Continuing lack of evidence for the psychotic subtyping of PTSD

Gaudiano & Zimmerman conclude that psychotic symptoms in post-traumatic stress disorder (PTSD) are associated with comorbid conditions, especially major depressive disorders, and that their results therefore do not support the existence of a psychotic subtype of PTSD. However, they did not evaluate certain factors that might be responsible for misinterpretation of their results. First, they did not report the severity of post-traumatic and depressive symptoms. It is possible that patients with PTSD without comorbid depressive disorder had a milder post-traumatic disorder and consequently less probability of presenting with psychotic symptoms. Second, in clinical practice the congruence of delusions and hallucinations with traumatic events seems to be distributed across a continuum: at one extreme there is complete congruence with trauma and at the other there are exuberant and bizarre symptoms similar to those described in schizophrenia. The elucidation of the possible existence of a psychotic subtype of PTSD must necessarily include the development of adequate instruments to measure severity and congruence of psychotic symptoms in ‘non-psychotic’ conditions (e.g. mood and anxiety disorders), as well as their biological correlates.

Is transference-focused psychotherapy efficacious for borderline personality disorder?

In their study of treatment for borderline personality disorder, Doering et al state that their results ‘demonstrate the significant superiority of transference-focused psychotherapy with regard to the primary outcome criteria of drop-out rate and suicide attempts during the treatment year’ when compared with treatment by experienced community psychotherapists. They report that ‘significantly fewer participants dropped out of the transference-focused psychotherapy group (38.5% v. 67.3%) and also significantly fewer attempted suicide (d = 0.8, P < 0.009)’.

In our view, this interpretation of primary outcome criteria might lead to misunderstandings. As regards suicidality, the authors suggest that the P-value of 0.009 would relate to absolute numbers of attempted suicides during the treatment year. However, the actual difference in suicide attempts during the treatment year (7/52 v. 11/52) is not significant (P = 0.44, continuity-corrected χ²-test, LOCF analysis). The significant P-value reported by the authors seems to correspond to change scores (defined as 1/0/−1 by the authors), not to suicide attempts during the treatment year, which seems to be the outcome as defined in the study protocol (trial NCT00714311). The authors further suggest that the effect size of 0.8 would refer to the between-group comparison. However, the reported effect size seems to correspond to the within-group comparisons reported in Table DS2. The between-group effect size for suicide attempts during the treatment year would be small.