make the grave error of extrapolating from community estimates to the special population of the elderly in hostels and nursing homes.

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Antidepressants and suicide risk

Donovan *et al* (2000) make interesting points about deliberate self-harm (DSH) and antidepressant drugs, but their report as written is open to grave misinterpretation. Indeed, a reporter brought the article to my attention wanting to know why selective serotonin reuptake inhibitors (SSRIs) increased suicide risk relative to tricyclic antidepressants (TCAs).

A key problem with this cross-sectional, naturalistic study of DSH and antidepressant medications at emergency department presentation is that patients were not diagnosed. The authors write as if antidepressant medications are almost invariably prescribed to treat depression, yet clearly this is not always true. Even within mood disorders, patients may differ greatly in suicide risk. The authors found fragmentary evidence that patients on SSRIs may have been relatively treatment-resistant.

Moreover, SSRIs are prescribed for a growing spectrum of psychiatric illnesses beyond depression. The authors hint at the multiplicity of indications, mentioning enuresis as an indication (presumably for TCAs). Astoundingly, however, they never mention borderline personality disorder (BPD). Patients with BPD, known for their frequent parasuicidal gestures (Davis *et al*, 1999), are more likely to receive SSRIs than TCAs: partly because of their safety in overdose, partly for their benefit for impulsivity independent of mood disorder. Hence BPD and other patients at higher risk for DSH may have received SSRIs rather than TCAs. The authors mention this briefly (" . . . the question of whether patients prescribed TCAs were similar in terms of DSH risk to those prescribed SSRIs", p. 553) but fail to emphasise how crucial this issue is. (Neither do they mention substance misuse, a further risk factor for self-destructive behaviour.) Given this likely diagnostic and prescriptive imbalance, it is unsurprising that more suicidal patients presenting at emergency departments were taking SSRIs.

In summary, without knowing that equivalent patient populations were receiving the two classes of medications, we cannot compare their effect on suicide risk.

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Cognitive therapy and social functioning in chronic depression

We clinicians constantly encounter patients with major depression in partial remission. They are no longer acutely depressed but continue to present with substantial functional impairment (Paykel *et al*, 1995). For treatment-resistant depression, only one pharmacological intervention can be recommended today with reasonable evidence, namely lithium augmentation (Austin *et al*, 1991; Aronson *et al*, 1996), but this may not be the answer for those with low-grade residual depression.

Scott *et al* (2000) demonstrated that cognitive therapy can help these people. Critically appraising their article in our evidence-based psychiatry case conference, however, it was very difficult for us to appreciate the substantive significance of this improvement, because only means and standard deviations of scores on the Social Adjustment Scale were reported. Analyses based on these data can show whether or not the treatment is better than the control condition, but cannot show how much better it is – a crucial piece of information for both patients and clinicians. We therefore resorted to the normative data for this scale (Bothwell & Weissman, 1977). Calculation based on the means and standard deviations under the assumption of a normal distribution showed that, at week 20, 68% of patients with residual depression reached the 95% range of the control subjects when treated with clinical management plus cognitive therapy, whereas only 45% did so when treated with clinical management only. This translates into a 'number needed to treat' of 4.4 (95% CI 2.6–12.6).

This is an impressive figure. By adding 16 sessions of cognitive therapy to usual care, we can achieve social remission in one additional patient out of four, compared with continued standard care only. The original authors had concluded, "In patients showing only partial response to antidepressants, the addition of CT produced modest improvement in social and psychological functioning". We find that the improvement was more than modest and would be clinically meaningful.

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Author's reply: I am a strong advocate of the use of cognitive therapy in chronic and residual depressive disorders. I am therefore the last to disagree with the comments of Ito and colleagues that there is real benefit in providing psychosocial treatments to individuals with residual depressive symptoms. My comment on social functioning was not meant to underestimate the benefits, but paid heed to two factors. First, although individuals who received cognitive therapy undoubtedly

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showed significant improvements in social functioning, there were still obvious impairments within this population. Second, and very importantly, the differences between the cognitive therapy group and the control group were only apparent during the active phase of treatment – the control group continued to make modest gains during the follow-up period so that at 1 year after cognitive therapy there was no difference in social functioning between the two groups. One conclusion from this result is that individuals who receive 16 sessions of cognitive therapy for chronic or residual depressive symptoms may benefit from additional but less-frequent maintenance cognitive therapy sessions.

Lastly, Ito *et al* are right to point out that calculations of numbers needed to treat from this study are indeed indicative of substantial benefits from using cognitive therapy. For the record, using data from our study and other recent studies, only four to six additional patients need be treated with cognitive therapy to prevent one relapse.

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Long-term psychotherapeutic relationships in schizophrenia

I would like to add what I believe is an important factor not mentioned by Thornicroft & Susser (2001) in their editorial on evidence-based psychotherapies in the community care of schizophrenia. It is a factor that I think is missing from a great deal of psychiatric literature on what helps patients get better and what makes us human. People with schizophrenia have withdrawn from being able to relate to others. They need somebody who is able to provide a long-term therapeutic relationship and is not frightened off by those who say ‘beware of dependency’ or seduced by the culture of brief interventions; a person who can stand up to the ‘package culture’ and stay with the patient and family over a long period of time. This sort of work does not make headlines. I think it is the role of psychodynamic psychotherapists to champion dependency in order that the patient can find something of his or her own from the shattered fragments of self; a mature dependence, within the constraints of illness. This work is not easy, requires support, supervision, time and resources. Perhaps the paucity of evidence is because this apparently simplistic viewpoint meets great resistance and is culturally dystonic.

Thornicroft, G. & Susser, E. (2001) Evidence-based psychotherapeutic interventions in the community care of schizophrenia. *British Journal of Psychiatry*, **178**, 2–4.

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Psychodynamic thinking and the community mental health team

I read with great interest Thornicroft & Susser’s (2001) editorial on evidence-based psychotherapeutic care in schizophrenia. It called for evidence-based interventions being implemented in the face of resource limitations and a remedy to the absence of implementation plans for well-established effective interventions such as family therapy. However, Thornicroft & Susser dismiss psychodynamic approaches. Although the general view is that people with schizophrenia do not benefit from intensive psychoanalytic psychotherapy, there are some heroic efforts by analysts such as Herbert Rosenfeld (1987). In particular, such approaches do address the imperfection of our models of mental disorder.

One thing the psychodynamic way of thinking can offer members of the community mental health team (CMHT) is understanding of complex mental states from the patient’s perspective, and new ways of understanding those that fall outside of our management strategies. There is no doubt that the delivery of psychoanalytic psychotherapy to people with schizophrenia, on an intensive basis, will not be resourced, nor will the symptom outcomes necessarily be better. Therefore, the cost cannot be justified. However, part of the problem that faces CMHTs is the long-term nature of their work with little reward in terms of symptom improvement and recovery for those with enduring severe mental illness. This can be frustrating and de-skilling for staff, particularly if they have a limited range of therapeutic models. I have worked in an assertive treatment team for the people with severe mental illnesses and one for homeless people with mental illnesses. Staff retain curiosity and capacity to think and question their formulations about patients in a psychodynamic way. Their work continues to be fresh and motivating. This is particularly welcome in light of Wykes *et al*’s (1997) finding that CMHT staff are not uncommonly depersonalised and therefore unable to empathise with their patients. At a time when there is a movement to ensure good human relationships as well as therapeutic relationships with patients, dismissal of the relevance of psychodynamic thinking in the healthy functioning of a CMHT is premature. This is one area of CMHT functioning that warrants further research, as suggested by Thornicroft & Susser.

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What came first: dimensions or categories?

We read with much interest the paper by O’Dwyer & Marks (2000), and think that the case vignettes reported by the authors fit perfectly with Insel & Akiskal’s (1986) model that considers obsessive–compulsive disorder as a disorder that can develop along a continuum of insight. Therefore, the primary problem is not the boundaries between obsessive–compulsive disorder (or anorexia, or body dysmorphic disorder) and psychosis, but rather at which point insight is lost and the disorder under consideration becomes a frankly psychotic one. If one considers insight as a dimension spanning from normality to the most severe psychiatric conditions, then it will not be difficult to posit several psychiatric disorders along it, with all possible heterogenous combinations. The model becomes even more comprehensive if we add the ‘uncertainty/

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