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.

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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.

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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.

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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