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Borderline personality disorder treated with the conversational model: a replication study

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Abstract

Recent work has lead to a greater degree of optimism in the treatment of borderline personality disorder (BPD). This study looks at a group of patients with BPD treated with outpatient psychotherapy using the conversational model of Hobson and Meares. The study group is compared, first, with the original cohort previously reported by Stevenson and Meares [Stevenson J, Meares R. An outcome study of psychotherapy for patients with borderline personality disorder. *Am J Psychiatry* 1992;149(3):358-62] and, second, with a wait-list "treatment-as-usual" control group. Patients were recruited well after initiation of the program and, hence, can be seen as a group treated under more usual clinical conditions rather than as a cohort subject to the initial wave of research enthusiasm. Subjects were rated at baseline and 12 months on a range of symptomatic, functional, and objective measures. The rate and degree of improvement in the later cohort are very similar to the original 1992 cohort and significantly greater than what is found in the treatment-as-usual controls. We believe that this is the first replication study demonstrating success in treating patients with BPD using an established form of individual psychodynamic therapy delivered in an outpatient setting.

1. Introduction

Over the last 15 years, the application of various treatment approaches to the management of borderline personality disorder (BPD) has led to a "guarded optimism" that such personality conditions are "changeable and treatable" [1]. Such hopefulness was derived, in part, from several outcome studies that have demonstrated symptomatic and behavioral improvements in these patients. In one of the first outcome studies evaluating the effectiveness of a specific psychotherapeutic approach to patients with BPD, Stevenson and Meares [2] described significant improvement after 12 months' therapy, which was sustained for 1 year posttermination. Further follow-up of this original cohort at 5 years showed that symptomatic and behavioral gains (encompassing reduced distress and affective symptoms, reduced self-harm, violence, medical visits, and hospital admission) were maintained at 5 years [3].

In reviewing the positive outcomes of the study by Stevenson and Meares, Gunderson [4] commented that "replication with a control group is the much-awaited next stage" (p 266). The present report looks at the outcomes for a subsequent cohort of 29 patients who entered our clinical research program between 1994 and 2001. This cohort is compared with a group of 31 wait-listed "treatment-as-usual" (TAU) controls and with the original cohort and reflects work carried out after the initial stage of enthusiasm that accompanies a new project had worn off to some degree.

There is now a significant outcome literature on the psychotherapeutic treatment of BPD. For example, studies such as those of Stevenson and Meares [2], Linehan et al [5], Bateman and Fonagy [6], Monsen et al [7], and Clarkin et al [8] have all shown promising results with varying theoretical orientations. All researchers in the field would agree with Gunderson that there is a need for replication of findings. All studies in the field have methodological limitations such that conclusions are tentative.

It is common to raise questions as to the replicability of the original findings in the field of psychotherapy research. The enthusiasm of primary researchers and the resources put into projects may be difficult to replicate in naturalistic settings. The question of generalizability of results from individual research studies to ordinary clinical conditions is often raised, as expressed by Clemens [9]: "What efficacy studies gain in scientific validity, they lose in applicability to

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real-life practice, sometimes being characterized as artificial treatments of artificial patients under artificial conditions."

After the success with the original cohort of 30 patients [2], an ongoing program was established, which varied in some ways from the original study. Although therapists generally had a similar level of past psychotherapeutic experience compared with that of the original cohort, they became a somewhat more disparate group with less overall exposure to psychodynamic psychiatry in their general psychiatric training, due partly to changes in the structure of the public area health service. From 1997, the therapist group also included general medical practitioners with no background in specialized psychiatric practice. A wait-list condition became established for naturalistic reasons: the clinical demand for the program (the only one of its kind in a city of 4 million people) and the limited number of available therapists (trainees in a psychotherapy program). Therefore, the second cohort could be compared with a wait-list control group that had not evolved at the time of the original study. Because this control group continued to receive standard treatment, it will henceforward be referred to simply as the TAU control group. Although not all of the original measures were used (eg, the Cornell index [10]) in the second cohort, direct comparisons can be made with the original cohort on a number of measures as well as with the control group.

Common factors between the 2 cohorts are that the therapists were involved in a training program that included supervision using audiotapes and provided a coherent theoretical model, the conversational model developed by Hobson and Meares [11-13]. The study population was similar in both cases with all patients meeting criteria for BPD according to the *Diagnostic and Statistical Manual of Mental Disorders, Revised Third Edition* (*DSM-III-R*), criteria. There was a substantial comorbidity, primarily with substance abuse and depressive disorder, in this patient population. The second cohort consisted of patients who had only 12 months' therapy to allow comparison with the original cohort. (Some patients were in the program longer than others, as reported elsewhere [14].)

Bateman and Fonagy [15] pointed out that "the ... majority of studies in the field are uncontrolled and independent raters are never used," urging caution in interpretation of results. Westen et al [16] discuss the inherent difficulties in mounting randomized controlled trials (RCTs) in relation to Axis II diagnoses. They point out that data from naturalistic sources tend to show evidence of better results with longer periods of treatment, whereas RCTs tend to show the opposite [16]. They suggest that this may be, among other reasons, because RCTs are typically set up with relatively pure patient groups with Axis I disorders and run under controlled conditions more easily implemented in brief interventions [16].

Despite the studies outlined above, Bateman and Fonagy [15] still come to the conclusion that "there is relatively little compelling evidence that individuals with personality disorders and low levels of functioning can be successfully treated on an outpatient basis". Perry et al [17] reach a different conclusion in finding in their meta-analysis that psychotherapy is an effective treatment of BPD. It is important for researchers to demonstrate effectiveness under more ordinary clinical conditions as well as to continue efforts to control experimental conditions.

The present study is a contribution to this area, which looks at outcomes with outpatient therapy under relatively naturalistic conditions that have been sustained for more than a decade since the original cohort was studied. Although clinically naturalistic, comparison with a TAU control group, which evolved naturally because of the demand for the therapy program, and with the original cohort may strengthen the capacity to draw conclusions about the effectiveness of this form of treatment.

2. Method

2.1. Participants

The original cohort of the Westmead Personality Disorder Research and Treatment Program of 30 participants came from a group of 48 who originally entered treatment. The 29 therapy participants of this study entered treatment between 1994 and 2001. The patients in this study were selected on the basis that they had a period in therapy comparable with the original cohort: all 29 patients in this study were in therapy for 12 months. The control group consisted of patients who waited for a period of 12 months continuing with the usual treatment as carried out by the referring clinicians. As mentioned, this TAU group had evolved naturalistically. People who were referred to the program as well as referring clinicians understood that there was a wait-list because of the demand for and the limited resources of the program. All patients continued to receive ongoing care and crisis support. In other words, all patients continued to receive a standard of care comparable with all other area health services in the city.

All patients entering the program gave informed consent to the research procedures. The length of time that patients spent in the wait-list varied to some degree, again depending on the naturalistic factors of supply and demand. All 31 patients in the control group completed their 12-month review without having entered into therapy. In terms of the demographic variables of age, marital status, occupational status, and educational status, there was no statistically significant difference between the study and control groups. With respect to symptom measures, there was no significant difference between the study and control groups at baseline.

2.2. Measures

After the method of a previous study [2], all subjects were screened at an assessment interview with the Westmead Severity Scale. This scale was constructed from the 27 items making up the diagnostic criteria for BPD in