Correspondence

EDITED BY KIRIAKOS XENITIDIS and COLIN CAMPBELL

Drug treatment for psychotic depression

I read the review article by Wijkstra *et al* (2006) with much interest as I found the results in the abstract quite striking. However, I wish to raise a few points about the methodology and description of results.

First, the authors have concluded from two studies by Bruijn *et al* (1996) and van den Broek *et al* (2004) that tricyclic antidepressants (TCAs) are more efficacious than non-TCAs in treating unipolar psychotic depression. They have also quoted these studies to state that antidepressant monotherapy is efficacious in treating this disorder. However, both these studies used haloperidol 1–15 mg/day as additional medication during the trial and this would affect the validity of these statements.

Second, the meta-analysis comparing TCAs with TCAs plus classical antipsychotics does not produce a statistically significant result because of the limited number (two randomised controlled trials) and few patients that have taken part in these trials. The overall effect calculated as the relative risk is 1.44 favouring the combination of tricyclics and classical antipsychotics with a confidence interval of 0.86–2.41. The wide confidence interval has affected the statistical significance of these results. However, I think that it is incorrect and possibly misleading for the authors to conclude that they found 'no evidence that the combination of an antidepressant with an antipsychotic is more effective than an antidepressant alone' as the result of the meta-analysis favours the combination and the reason for not obtaining a statistically significant result is the poor quality of constituent studies.

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van den Broek, W. W., Birkenhäger, T. K., Mulder, P. G., *et al* (2004) A double-blind randomized study comparing imipramine with fluvoxamine in depressed in-patients. *Psychopharmacology*, **175**, 481–486.

Wijkstra, J., Lijmer, J., Balk, F. J., *et al* (2006) Pharmacological treatment for unipolar psychotic depression: systematic review and meta-analysis. *British Journal of Psychiatry*, **188**, 410–415.

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Authors' reply: It is correct that some patients with psychotic depression in the studies by Bruijn *et al* (1996) and van den Broek *et al* (2004) were given haloperidol as adjunctive treatment. However, as mentioned in our article, in our intention-to-treat analysis we counted these patients as having dropped out. So, additional treatment with haloperidol did not affect the validity of our findings regarding patients receiving antidepressant monotherapy.

We agree, as mentioned in our article, that the quality of the constituent studies and the small sample sizes does influence the outcome of our meta-analysis regarding the comparison of antidepressant monotherapy *v.* the combination of an antidepressant and an antipsychotic. But to say that these data favour the combination is statistically not true and surely is no sound basis for contemporary clinical practice to use the combination. Moreover, the data indicate that there is no evidence for the clinical belief that an antidepressant alone is ineffective. Thus, we maintain our conclusion that both antidepressant monotherapy and the combination of an antidepressant and an antipsychotic are appropriate options for patients with psychotic depression.

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Refugee doctors and the development of psychiatry

Cohn *et al* (2006) were perfectly correct to point out the potential of refugee psychiatrists in reducing the recruitment crisis in psychiatry. However, on the basis of the contribution to psychiatry of previous generations of refugees, they also have the potential to contribute significantly to the development of the discipline.

In considering the careers of our refugee colleagues today, we need also to look back to the influx of refugees during the Nazi era, many of whom were hugely influential in the development of psychiatry in Britain from the 1930s onwards. As refugees, they had hurdles to overcome similar to those faced by today's refugees; a new language, the loss of their homelands and, for many, the traumatic deaths of their families. Some are known to have escaped the Nazis at the very last minute, such as Max Glatt (a pioneer in the treatment of alcoholism), Erwin Stengel (remembered for his later work on suicide and attempted suicide and as a professor of psychiatry in Sheffield) and Sigmund Freud. Even in the 1930s, well-qualified doctors from abroad were required to obtain a British medical qualification in order to continue in medical practice.

During the Second World War, some refugees had the further indignity of internment in the Isle of Man as 'enemy aliens'. They included Erwin Stengel, Felix Post (pioneer in old age psychiatry) and the psychiatrist and psychotherapist Adam Limentani. Some, such as Frederick Kräupl Taylor and Felix Post, went into psychiatry aware that their foreign backgrounds would not permit them entry to more popular medical specialties.

Among the refugees was Willi Mayer-Gross, previously a professor of psychiatry in Heidelberg, who also had a distinguished career in Britain; his *Clinical Psychiatry* with Eliot Slater and Martin Roth became a standard textbook. Alfred Meyer became a professor of neuropathology, Joshua Bierer founded the first day hospital in Britain and Michael Balint became widely known for his work on psychological aspects of general practice.

There were women psychiatrists too, such as Liselotte Frankl, Stefanie Felsenberg and Ida Macalpine (psychiatrist and medical historian), as well as others who came to this country as children and

after a lifetime of psychiatric practice continue to contribute in retirement to British psychiatry.

This list is by no means exhaustive, but in essence, the best summary is probably that in Ida Macalpine's obituary (C.J.E., 1974): 'she was one of that number of medical men and women who sought and found refuge in Britain from Nazi persecution... and lived to enrich by her achievements the country of her adoption'.

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Recovery-oriented mental healthcare

I commend Drs Lester & Gask (Lester & Gask, 2006) on their excellent and challenging editorial highlighting some of the issues involved in the development of high-quality recovery-oriented mental healthcare. Having begun my medical training in New Zealand, where recovery is heavily embedded into every facet of mental health services (Mental Health Commission, 1998), I have watched with interest the emerging prominence of recovery as a model for services in the UK. I would like to suggest two further avenues that are central to this continued evolution.

The first is to integrate recovery into the training of all psychiatrists. As the editorial rightly states, 'promoting recovery' is seen as an essential capability for all mental health professionals (Department of Health, 2004). We have an opportunity, while implementing the greatest change to modern medical training in the UK to date, to ensure that knowledge and skills in recovery-based practice are core competencies of psychiatric trainees. The current provisional curriculum pays little more than lip service to this crucial component, stating that trainees should be able to 'describe the principles of rehabilitation and recovery' in the context of treating chronic illness (Royal College of Psychiatrists, 2006). If we are to produce psychiatrists with the ability to 'promote recovery', the principles need to be a component of all areas of clinical training as is the case within the development of nurse training in the Chief Nursing Officer's recent and appropriately titled report, *From Values to Action* (Department of Health, 2006).

Second, we need to find methods and tools to meaningfully measure the recovery orientation of our services. There are currently no fully developed tools to achieve this, but the most promising recovery-sensitive measures require collaborative work with service users in their implementation, thus ensuring that the recovery principles measured become a core component of service evaluations, development and research.

As the Royal College of Psychiatrists moves towards 2007, when its annual meeting will embrace recovery as its core theme, I join the authors of this editorial in their call for recovery to play an increasingly central role in all areas of psychiatry.

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One hundred years ago

Hospital and dispensary management. Glasgow District Asylum, Gartloch

FROM the annual report for the year ending May 15th, 1905, of Dr. W. A. Parker, Medical Superintendent of this asylum, we see that there were 683 patients on the asylum register on May 15th, 1905, and that on May 15th, 1906, there were 684. The total number of cases under care during the year was 971, and the average number resident 702.1. During the year 288 cases were admitted as compared with 297 for the previous twelve months. The majority of these were unfavourable cases, because now all the cases likely to recover speedily, transient alcoholic and *delirium tremens* cases, are treated at the mental block of the Duke Street Hospital. Of the total admissions 95 were the subjects of first attacks within three and 24 more within twelve months of admission, in 57 the attacks were not first attacks within twelve months of admission, in 87 the attacks were of more than twelve months' duration on admission, and 25 cases were of congenital origin. Thus 169, or 58.3 per cent., had either been ill over a year on admission, were congenital imbeciles, or had suffered previous attacks, and even of the remaining 41 per cent., Dr. Parker says many were hopelessly senile cases, or general paralytics, or otherwise incurable. They were classified as to the forms of mental disorder into: Mania 49; melancholia 56; confusional, delusional, or adolescent insanity 78; dementia 36; general paralysis 26; epileptic insanity 16; congenital defect 25; and syphilitic and moral insanity each 1.

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