might be harmful or exploitative. The UK Council for the Psychotherapies requires all accredited member organisations to show how their training makes therapists aware of their own personal contributions to the process of therapy – this includes cognitive–behavioural therapists.

In a brief letter it is not possible to deal with all of the assertions about cost and efficacy. Briefly, we would suggest a different approach for purchasers of health care. We agree that there is good evidence that cognitive–behavioural therapy is effective and should be an integral part of any comprehensive service. It is striking, however, that direct comparisons between alternative modes of therapy usually reveal trivial treatment differences (the so called "equivalence paradox"; Stiles *et al*, 1986), even when studies are optimised to reveal such differences (e.g. Shapiro & Firth, *Journal*, December 1987, **151,** 790–799). In such a situation it is illogical to reduce patient choice. We would suggest that more sophisticated research is needed to examine the mechanisms underlying therapeutic change and the allocation of patients to specific types of therapy.

The arguments about cost are complex (McGrath & Lowson, *Journal*, January 1986, **150,** 65–71), but the work of Howard *et al* (1986) cited in the review does not support the conclusion reached by Dr Andrews. Howard and colleagues have pointed out that the gradient of the cost-benefit curve differs according to whether the target for improvement is distress, symptoms, or longer-term interpersonal dysfunction. Treatments of 50 sessions or more are then rational if the purchasers of health care are intending to provide more than just short-term, symptom-oriented treatment.

Dr Andrews' review deals specifically with the Australian health care system and it is important to note that in the UK the proportion of patients receiving long-term psychotherapy (more than 50 sessions) is small, even in specialist psychotherapy departments.

We would agree with Dr Andrews that it is necessary to be discriminating in the selection of patients and in attempting to minimise harmful effects, but his polemical view that dynamic therapies have no role in public sector services goes considerably beyond the evidence available and should not go unchallenged.

EYSENCK, H. J. (1952) The effect of psychotherapy: an evaluation. *Journal of Consulting Psychology*, **16,** 319–324.

HOWARD, K. I., KOPTA, S. M., KRAUSE, M. S., *et al* (1986) The dose-effect relationship in psychotherapy. *American Psychologist*, **41,** 159–164.

MEARES, R. & HOBSON, R. F. (1977) The persecutory therapist. *British Journal of Medical Psychology*, **50,** 349–359.

STILES, W. B., SHAPIRO, D. A. & ELLIOTT, R. (1986) Are all psychotherapies equivalent? *American Psychologist*, **41,** 165–180.

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Integration of psychodynamics in Scandinavian psychiatry

SIR: The recent death of Erik Strömgren in Aarhus, Denmark, marks the passing of a remarkable man who was largely responsible for the international reputation long enjoyed by the Risskov Hospital. His breadth of vision was similar to that of Aubrey Lewis, who built up the Maudsley Hospital. When Denis Hill was appointed successor to Lewis, he was particularly concerned to teach that the psychiatrist should be literate in both psychodynamic and biological discourse (Hill, *Journal*, August 1978, **133,** 97–105). These leaders insisted that all aspects of psychiatry should be adequately represented under one roof of a great teaching centre, an attitude which encouraged the pursuit of an integrated psychiatry in which neuroscience and psychodynamics are fully integrated.

Strömgren's legacy can be seen today in the Risskov Hospital, where Mogens Schou, the doyen of lithium researchers, is still working, although retired, in the same hospital in which epidemiological research is active, and psychoanalytic ideas and psychotherapy are flourishing. The large and active psychotherapy department provides training for nurses in the elements of psychodynamics and the integration of the psychotherapeutic perspective into the treatment plans for psychotic patients. Many senior consultants are themselves practising individual psychotherapy with selected psychotic patients and supervising trainees, with encouraging results.

In many Scandinavian countries such an integrated approach has been the rule for decades. A group of practitioners, eminent in their field, have recently formed the Nordic Association for the Psychotherapy of Psychosis, for the purpose of exchanging experiences and research across the borders of the Scandinavian countries. They have just published a book of essays by founder members. This small book, *Crossing the Borders* (Hansen, 1993), contains several papers that should be of great interest to British psychiatrists. Perhaps the most compelling is the description of the Finnish 'need-adapted' approach to the treatment of schizophrenic psychoses.

This timely publication may help to remind psychiatrists of the limitations of any approach to the understanding and treatment of psychotic disorders that ignores the inner life and psychodynamics of the individual. It may also remind psychoanalysts and psychoanalytic psychotherapists working in the health service of the urgency of the need to find ways to increase their input to the treatment of psychotic patients, and to improve cooperation with those of their colleagues who adopt a more exclusively biological approach to the task at the expense of psychodynamics.

HANSEN, J. B. (ed.) (1993) *Crossing the Borders: Psychotherapy of Schizophrenia*. Ludvika, Sweden: Dualis Forlag.

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Long-term antidepressant treatment in the elderly

SIR: The Old Age Depression Interest Group (OADIG) (*Journal*, February 1993, **162,** 175–182) reported the results of their important study of continuation and maintenance of antidepressant treatment in depressed elderly subjects. Compared to placebo, dothiepin reduced the risk of a recurrence of depression by two-and-a-half times during the two-year study. The authors concluded that "elderly patients who recover from a major depressive illness should continue with antidepressant medication for at least two years". While most clinicians would agree with this recommendation for patients with recurrent depression, it is more controversial for the elderly patient with a first episode of depression. Indeed, the recently published NIH Consensus Development conference statement on the diagnosis and treatment of depression in late life recommends only six months of treatment after remission from a first episode of major depression in old age (NIH Consensus Development Panel, 1992).

Sixty per cent of patients in the OADIG study were experiencing their first depressive episode. The authors found that age at first onset of affective disorder did not predict outcome. However, they did not specifically report on the rate of recurrence in the group of patients suffering their first depression. This piece of information would be of particular interest and value. There is evidence from other studies that elderly persons with a first episode of depression are at the same risk of recurrence, within two years of the index episode, as those with recurrent depression (Flint, 1992). A similar finding from the OADIG study would further support the contention that *all* patients over the age of 60 years with major depression should continue with treatment for a minimum of two years following recovery.

FLINT, A. J. (1992) The optimum duration of antidepressant treatment in the elderly. *International Journal of Geriatric Psychiatry*, **7**, 617–619.

NIH CONSENSUS DEVELOPMENT PANEL (1992) Diagnosis and treatment of depression in late life. *Journal of the American Medical Association*, **268**, 1018–1024.

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Child psychiatric syndromes with a somatic presentation

SIR: Garralda's useful review (*Journal*, December 1992, **161,** 759–773) missed one important series of papers in the literature on conversion disorder. Seltzer's papers in *Family Systems Medicine* (Seltzer, 1985*a*,*b*) give detailed accounts of the family and cultural background of such patients with a conversion disorder, and offers some helpful therapeutic advice. Nowhere else have I seen a discussion of the personality and environment of childrens' hysteria in such depth, and I recommend these papers to your readers.

SELTZER, W. J. (1985*a*) Conversion disorder in childhood and adolescence: a familial/cultural approach, part I. *Family Systems Medicine*, **3**, 261–280.

— (1985*b*) Conversion disorder in childhood and adolescence, part II. Therapeutic issues. *Family Systems Medicine*, **3**, 397–416.

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Distribution of adipose tissue in patients receiving psychotropic drugs

SIR: Stedman & Welham (*Journal*, February 1993, **162,** 249–250) investigated the problem of obesity in long-term female in-patients on psychotropic medication. They found similar levels of obesity to those reported in other studies. Within this context they demonstrated a previously unrecognised problem with central obesity, and they argue for the importance of this finding.