Letters to the Editor

Re: Day Treatment for Personality Disorders

Dear Editor:

Dr Paris’ article on the treatment of BPD and Dr Livesley’s article on strategies for treating personality disorder, both in July’s Journal, were good reviews serving to combat undue pessimism in the treatment of those disorders (1,2).

Both authors refer to day treatment as an evidence-based alternative for patients in crisis (1, p 439; 2, p 446). It is important to understand that the day treatment program we studied, using a randomized controlled design, is not for patients in crisis (3,4). This program is designed for patients who are able to tolerate intensive self- and behavioural exploration. It corresponds to Livesley’s stage of “exploration and change” (2, p 448) in the sequence of strategies for treating personality disorder. Such day treatment programs are highly specialized, requiring competent leadership and several years of staff training to become effective (5). Day treatment programs should be distinguished from day hospitals, which are units designed as an alternative to inpatient care (6). Ideally, day hospitals for patients with personality disorders might operate on Livesley’s principles of “safety and managing crises” and “containment” (2, p 446).

References


John Rosie, MBChB, MRCPsych
Anthony Joyce, PhD

John G O’Kelly, MB, MRCPsych
Paul Steinberg, MD
Edmonton, Alberta

Re: Recent Advances in the Treatment of Borderline Personality Disorder

Dear Editor:

In his recent article on borderline personality disorder (BPD), Joel Paris comments on a study of the treatment of BPD that is underway in Sydney, Australia (1). These remarks warrant a response.

Attitudes toward BPD have recently changed. The pessimism formerly associated with such a diagnosis has been mitigated by evidence from prospective and controlled studies. Early studies were conducted in Seattle, Washington, and Sydney, Australia (2–4). Of the Sydney study, Paris writes that the 30 patients received 2 years of treatment. In fact, they received 1 year of treatment. They were followed up 1 year after treatment. Paris then describes the control group, whose members received treatment as usual, as untreated while on a waiting list. Our published description states, that during the waiting period, they had their usual treatments, which were various (e.g. supportive psychotherapy, crisis intervention only, cognitive therapy, pharmacotherapy). Some patients were hospitalised. There was no typical course of treatment (2).

Paris describes our treatment as self-psychology. It is actually guided by the conversational model (5), the main aim of which is to foster the emergence of reflective consciousness that William James called self consciousness (6,7). A principal tenet of this approach is that this form of consciousness, discovered through a particular form of conversation, reflects a specific kind of relatedness. The nearest North American equivalent to this approach comes from Kohut and his followers.

Paris remarks, that since there was a low attrition rate in our sample, the patients were unlikely to be “representative of a clinical population” (1). Our dropout rate was 16%, the same as that of the Seattle study. In terms of severity, our published report notes “57% of the cohort showed all eight DSM-III criteria, compared with 7% in Stone’s large series.”

Paris also notes that these early studies should be properly followed up. Our cohort has been followed up: all patients were traced to the 5-year mark. They maintained their improvements (4).

I appreciate the opportunity to make these clarifications.
References


Russell Meares, MD
Parramatta, Australia

Reply: Recent Advances in the Treatment of Borderline Personality Disorder

I would like to thank Dr Meares for correcting some inaccuracies in my brief summary of his report. This was a pioneering and valuable study, but the main limitation I mentioned in my review, the absence of a control group, still leads to uncertainty about its clinical applicability.

Joel Paris, MD
Montreal, Quebec