Correspondence

EDITED BY TOM FAHY

Treatment of severe personality disorder

Sir: I was interested to read the paper by Dolan *et al* (1997) as I am involved in developing guidelines for the treatment of patients with severe personality disorder. I was, however, concerned that the conclusions and recommendations of the paper were inconsistent with the data provided. There are three areas of concern.

First is the nature of the controls used in the study. The authors highlight the 22 controls who were refused funding for admission and their similarity to patients admitted to Henderson Hospital. Less emphasis is given to the remaining two-thirds (n=45) who were not admitted because of non-attendance, clinical unsuitability or admission elsewhere. This is hardly a random sample but an often self-selected group with a particularly poor prognosis.

Second, in discussing the limitations of their study, the authors fail to stress that only 25% of the original sample was successfully followed-up (137 out of 598). It is, of course, difficult to undertake a study of this type in this group of patients, but such a degree of follow-up bias must limit the generalisability of Dolan *et al*'s results.

Third, the authors fail to mention that the outcome measure used, the Borderline Syndrome Index, could not be validated against another standardised psychiatric instrument of borderline personality disorder (Marlowe *et al*, 1996).

Given these methodological problems it is hardly surprising that health authorities are reluctant to fund expensive in-patient treatment at Henderson Hospital. Rather than berating health authorities, it might be more appropriate to undertake further research into what still remains an unproven treatment.

Dolan, B., Warren, F. & Norton, K. (1997) Change in borderline symptoms one year after therapeutic community treatment for severe personality disorder. *British Journal of Psychiatry*, **171**, 274–279.

Marlowe, M. J., O'Neill-Byrne, K., Lowe-Ponsford, F., *et al* (1996) The Borderline Syndrome Index: a validation study using the Personality Assessment Schedule. *British Journal of Psychiatry*, **168**, 72–75.

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Authors' reply: We support some of Dr Kisely's reservations about the methodology we employed. However, in our view, these limitations were clearly stated and openly acknowledged in the original paper.

At no point did we claim that the non-admitted group was a control group, and the extent to which they are comparison groups, with all the accompanying disadvantages, is clearly stated in the paper. Dr Kisely is correct that the whole non-admitted group is not a random sample and this was our point in mentioning the group whose funding was refused by health authorities. Since we made no attempt to obtain a randomly allocated sample, on ethical and clinical grounds, and no claim for such methodology was made, the criticism that the sample was not random is irrelevant. Dr Kisely provides no evidence for his assertion that non-admitted patients form a "self-selected group with a particularly poor prognosis". Research data which may have informed any clinical differences between the non-admitted (self-selected or otherwise) and the admitted groups are reported in our paper.

The low response rate was fully acknowledged, and the potential limitations of this were highlighted (Dolan *et al*, 1997, p. 275).

We acknowledge Marlowe *et al*'s (1996) criticism of the Borderline Syndrome Index (BSI), and we cited his paper for the reader. It is important in interpreting Marlowe *et al*'s findings to note that they compared the BSI with the Personality Assessment Schedule, which was devised prior to publication of the DSM system and, although it is compatible, is derived from ICD–10 categories. Furthermore, Marlowe *et al* did not control for multiple personality disorder diagnoses. Although the subjects in that study were diagnosed with borderline personality disorder, we do not know for how many other diagnoses they also met criteria. Furthermore, Marlowe *et al*'s study addressed the question of whether the BSI could help to identify personality-disordered patients in a heterogeneous group, whereas the study of changes following specialist treatment addresses the severity of personality disorder in a population already known to be personality-disordered.

Health authorities have been reluctant to fund patients with severe personality disorder long before the publication of our prospective outcome study, which could clearly not have influenced their decisions, positively or negatively, in retrospect. Previously (Dolan *et al*, 1994) it was reported that only one in three patients with severe personality disorder, referred as extra-contractual referrals, received funding. Such decisions were made on a financial rather than a clinical basis.

Dolan, B. M., Evans, C. & Norton, K. (1994) Funding treatment of offender patients with severe personality disorder: do financial considerations trump clinical need? *Journal of Forensic Psychiatry*, **5**, 263–274.

——, Warren, F. & Norton, K. (1997) Change in borderline symptoms one year after therapeutic community treatment for severe personality disorder. *British Journal of Psychiatry*, **171**, 274–279.

Marlowe, M. J., O'Neill-Byrne, K., Lowe-Ponsford, F., *et al* (1996) The Borderline Syndrome Index: a validation study using the Personality Assessment Schedule. *British Journal of Psychiatry*, **168**, 72–75.

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Economics of attachment disorders

Sir: Adshead (1998) eloquently describes the impact on staff of those who have disturbed patterns of attachment, but her reasoning can be taken a little further and point to service-level considerations and a link between cost of treatment, which is often inappropriate, and severity of attachment disorder.

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