(a) Experimental studies which have shown that psychological measures of dissociation and psychosis are highly correlated and do not have convincing differential construct validity.[4]

(b) Historical analysis of changing diagnostic trends, demonstrating a waning in the popularity of multiple personality disorder at the time that the diagnosis of schizophrenia began to gain ascendance is argued to be no coincidence.[5] That childhood abuse is now suggested by some studies to have a 'dose-dependent' relationship with later risk of psychotic symptom development, in particular hallucinations,[6] also weakens the basis for any presumed aetiological distinction between the two.

(c) Psychological modelling of how child maltreatment and trauma may give rise to psychotic symptoms (including negative symptoms). Presumed differences between traumatic flashbacks and 'hallucinations' may be based more on whether insight into a link between trauma and symptom is acknowledged by the patient (and psychiatrist).[6] This becomes harder still when the hallucination is symbolic rather than simply echoic or thematic.

If such a model is correct, then we can begin to take more seriously the claims of such relational therapies as the open dialogue family therapy model for early psychosis in Finland, which claims to have reduced the transformation of new-onset psychosis to chronic schizophrenia to a remarkable degree.[7] We might also take seriously the ideas of relating therapy for voices and even the more radical, direct voice dialogue advocated by some.[8] The implications for wider practice are also substantial – after all, the difference between voice elimination/repression and integration/transformation cannot be overstated, although clearly some patients are likely to still favour a 'sealing off' recovery style.

Julian Leff's team and the editorial board of the *British Journal of Psychiatry* are to be congratulated for the publication of this paper. Greater insight into how the therapist learns to convincingly embody the patient's persecutory voice, through the avatar, would however be welcome.

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doi: 10.1192/bjp.203.3.233a

Author's reply: Dr Rodger's view of the clinical importance of the introduction of avatar therapy is encouraging. He makes a number of important points with which I entirely agree. In particular, the frail boundary between dissociation and psychosis was brought home to me by four adolescent girls in our trial, two of whom had been sexually abused in childhood, and experienced auditory, visual and somatosensory hallucinations. One girl re-experienced the rape every night and was convinced that the rapist entered her bedroom for that purpose.

In answer to Dr Rodger's question about the therapist's voicing of the avatar, it is a crucial requirement that the patient accepts the avatar as a realistic representation of their persecutory voice. This is achieved by asking the patient at first contact to report on the habitual phrases they hear. The therapist's voice is morphed into a variety of forms, from which the patient selects the one that is closest to the voice they hear. Patients assessed the closeness of the match at between 60 and 90%. In the first session of therapy the therapist, as the avatar, speaks the phrases the patient has reported hearing in order to establish the identity of the avatar as their persecutor. Of the 16 patients who experienced the full course of six sessions of therapy, only 2 failed to respond to the avatar as a convincing simulacrum of the voice they hear. Neither of them benefited from the therapy. We have discussed the possible mechanisms by which the therapy achieves its effects.[1]

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doi: 10.1192/bjp.203.3.234

Specialised mood disorder clinic *v.* standard care for out-patients with bipolar disorder

The recent paper by Kessing *et al*[1] was an interesting read. However, the likelihood of the findings being useful in a setting outside Denmark could reduce the paper's relevance to the international audience. First, the vast difference between the type of treatment received by patients in the mood disorder clinic and standard out-patient care makes it almost impossible to identify the features of the clinic that make it successful, such that they may be replicated to improve service elsewhere. Although the authors go into significant detail with regard to the type of treatment and support received by the patients in the clinic, there is very little information on the patients who went through standard care. If standard care is an appointment with a general practitioner or a private psychiatrist without any support from community mental health teams, then generalising the results to the UK might be problematic as these patients would normally be with community mental health teams with some or other type of enhanced care programme approach. Second, when refusal rates are as high as the authors mentioned in this article – out of 474 eligible patients only 158 participated in the trial – a judgement must be made as to how far the volunteers that remain can be considered representative of the target population. They might, for example, in this study be younger on average than the refusers. Is this important in relation to the study question? Third, the authors refer to psychopharmacological treatments in standard care being 'more likely to be based on the preferences of the individual physician than on national and international guidelines'; however, they make no effort to control or correct for these factors in the analysis of results, although it has been recognised that patients from the mood disorder clinic are more likely to use mood stabilisers. Finally, the cost difference between standard care and the mood disorder clinic is mainly due to the