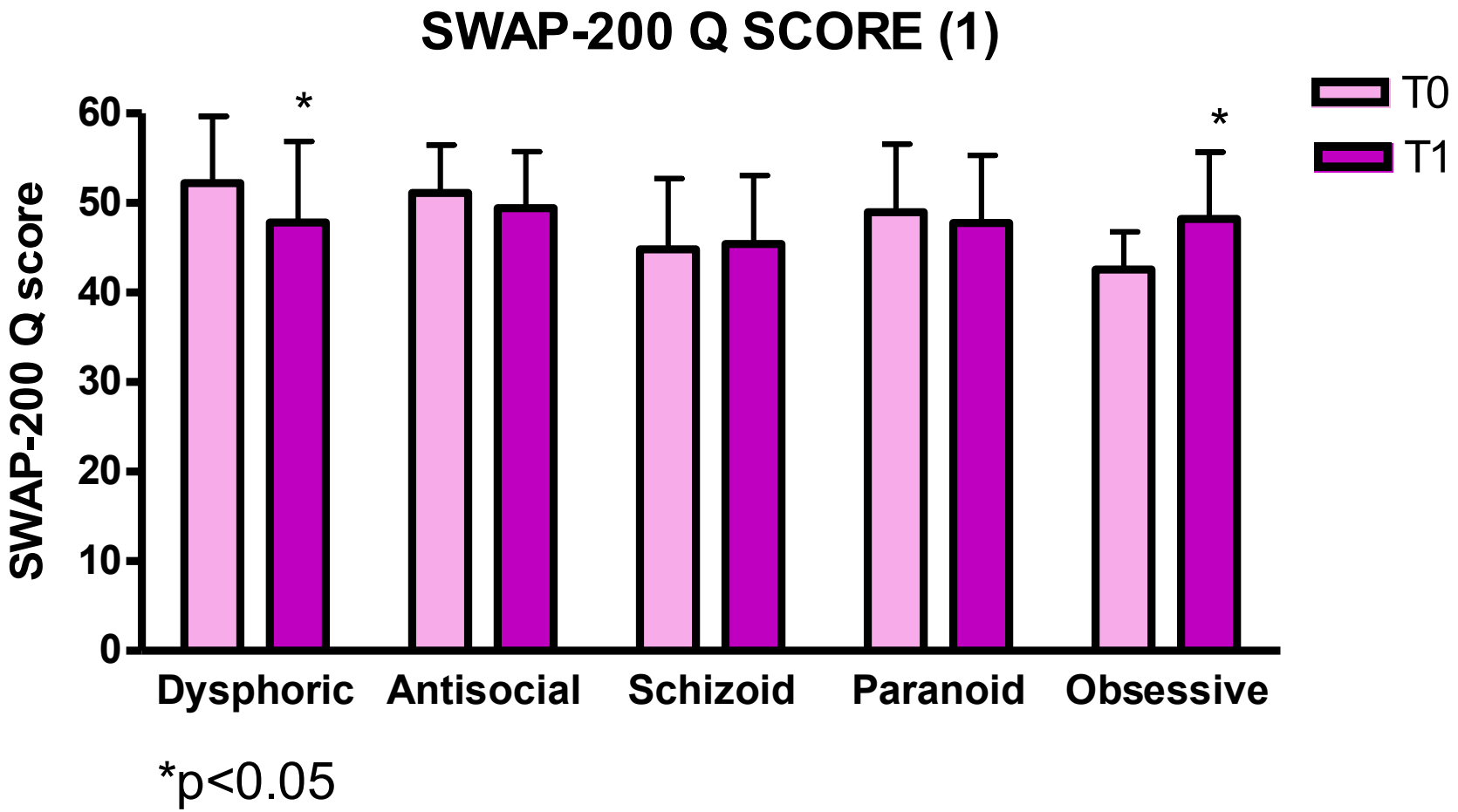
* Significant reduction in borderline PD scores

Changes from baseline in SWAP-200 PD scores for cluster C personality types



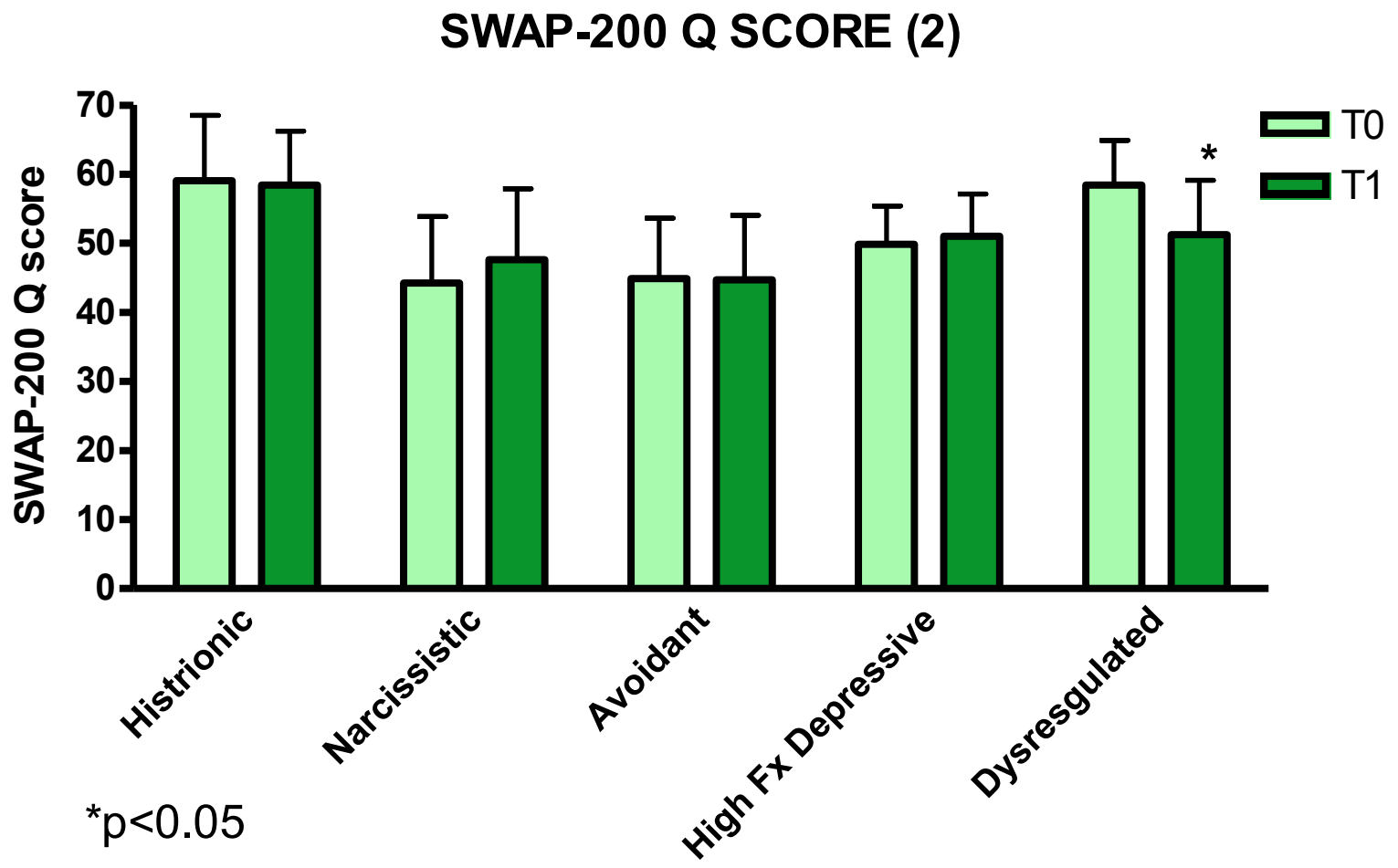
* No significant differences from baseline

Changes* from baseline in SWAP-200 Q scores



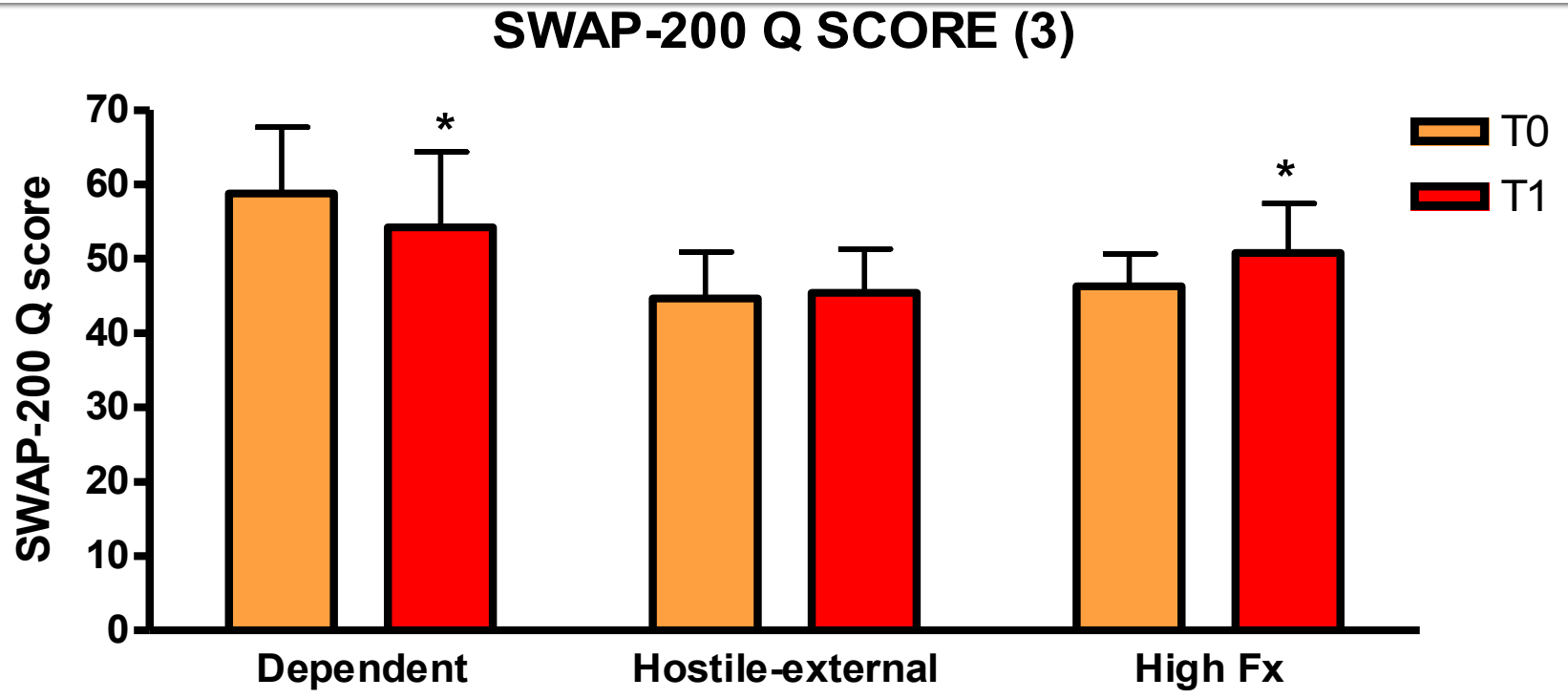
* Significant reduction from baseline in dysphoric and obsessive Q scores

Changes from baseline in SWAP-200 Q scores



*Significant reduction from baseline in the affective dysregulation Q score

Changes from baseline in SWAP-200 Q scores



*p<0.05

*Significant reduction from baseline in dependent Q scores. Significant improvement of high function

Remission Rate and Predictors

- Remission rate according to the DSM-IV criteria was 20% (4)
- If we considered a reduction of 25% in the Zanarini total score as a measure of improvement, we observed that 52.4% of our sample showed an improvement
- We conducted a multiple regression analysis to identify independent predictors of improvement: after allowing for sex, age, educational level, only baseline HAM-D level appeared a significant predictor of improvement (β =-1.04, p=0.021).

Conclusion

- MBT appear to be an effective treatment for BDP patients in an Italian contest.
- Several limitation should be taken into consideration: sample size is very small and we conducted an observational study.
- Future randomized studies should be performed to better elucidate our findings.
- Additionally the effect of medications should be taken into consideration

Thank you very much for your attention