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Correspondence

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Psychological treatments for depression

SIR: We offer three comments on Professor Scott's timely review of psychological treatments for depression (Scott, 1995).

First, the criteria for successful "manualisation" of a treatment have not been specified sufficiently thoroughly to guide clinical practice. The term is generally taken to mean that there are agreed procedures to which a trained therapist will adhere to a criterion level. However current manuals tend to specify criteria to be achieved in basic training but do not describe the more complex choices and decisions made in actual practice.

Second, the fourfold classification into behavioural, cognitive, interpersonal and dynamic therapies is unrepresentative of research and practice in the UK. Therapeutic practice is less narrowly channelled than this implies. Cognitive analytic therapy integrates strategies from cognitive and dynamic traditions, rather than residing solely within the dynamic class to which Professor Scott assigns it. Many practitioners combine cognitive and behavioural approaches in their daily practice; similarly, others combine dynamic and interpersonal strategies. How treatments are best categorised is an empirical question. For example, the finding by Jacobson *et al* (in press) that the behavioural activation component of Beck's cognitive therapy was as effective as the full treatment argues against CT's distinctiveness from the larger family of cognitive–behavioural methods.

The research–practice gap is therefore appropriately bridged via somewhat broader treatment protocols such as cognitive–behavioural (CB) and psychodynamic–interpersonal (PI) methods (Shapiro, 1995). Two comparative trials (e.g. Shapiro *et al*, 1994) established similar efficacy of manualised CB and PI treatments, and showed that therapists can adhere consistently to these models, even in the demanding context of research requiring them to practise both. For the PI method of these studies (Hobson's Conversational Model) there are well established and effective training methods (Margison & Moss, 1994).

Finally, we are concerned that research on "pure" depression does not correspond to practice in which depression often co-exists with personality disorder, anxiety disorder, substance abuse and other co-morbid conditions. When assessing overall effectiveness in practice, as contrasted with efficacy as established in research trials, the impact of this comorbidity needs to be taken into account.

JACOBSON N. S., DOBSON, K. A., TRUAX, P. A., *et al* (in press) A component analysis of cognitive-behavioural treatment for depression. *Journal of Consulting and Clinical Psychology*.

MARGISON F. & MOSS, S. (1994) Teaching psychotherapy skills to inexperienced psychiatry trainees using the Conversational Model. *Psychotherapy Research*, **4**, 141–148.

SCOTT, J. (1995) Psychological treatments for depression: An update. *British Journal of Psychiatry*, **167**, 289–292.

SHAPIRO, D. A. (1995) Finding out how psychotherapies help people change. *Psychotherapy Research*, **5**, 1–21.

——, BARKHAM, M., REES, A., *et al* (1994) Effects of treatment duration and severity of depression on the effectiveness of cognitive-behavioural and psychodynamic-interpersonal psychotherapy. *Journal of Consulting and Clinical Psychology*, **62**, 522–534.

F. MARGISON

Manchester Infirmary

D. A. SHAPIRO

Psychological Therapies Research Centre
University of Leeds LS2 9JT

SIR: In her excellent review of this subject (Scott, 1995), Professor Scott says that the therapist's level of skill and adherence to the treatment model account for up to 30% of the variance in outcome. In that case, it seems to become very difficult to make group comparisons between these therapies and others, or indeed to make any general statement on the efficacy of psychological methods.

In fact, the data relating to psychological treatments in depression have come very largely from highly specialised centres, often associated with

charismatic individuals. The fact that these methods have not been widely taken up, in spite of the claims made for them, may well be explained by them being 30% less effective in the hands of those whose skill and adherence to the model is much less satisfactory.

The efficacy of antidepressants may be somewhat influenced by the doctor's interest in the patient and belief in the treatment, but on the whole, results will be much the same, whoever does the prescribing. That would seem to be a major advantage of drug treatment.

SCOTT, J. (1995) Psychological treatments for depression: an update. *British Journal of Psychiatry*, **167**, 289–292.

H. FREEMAN

21 Montagu Square
London W1H 1RE

Risperidone in schizophrenia

SIR: Peuskens *et al* (1995) have published a welcome confirmation of the low level of extra-pyramidal side-effects at low dose and short-term efficacy of risperidone. I am unclear, however, how a study designed to evaluate the short-term efficacy of risperidone can arrive at the conclusion that risperidone is thus "an effective antipsychotic for the treatment *of chronic* schizophrenia" (my emphasis).

This was an eight week trial using only a maximum of seven days washout and where over a third of the participants were on long-acting depot neuroleptics before the trial. It is well recognised that when typical antipsychotics are stopped, it is not uncommon for chronic schizophrenics, freed from the burden of (intolerable) sedation and extra-pyramidal side-effects such as akathisia, to start to feel better for several months. Relapse rates then tend to rise after this time. Indeed, even just reducing antipsychotic doses can have a beneficial effect on symptoms and side-effects (Liberman *et al*, 1994).

I would have thought that the trial would need to have been continued for a further 6–12 months before the stated conclusion could be drawn. Until then, I feel that the valid conclusion is that risperidone is at least an effective antipsychotic *in* chronic schizophrenics, but not *of* chronic schizophrenia, a subtle yet important difference.

LIBERMAN, R. P., VAN PUTTEN, T., MARSHALL, B. D. JR., *et al* (1994) Optimal drug and behavior therapy for treatment-refractory schizophrenic patients. *American Journal of Psychiatry*, **151**, 756–759.

PEUSKENS, J., FOR THE RISPERIDONE STUDY GROUP (1995) Risperidone in the treatment of patients with chronic schizophrenia: a multi-national, multi-centre, double-blind, parallel-group study versus haloperidol. *British Journal of Psychiatry*, **166**, 712–726.

S. BAZIRE

Hellesdon Hospital
Norwich NR6 5BE

The essence of supportive psychotherapy

SIR: In his peer review of Holmes' article on Supportive Psychotherapy, Tyrer complained of the absence of "read-lutes" – phrases or sentences that are memorable and which encapsulate the theme (Holmes, 1995; Robertson & Tyrer, 1995). Tyrer rightly emphasised that it is not only psychiatrists with a psychotherapeutic bent who administer supportive psychotherapy, but a wide spectrum of other workers in their daily routine.

Recently, Dr David Fox, a local GP, retired after 38 years providing a supportive out-patient clinical assistant session. The patients seen included chronic schizophrenics, severe depressives and longstanding personality disorders. At a farewell party, reflecting on these years of supportive therapy, he concluded that it was "5% psychiatry, 25% counselling and 70% non-medical – acting as a listening human being".

I feel that it would be hard to better that "sound bite" in encapsulating the very essence of supportive psychotherapy.

HOLMES, J. (1995) Supportive psychotherapy. The search for positive meanings. *British Journal of Psychiatry*, **167**, 439–445.

ROBERTSON, M. F. & TYRER, P. (1995) Peer review of "Supportive Psychotherapy". *British Journal of Psychiatry*, **167**, 446–447.

R. N. LUCAS

North Middlesex Hospital
London N18 1QX

Biological psychiatry and psychotherapy

SIR: Karlsson & Kamppinen (1995) argue for emergent materialism – the idea that everything is material but organised at multiple levels, each having its own emergent properties – as an ontology for biological psychiatry; but they lack theory about emergence and how different levels interact.

This is familiar territory for clinicians who use systems theory. Durkin (1981) developed a theory of 'transcendence' and family therapists use ideas about relationships between social systems and their subsystems (Hoffman, 1981). Much of psychodynamic theory is based on a hierarchy of levels of mental organisation, in which cognitions