Correspondence

EDITED BY STANLEY ZAMMIT

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A new dawn for the yellow journal?
I welcome the new Editor’s plans to bring the Journal firmly into the 21st century by making it intellectually stimulating but also inviting and readable for all (Tyrer, 2003). The previous Editor may have done much to improve the Journal’s impact factor to the scientific community by increasing its citation rate but what has not been studied are the views of the core readership. Should not a survey of readers be carried out to see what people think about the Journal and who reads how much and of what? I suspect the answer may be not much of very little, and that for most of us the Journal has a fairly short ‘wrapper off to bookshelf time’.

The Journal’s core readers are many thousands of jobbing psychiatrists. We are looking for important new information that has bearing on our day-to-day clinical practice. Yes, we have the Psychiatric Bulletin, with its zippy and original offerings, but sometimes a subject needs a more academic and lengthy airing. Perhaps the readership could suggest subjects for editorials, and why not have each book review written by both an expert in the field and an ordinary reader, so as to capture different perspectives? I hope that the new Editor can increase the interaction between the Journal and all psychiatrists. Good luck.


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Editor’s response: Dr Haw is probably right in her assertions that the jobbing psychiatrist is likely to become the bobbing psychiatrist when reading the Journal – jumping from one item to the next with little close examination of the content – and it is clear from a recent paper that the ability of good ghostwriting to make an arresting impact on the reader pays dividends (Healy & Cattell, 2003). We are taking notice of this by trying to improve and shorten the titles of papers submitted to the Journal; prospective authors please note. However, Dr Haw has stimulated me to go further; I have a hypothesis that readers of the Journal might help me in testing. It is a hypothesis that is best kept blind at this stage, and I am disclosing it only to the Associate Editors. For each of the main sections of the Journal (editorials, debates, original papers, review articles, book reviews and correspondence) I invite readers to score on a four-point scale (0=rarely or never read, 1=seldom read, 2=frequently read and 3=regularly or always read) in which ‘read’ is taken to be a reasonably full examination of the article (a good test of this is that you could summarise the main impact of the article to others). Could you send your responses to me at the address below by the end of January 2004, and I will report the results – and the hypothesis – shortly afterwards.

Meanwhile, I hope our readers are aware of a third journal published by the Royal College of Psychiatrists – Advances in Psychiatric Treatment (APT). Although not an organ for original research, APT publishes expert, in-depth reviews of topics of current clinical interest (http://apt.rcpsych.org/).


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Mental health of refugees
Using quantitative measures Turner et al (2003) found that about half of a sample of 842 Kosovan refugees in the UK had post-traumatic stress disorder, with substantial comorbid depressive disorder and anxiety disorder. But there is more to be reported. I was involved in having a few open-ended questions tackled on to the study, tapping subjects’ own views of their health/mental health and what they saw as their most urgent priorities for recovery. Only a tiny number saw themselves as having a mental health problem of any kind, bearing out observations by refugee workers in the reception centres housing them that there was no interest in counselling. Almost everyone nominated work, schooling and family reunion as their major concerns. This chimes with what I and others have found in clinical settings with refugees over many years. Significant psycho-pathology is uncommon (Summerfield, 2002).

The responses to the open-ended questions paint a picture that is a world away from that reported by Turner and colleagues; how is this contradiction to be explained? First, the question of validity. Translation/back-translation of psychiatric inventories originating in the USA and Western Europe does not by itself overcome the category fallacy to which Kleinman (1987) pointed: particular phenomena may be identified in different settings but it does not follow that they mean the same thing in each setting. Moreover, refugees in distressed and insecure circumstances may be particularly susceptible to the demand characteristics of questionnaires. Second, and fundamentally, how human beings experience an adverse event, and what they say and do about it, is primarily a function of the social meanings and understandings attached to it. No psychiatric category captures this active appraisal and meaning-making.

Quantitative methodologies serving psychiatric categorisations risk a distorting pathologisation of refugee distress, with what is social and collective being reassigned as individual and biological (Summerfield, 1999). Turner et al caution against ‘the tendency of some to reject the diagnostic paradigm in refugee populations’, but they do not make a persuasive case here that they know better than the Kosovan refugees themselves, and that many of the refugees really do need psychiatric treatment. There is simply no good evidence to back their conclusion that refugee populations anywhere are carrying a major burden of clinically significant mental ill health. As the answers to my questions demonstrated, refugees see recovery as primarily something that must
happen in their social worlds, not in the space between their ears.


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Author’s reply: Newly arrived refugees will often see their problems initially in terms of past experience (e.g. war-violence or torture) rather than emotional impact. They share a need for security and safety. However, it would be illogical to conclude that they are thereby free of psychopathology. It is not a case of either one state or the other. Factors operating in different domains frequently interact. This is the situation here.

Interestingly, as many as 11.1% of 522 subjects responded that they had a mental health problem and that they now wanted help (i.e. ‘Western’ treatment). We would expect help-seeking to increase in those with persisting symptoms, in line with experience in treatment services after any major incident.

To assert that significant psychopathology is ‘uncommon’ is wrong. It implies that civil war, rape and torture do not have important psychopathological consequences in significant numbers of people. This flies in the face of the evidence. It is reminiscent of the problems that Eitinger and others had when trying to justify reparation for some concentration camp survivors on the basis of psychological injury. Surely we have moved on since then.

In this instance, we do not assert psychopathology on the basis of self-report measures. This would have been an overestimate as we demonstrated in our report. An Albanian-speaking doctor undertook semi-structured clinical interviews (in Albanian).

Summerfield refers to additional data in our survey. We wish to present a factual analysis of these. We asked an open question about respondents’ main concerns. The responses to this question are in the respondents’ own words but, if anxiety, tension, nervousness, stress or trembling are grouped together as likely anxiety symptoms, these were in fact the most frequent of the first priority problems and overall were reported by 21% (of 509 respondents). Sleep disturbance was reported by 16%, depression, hopelessness, sadness, mental problems and (poor) concentration by 8%. Many reported additional somatic complaints or general health problems, probably including a significant additional burden of psychological difficulty. Surprisingly, worries about family and friends were reported by only 17%. Concerns about work/economy (6%) and school/language (3%) were infrequent.

Rather than contradict the responses to the more structured questions, answers to these open questions reinforce our more quantitative findings.

Declaration of interest

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Effect of clozapine on mortality

Duggan et al (2003) elegantly model the effect of clozapine on suicide, and highlight that 53 lives could be saved each year if all patients with treatment-resistant schizophrenia were offered clozapine treatment. The model does not, however, take into account the effect of clozapine on mortality from causes other than suicide. Clozapine is associated with weight gain, diabetes mellitus, and increased mortality from pulmonary embolism and other adverse events in addition to the risk of agranulocytosis (Walker et al, 1997). Fontaine et al (2001) estimated mortality due to clozapine-associated weight gain using data from the Framingham Heart Study. They conclude that the reduction in the suicide rate would be almost entirely offset over 10 years by the increased mortality associated with weight gain of 10 kg. Walker et al (1997) report that mortality from causes other than suicide is increased with clozapine treatment, although overall mortality is lower. To completely model the effect of clozapine on mortality, the effects of the alternatives – active treatment and no treatment – on mortality, including suicide and adverse events related to treatment with other antipsychotics, should be included. These remarks do not detract from the main point that clozapine is still the most effective intervention for treatment-resistant schizophrenia, and mortality is only one outcome to be weighed in the overall risk–benefit analysis.

Declaration of interest

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Health care contact and suicide

We read with interest the study by Gairin et al (2003), which highlighted the suboptimal working relationship between the accident and emergency department as a first point of contact and psychiatric services. Thirty-nine per cent of suicide victims got in contact with the accident and emergency department at some point in the last year of their lives and, according to the National Confidential Inquiry into Suicides in England and Wales, only a quarter of suicides are preceded by mental health service contact in that same period.

Although I appreciate the above point, I still think that contact with primary services has an equal if not greater role to play.
in reducing suicide, especially in those age groups whose members are less likely to attend the accident and emergency department at times of crisis, such as children and the elderly.

Duckworth & McBride (1996) have reported that 80% of elderly suicide victims received no psychiatric referrals, and according to Harwood et al (2001), only 15% of elderly people who died by suicide were under psychiatric care at the time of death.

In our study, analysing coroners’ inquests of 200 cases of suicide in old age in Cheshire, 1989–2001 (Salib & El-Nimr, 2003), the role of primary care was emphasised. Interestingly, even those victims who were known to psychiatric services still preferred to contact their general practitioners (GPs) in the last few weeks before the fatal act.

One conclusion might be that people whose GPs acknowledged their mental health problems and cared to refer them to a specialist service were able to build a more meaningful therapeutic relationship with their doctors and readily contacted them as a final desperate act in the last period of their lives. A well-trained GP can act not only as an effective first point of contact but also a final one!


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**Assertive outreach in Tyneside**

Priebé et al (2003) have questioned whether the findings of the Pan-London Assertive Outreach Study can be generalised to assertive outreach services in the rest of the UK. Cornwell & Haveman (2003) evaluated the Newcastle and North Tyneside assertive outreach service using the same research instruments as those in the Pan-London study, so direct comparisons can be made.

After 17 months of operation, the Newcastle and North Tyneside team was similar in size to the London mean (n=36) with a score on the Dartmouth Assertive Community Treatment Scale (Teague et al, 1998) of 3.5 (medium fidelity to the model). The team has care programme approach (CPA) responsibility and small case-loads, operates out of office hours but without dedicated in-patient beds and, at the time of evaluation, no consultant psychiatrist. It thus corresponds to a Cluster B team in the Pan-London study (Wright et al, 2003).

Patient contact frequency and duration was higher than the London mean with an average face-to-face contact of 94 minutes per week. There was also a greater focus on patient engagement, with this being the primary focus in 33.1% of contacts. Engagement with the service in assertive outreach patients was compared with a random sample of community mental health team (CMHT) patients on enhanced CPA. There was no difference in the level of engagement, raising the possibility that the focus on engagement was having an impact in a previously hard-to-engage patient group.

Similar to the London study (Billings et al, 2003), team members were fairly satisfied with their jobs and most were not experiencing high levels of burnout. Compared with two local CMHTs, assertive outreach staff reported a higher level of personal accomplishment, replicating the Pan-London study finding. Another common finding was that the assertive outreach staff rated lack of support from senior staff in the service as a greater source of stress than did CMHT staff. Team members also identified dual diagnosis as an unmet training need.

Newcastle and North Tyneside patients were more likely than London patients to be White (86% vs. 45%) or living alone (68% vs. 52%). More surprisingly, they had significantly higher levels of alcohol misuse or dependency (31% vs. 16%) and drug misuse or dependency (40% vs. 20%). This reflects the fact that the Newcastle and North Tyneside service may be managing a more severely ill patient group, with 93% having experience of compulsory admission and 70% having had an in-patient admission lasting more than 6 months. Using the mean MARC severity score (Huxley et al., 2000), assertive outreach patients in Newcastle and North Tyneside had significantly more severe problems than the sample of local CMHT patients on enhanced CPA (7.4 vs. 3.4; t = 6.35, d.f. = 83, P < 0.001; mean difference = 4.0, 95% CI 2.7–5.3).

Wright et al (2003) have suggested that the London teams are assertive community treatment-like teams, but that the US assertive community treatment model may not easily translate to the UK context. The Newcastle and North Tyneside data contrast with both the London data and data from the UK700 study (Burns et al., 1999) in terms of the strong focus on patient engagement. Longitudinal studies are needed to determine whether this will actually enhance engagement and whether that improves outcome.


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**Treating maternal depression?**

Cooper et al (2003) reported a randomised trial with mothers with post-partum depression that compared routine primary care, non-directive counselling, cognitive-behavioural therapy (CBT) and psycho-dynamic therapy and found that psychological therapy improved maternal mood in the short term but the long-term effect was no better than spontaneous remission.
The trial was generally well done and the procedures followed the clinical guidelines. However, the results were not as good as expected. The authors note that the study was not designed to evaluate the efficacy of treatment, but rather to assess the feasibility of using a particular approach in the treatment of depression.

Several randomized placebo-controlled trials have shown that CBT reduces depression, and that the effects are maintained over time. The results of these trials suggest that CBT is an effective treatment for depression.

The authors acknowledge that there are limitations to the study, including the small sample size and the lack of a comparison group. They also note that the results may not be generalizable to other populations or settings.

The study was supported by a grant from the National Institute of Mental Health.
As a result of the distrust of psychological approaches, studies of CBT (e.g. Kuipers et al., 1997; Sensky et al., 2000) have invariably recruited patients whose symptoms are ‘resistant’ to medication. The fact that these studies have still shown significant improvement over either a control intervention or routine care is testament to the greater benefits that might be demonstrated if the patients enrolled in research were representative of those in clinical practice targeted for psychological intervention.

In any case, surely the question is not which is more effective, but how both pharmacological and psychological approaches could be combined for greatest effect.

Declaration of interest

The author has received grants from the Wolfson Foundation and the Association of Physicians of Great Britain and Northern Ireland for research into the durability of cognitive–behavioural therapy for the treatment of schizophrenia.


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Thank you for the debate on CBT and schizophrenia (Turkington/McKenna, 2003). I would like to make the following points.

First, CBT is not a single treatment – it contains many complex components and skills, and therapist variables must be an essential issue for careful evaluation as with all psychological therapies.

Second, befriending fares significantly better than ‘treatment as usual’ in much CBT research. McKenna dismisses this as placebo or ‘special treatment’. The fact of such significant improvement from befriending says something very serious about treatment as usual. Why should those suffering from psychosis not receive special treatment? The finding points to the need for more consideration of the (poorly termed) ‘non-specific factors in psychotherapy’ – factors clearly not treated as sufficiently important in basic care in psychosis (Paley & Shapiro, 2002).

Third, in the Sensky et al. (2000) trial quoted, CBT patients maintained their (significant) clinical improvement at follow-up, whereas the befriending controls fell back towards previous levels. It seems that CBT gives the patients a thinking structure to help manage some of their symptoms in the longer term.

Fourth, many people believe that you cannot treat persons with psychosis as if they were suffering from something such as diabetes, for which a single remedy like insulin might be sufficient. McKenna’s pronouncement on randomised controlled trials is, therefore, open to serious questioning. The need adapted approach is the antithesis of the randomised controlled trial method. In the former, the treatment is individualised and intentionally different (qualitatively and quantitatively) from one case to another and may well change over time. A randomised controlled trial, equally intentionally, eliminates individuality in the treatment. Because the idea of relationships can be especially disturbing to patients with psychosis, psychological therapies can be seen by patients as threatening; therefore, the therapy has to be very carefully “administered” – individually and flexibly.

Fifth, there are other outcome measurements at least as important as psychiatric symptoms. The experience of treatment is very important, as well as quality of life measurements. Turkington emphasises the high take-up rate of CBT, far higher than uptake of medication in psychosis.

Sixth, thank goodness for CBT, just one of several ways for practitioners to re-discover some tools that enable them to relate to patients with psychosis. McCabe et al. (2002) show how uncomfortable ordinary psychiatrists are without such tools when engaging with patients when the latter want to discuss symptoms.

Seventh, CBT and psychodynamic approaches overlap to a degree, at least as practised by Turkington (Martindale, 1998; Turkington & Siddle, 1998). Much has changed in psychodynamic therapy since the flawed studies of old. Modern psychodynamic approaches to psychosis have a much more flexible technique in engaging patients, and a greater and broader appreciation of mental mechanisms in psychosis.

Finally, relationship approaches in psychosis need encouragement, support and research. All psychiatrists need basic training in engaging with patients with psychosis. Research indicates that befriending might be a good place to start, but it is clearly not so easy – as the outcome of ‘treatment as usual’ indicates.

Declaration of interest

B.M. is Chair of ISPS (International Society for the Psychological Treatments of Schizophrenia) UK, a network the main objective of which is to promote psychological approaches to psychosis (treatment, education and research).


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Efficacy of antidepressant medication

The debate between Parker and Anderson & Haddad (2003) neatly summarised contemporary thinking on the question of antidepressant effect. It was a pity, though, that they provided no discussion of any historical perspective. The wonderfully clear account provided by David Healy (2002), for instance, shows how the marketing tail of psychopharmaceuticals now often wags the entire dog. The process by which this came about has been gathering momentum since the early 1960s. Healy explores its various causes and corollaries.
in detail. It is not, he argues, due to any uniquely pernicious qualities of drug companies since similar trends can be seen in relation to some other types of therapy.

If this additional, temporal dimension had been taken into account, one suspects that Gordon Parker might have placed greater emphasis on one of the factors that he identified as contributing to the current situation: namely that ‘‘depression’’ is currently modelled as a single entity, varying only in severity (p. 102). The term ‘depression’ is thus semantically equivalent nowadays to ‘abdominal pain’, not to ‘appendicitis’ or ‘peptic ulcer’. If trials of an antacid, say, were undertaken on patients selected for ‘abdominal pain’ the results obtained would sometimes be favourable, sometimes not. Debate over antacid usefulness would exactly parallel that over the effectiveness of antidepressants.

How did we get into this situation? It seems likely that a lot of the blame can be laid at the door of DSM–III (American Psychiatric Association, 1980), which explicitly aimed for reliability of diagnosis. Unhappily, there was an implicit downside. The state of the art in psychiatry, when DSM–III was under development, was such that reliability could be attained only at the expense of validity. Partly as a consequence of choices that were made then, this problem still remains. It is no good blaming the failings of clinical trials, the machinations of drug companies, the uselessness of antidepressants or reporting bias, for our predicament. The main fault lies in the consequences of a bad choice of diagnostic system, made by our predecessors for what seemed, at the time, good reasons. The remedy must lie primarily in seeing DSM for the hindrance that it is, and one day replacing it with a system that separates the ‘peptic ulcers’ from the ‘appendicitides’.


Parker, G./Andersen I. M. & Haddad, P. (2003) Unhappy. As the field moves more towards the implementation of evidence-based practice guidelines, the importance of removing bias remains central to providing optimal clinical care. If the extensive financial arrangements between industry and academia resulted in no bias to knowledge, I would probably agree with Dr Thase that no new policies are necessary to ‘safeguard our integrity’ (p. 390). However a recent systematic review and meta-analysis of evidence bearing on this question found ‘strong and consistent evidence . . . that industry-sponsored research tends to draw pro-industry conclusions’ (Bekelman et al., 2003: p. 463). The question now becomes, ‘What safeguards should be implemented to remove this bias from the knowledge that guides clinical practice (cf. Bodenheimer, 2000)?’ Commitment to our patients’ well-being requires that we act from this integrity.


Decloration of interest
E.W. is an author of the GPP for pharmaceutical companies guidelines. He also makes a living as a freelance medical writer, which sometimes involves ghostwriting.


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One hundred years ago

Psychological medicine

Friday, August 1st. Dr. F. W. Mott (London) opened a discussion on Syphilis as a Cause of Insanity... A number of statistical data were cited by Dr. Mott from different observers and it was shown that the most recent observations concurred in assigning the first place among the etiological factors to syphilis. Juvenile general paralysis was almost invariably found to be a result of congenital syphilis and in 20 per cent. of the cases observed it was found that the fathers of the patients had had general paralysis. Dr. Mott concluded by adopting, for the purposes of raising a discussion, the thesis, “No syphilis, no general paralysis”.

REFERENCE

Lancet, 23 August 1902, 525.
Researched by Henry Rollin, Emeritus Consultant Psychiatrist, Horton Hospital, Epsom, Surrey
Treating maternal depression?
P. J. McGrath, F. J. Elgar, C. Johnston, D. J. A. Dozois and S. Reyno
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References
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