Correspondence

Psychiatric medications are no more effective

Martin & Elworthy report that the biggest reason for prescribing electroconvulsive therapy (ECT) less frequently than before is the perception among psychiatrists that 'more effective medication' now exists.[1] Unfortunately, the authors collude with this exaggerated view, claiming that 'psychiatric medications have undoubtedly become more effective over recent years'. Their bold statement references a 2002 story in *The New York Times*.

Meta-analysis shows that the current first-line treatments for depressive disorder, selective serotonin reuptake inhibitors, are marginally less effective than older tricyclic antidepressants (TCAs), while serotonin–noradrenaline reuptake inhibitors show no statistically significant advantage over TCAs.[2] One newer drug, reboxetine, does not work at all,[3] yet is inexplicably still licensed as an antidepressant.

Lithium remains the only true mood stabiliser: it is the only drug with efficacy in treating acute manic and depressive symptoms and in prophylaxis of manic and depressive symptoms in bipolar disorder.[4]

One has to conclude that the prevailing delusion that treatments across psychiatry have become more effective has been mediated by the pharmaceutical industry. Psychiatrists should take their evidence from meta-analyses in peer-reviewed journals, not from advertising representatives and certainly not from the newsstand.

1 Martin F, Elworthy T. Scottish psychiatrists' attitudes to electroconvulsive therapy: survey analysis. *Psychiatrist* 2013; **37**: 261–6.

2 Machado M, Iskedjian M, Ruiza I, Einarson TR. Remission, dropouts, and adverse drug reaction rates in major depressive disorder: a meta-analysis of head-to-head trials. *Curr Med Res Opin* 2006; **22**: 1825–37.

3 Eyding D, Lelgemann M, Grouven U, Hrter M, Kromp M, Kaiser T, et al. Reboxetine for acute treatment of major depression: systematic review and meta-analysis of published and unpublished placebo and selective serotonin reuptake inhibitor controlled trials. *BMJ* 2010; **341**: c4737.

4 Bauer MS, Mitchner L. What is a 'mood stabilizer'? An evidence-based response. *Am J Psychiatry* 2004; **161**: 3–18.

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Author response: Dr Braithwaite is correct in challenging the view that antidepressants have become more effective. Our study did show that this is a dominant view within the profession that may contribute to reduced ECT prescribing rates, and articles such as those referenced may help to perpetuate this view. We concede that our use of the general media to support this assertion reflects clumsy referencing on our part. There are, however, peer-reviewed studies that support the view of increased effectiveness of some newer antidepressants over some older antidepressants.[1] This may in part be related to efficacy but also better tolerability, and pharmaceutical company influence could also be a factor. However, the perceived belief that new equates to better can easily be challenged and Dr Braithwaite's example of reboxetine is a good one.

1 Cipriani A, La Ferla T, Furukawa TA, Signoretti A, Nakagawa A, Churchill R, et al. Sertraline versus other antidepressive agents for depression. *Cochrane Database Syst Rev* 2009; **2**: CD006117

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Psychiatry needs more psychotherapy

I could not disagree more strongly with Michael Fitzgerald's letter[1] asserting that all future psychiatrists should be neuropsychiatrists. Having worked as a medical psychotherapist for over 20 years, my job changed and I had a choice between resigning and becoming a community psychiatrist. I found instead that what many of my colleagues and particularly the junior doctors seemingly had difficulty with was precisely that lack of certainty, the need to listen with minute attention to what the patient was saying, which of course is the bedrock of psychotherapy. We need more, not less, psychotherapy to be embedded into psychiatry. We desperately need medical psychotherapists to act as role models for trainees or else we will lose the essence of our art – and yes, I use the word advisedly – and we will become glorified technicians. Is this really what we want?

1 Fitzgerald M. All future psychiatrists should be neuropsychiatrists. *Psychiatrist* 2013; **37**: 309.

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Psychiatrists as neurologists . . . or biologists?

Michael Fitzgerald thinks that 'All future psychiatrists should be neuropsychiatrists'[1] – and, what's more, should only concern themselves with diagnosis and prescribing, leaving psychological treatments to non-psychiatrists. I disagree. Don't get me wrong, I enjoy 'hunt the lesion' as much as anyone I know. And I have valued my medical school-level neurology on the few occasions when it has come in really handy. But to hive off all psychological interventions to other professions is where I take issue. Let us look at the two 'core' tasks Fitzgerald suggests and try to take the psychology out of them.

In spite of the golden dawn promised over the course of my career, there are still no physical investigations that usefully inform the most common issues of psychiatric diagnosis. The main instrument of investigation continues to be conversation. William Osler stated one of the fundamental principles in this area – 'Listen to your patient, he is telling you the diagnosis'. This sounds simple, but it clearly is not. The patient will only tell the doctor the necessary information if the patient feels that they are being taken seriously and listened to.[2] Some of us