Correspondence

EDITED BY STANLEY ZAMMIT

Evidence needed for treatment strategies in refractory depression

Matthews & Elijamel (2003) lucidly describe the origin, mechanism and role of vagus nerve stimulation (VNS) in the treatment of refractory depression.

Lack of evidence for strategies to treat refractory depression and lack of perceived options necessitate a fresh look into research on the efficacy of existing treatments and development of new ones. Vagus nerve stimulation may prove to be an effective option and a major advancement, but it is too early even to speculate on recommending it for general use.

The authors state, "If any treatment for chronic, refractory depressive disorder were to offer the prospect of sustained, clinically significant changes in 20–30% of patients, this would represent a major therapeutic advancement". However, our systematic review of treatment of refractory depression (Stimpson *et al*, 2002) showed an overall placebo response rate of 15% with 95% CI of 7.9–23.4%. This rate is even higher in relatively less chronic depression, reaching up to 30–40% in some trials. Hence, the response rate of 31% in open trials for VNS may largely be due to placebo response and may not result in a satisfactory 'number needed to treat' in randomised trials.

The need for further research in this area cannot be overemphasised. Authors have highlighted the difficulty of finding an appropriate control condition. Even if we can satisfy the need for an appropriate placebo control, these trials should not be considered sufficient. For evidence to be robust, any new treatment for refractory depression should at least be compared with the existing active treatments, such as augmentation strategies, in addition to placebo control. Non-inferiority trials without active treatment comparison are not only unethical, they do not help clarify the question of what is the next best strategy in a particular patient with refractory depression. The second half of the past century saw a number of commonly used treatment strategies based only on preliminary evidence. Let us not perpetuate the same mistake in the 21st century.

Matthews, K. & Eljamel, M. S. (2003) Vagus nerve stimulation and refractory depression. Please can you switch me on doctor? *British Journal of Psychiatry*, **183**, 181–183.

Stimpson, N., Agrawal, N. & Lewis, G. (2002) Randomised controlled trials investigating pharmacological and psychological interventions for treatment refractory depression. Systematic review. *British Journal of Psychiatry*, **181**, 284–294.

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Drug misuse in pregnancy

I read with interest the recent editorial by Johnson *et al* (2003) and I agree with the authors that substance misuse, including in women of reproductive age, has increased markedly over the past 20 years. In my practice of obstetrics and obstetric anaesthesia, I have provided care to many drug-misusing parturients and would like to add some comments on this timely topic.

Five million Americans are regular users of cocaine, 6000 use the drug for the first time each day and more than 30 million have tried cocaine at least once. Approximately 250 000 women in the USA meet the criteria for intravenous drug abuse. Nearly 90% of these women are of childbearing age (Kuczkowski, 2003). Psychological personality characteristics seem to predispose to, rather than result from, drug addiction. Most often, drug misuse is first suspected or diagnosed during medical management of another condition such as hepatitis, HIV/AIDS or pregnancy. Most parturients with a history of drug misuse deny it when interviewed preoperatively by primary care physicians, obstetricians or obstetric anaesthesiologists. A high index of suspicion for drug misuse in pregnancy, combined with non-judgmental questioning of every parturient, is therefore necessary (Kuczkowski, 2003). Risk factors suggesting substance misuse in pregnancy include lack of prenatal care, history of premature labour and cigarette smoking. Substances most commonly misused in pregnancy include cocaine, amphetamines, opioids, ethanol, tobacco, marijuana, caffeine and toluene-based solvents. Polysubstance misuse is very common. The diverse clinical manifestations of substance misuse, combined with the physiological changes of pregnancy and the pathophysiology of coexisting pregnancy-related disease, might lead to life-threatening complications and significantly affect the pregnancy outcome.

Johnson, K., Gerada, C. & Greenough, A. (2003) Substance misuse during pregnancy. *British Journal of Psychiatry*, **183**, 187–189.

Kuczkowski, K. M. (2003) Anesthetic implications of drug abuse in pregnancy. *Journal of Clinical Anesthesia*, **15**, 382–394.

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The article by Johnson *et al* (2003) was disappointing as they failed to present a balanced view of this topic. It is, of course, important to discuss possible effects of drug misuse on pregnancy, but to emphasise them without due and thorough consideration of the many confounding factors in this area is misleading. These include smoking, alcohol use, social deprivation, poor nutrition, quality of antenatal care and drug treatment, as well as accessibility of services. Clearly, these are additional factors that drug-misusing women will have to contend with. Well-designed, unconfounded studies in this area are rare, which means that findings on the specific effects of illicit drugs are inconsistent and contradictory (Ford & Hepburn, 1997).

The article failed to reflect that much of the recent work in this area has looked at flexibility of treatment services and equity of access. Women drug users are deterred from engaging with health and social care providers because of judgmental attitudes (Klee *et al*, 2002). We felt that the article

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had an unsympathetic tone, and had missed the point that the onus is on treatment services to make themselves accessible to women who may have chaotic lives. Our approach to care is crucial if we are to retain these women in treatment throughout pregnancy, and this support needs to flow seamlessly into the postnatal period.

There is a relationship between maternal methadone dose and severity of neonatal abstinence syndrome, but this is not a close one (Johnstone, 1998). The onset, duration and severity of neonatal abstinence syndrome is multi-factorial and related to the infant's metabolism, gestational age and central nervous system maturity. It is essential to work with parents to prepare them for the possibility of neonatal abstinence syndrome and to try to involve them in the management of this condition.

Johnson *et al* (2003) have provided us with a comprehensive list of possible unfavourable outcomes, but a more measured picture of the many difficulties that face both clients and health care professionals in this area would have better informed the *Journal*'s readership.

Ford, C. & Hepburn, M. (1997) Caring for the pregnant drug user. In *Care of Drug Users in General Practice: A Harm-Minimisation Approach* (ed. B. Beaumont), pp. 107–122. Oxford: Radcliffe Medical.

Johnson, K., Gerada, C. & Greenough, A. (2003) Substance misuse during pregnancy. *British Journal of Psychiatry*, **183**, 187–189.

Johnstone, F. (1998) Pregnant drug users. In *Management of Drug Users in the Community: A Practical Handbook* (ed. J. R. Robertson), pp. 299–327. London: Arnold.

Klee, H., Jackson, S. & Lewis, S. (2002) *Drug Misuse and Motherhood*. London: Routledge.

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Author's reply: We thank Drs Whittaker and McIntosh for their interest in our article, but they have misinterpreted its contents. As stated, the aim of our editorial was to emphasise the importance of the topic by describing the unfavourable effects illicit substances can have on both pregnancy and infant outcome; we are therefore pleased that Whittaker and McIntosh state we have provided a comprehensive list of unfavourable outcomes. We agree that treatment services should be accessible to women, as it is important to retain them throughout pregnancy and provide support through into the postnatal period. Indeed, in the final paragraph of our editorial we described such a package of care. We are surprised that Whittaker & McIntosh feel that our article had an unsympathetic tone; careful reading of our editorial demonstrates that it emphasises the importance of optimising treatment and reducing morbidity and argues for adequate resources to be made available.

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Personality in psychiatry: what thin partitions?

In his editorial on the interpersonal domain, Hobson (2003) asserts that the analysis of intersubjective engagement in the therapeutic dyad is essential to the understanding of subjective meanings and their role in the manifestation of psychiatric disorder. In the same issue of the *Journal*, Lanman *et al* (2003) describe their attempts to determine a measure of 'fit' between individuals in a 'couple system'.

Both these papers acknowledge a fundamental fact concerning all human relationships; that they are, in their totality, the interaction between one personality and another. What is striking, however, both in these papers and in other recent literature concerning, in particular, personality disorders (Tyrer *et al*, 2002), is the lack of any discussion concerning the specific role the therapist's/clinician's personality plays in shaping the therapeutic relationship.

Hobson's use of Donne's metaphor ('No man is an Island, entire of it self') captures what I believe to be the *sine qua non* of personality disorder; namely, that personality disorders can only be understood in the context of interactions between personalities; that the construct of personality disorder cannot exist in isolation. This notion is akin to the distinction made between 'primary' and 'secondary' qualities by the philosopher John Locke. In a psychiatric context one might consider schizophrenia to be a primary phenomenon, an integral part of the individual, whereas personality disorder, being contingent on an interaction with another, is secondary.

If one can accept the notion of personality disorder as a consequence of the interaction between two personalities, then surely it behoves members of the psychiatric profession to consider how their personalities influence the therapeutic relationships that lie at the heart of the discipline. That this appears, historically, not to have been the case is revealed by Lewis & Appleby's (1988) seminal paper. While amply demonstrating psychiatrists' negative attitude towards individuals with personality disorder, the authors failed to address the possibility that this might be a function, in part, of the psychiatrists' personalities.

If we are to be 'scientific' about studying interpersonal functioning, then perhaps the first step might be to consider a systematic evaluation of *both* personalities involved in the therapeutic dyad. One possible method might employ a dimensional assessment of personality that would, in turn, help define how different personalities 'fit' together. For example it might be reasonable to expect a clinician, scoring highly on the 'openness' dimension of the NEO–PI–R (Costa & McCrae, 1992) to fit well with a patient scoring much lower on the same scale.

If this were shown to be the case, it could have important ramifications for resource allocation, both in psychotherapy and in the wider psychiatric field, allowing individual personalities to be fitted together in order to better facilitate the therapeutic relationship. An appreciation of the role their own personalities play in the construct known as personality disorder, might also diminish psychiatrists' negative attitudes to the disorder they appear to dislike.

Costa, P. T. & McCrae, R. R. (1992) *Revised NEO Personality Inventory (NEO–PI–R) and NEO Five-Factor Inventory (NEO–FFI) Professional Manual*. Odessa, FL: Psychological Assessment Resources.

Hobson, R. P. (2003) Between ourselves: psychodynamics and the interpersonal domain. *British Journal of Psychiatry*, **182**, 193–195.

Lanman, M., Grier, F. & Evans, C. (2003) Objectivity in psychoanalytic assessment of couple relationships. *British Journal of Psychiatry*, **182**, 255–260.

Lewis, G. & Appleby, L. (1988) Personality disorder: the patients psychiatrists dislike. *British Journal of Psychiatry*, **153**, 44–49.

Tyrer, P., Duggan, C. & Coid, J. (2002) Ramifications of personality disorder in clinical practice. *British Journal of Psychiatry*, **182** (suppl. 44), s1–s2.

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