

Correspondence

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Collaborative therapy: framework for mental health

We agree with the sentiments expressed by Lester & Gath (2006) in their recent editorial on promoting a collaborative model of recovery, and believe that the collaborative therapy model which we have developed goes some way towards meeting the need for ‘a collaborative approach...to the development of high-quality recovery-oriented mental healthcare’.

One of the key aspects of collaborative therapy is recognising that ‘recovery’ and chronic models of healthcare are not dichotomous. Recovery is an individual process that can be assisted through the application of a model of care embracing the reality of mental illness and encompassing both the management of acute episodes and long-term health needs.

Collaborative therapy is a comprehensive therapeutic framework for consumers, clinicians, services and others to work systematically towards the achievement of optimal mental health outcomes. The aim is to deliver, within mainstream services, comprehensive psychosocial treatments that are evidence-based and individually tailored. The ability to individually tailor treatments thus allows for the incorporation of personal definitions of recovery.

The collaborative therapy framework has three components that can be applied across the spectrum of mental disorders. Engagement encompasses a comprehensive screen for issues that may be barriers to treatment (including psychiatric comorbidity), as well as a mapping of ‘collaborative partners’, who agree to be involved in the individual’s care. These may include the general practitioner, case manager, psychiatrist, vocational worker and family members. All collaborative partners are explicitly involved in the planning of healthcare for the individual.

The therapy itself can be conducted in a group or one to one with a case manager. It

is run over 8–12 weeks, followed by booster sessions over a further 9 months, is based on an adaptation of the stress vulnerability model (stress vulnerability–self efficacy) and utilises self-efficacy and self-reliance as part of the process. It provides core components of the therapeutic interventions that have established efficacy across a wide range of diagnosis, including psychoeducation, coping and relapse prevention strategies. An allied tool is the collaborative treatment journal, a small pocket journal that can chart stressors, early warning signs, coping strategies, supports and other factors that influence the course and management of an individual’s health. It is held by the consumer and places them at the centre of their treatment.

The unique appeal of the collaborative therapy framework is that it is sensitive to the structure, resources and staff-mix of particular services, and meets all consumers’ needs. This helps to ensure that there is maximum likelihood that the components developed within the collaborative therapy framework are taken up within routine service delivery structures. It has been adopted by a number of Australian mental health services, and is well accepted by consumers, their families, and health professionals.

Lester, H. & Gask, L. (2006) Delivering medical care for patients with serious mental illness or promoting a collaborative model of recovery? *British Journal of Psychiatry*, **188**, 401–402.

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Physical contact with child and adolescent patients

Although I recognise and share some of the concerns about the appropriateness of certain types of physical contact with patients, I was surprised by several aspects of the survey by Blower *et al* (2006) of the views of child and adolescent psychiatrists.

First, I was puzzled by the fact that 1% of respondents selected the ‘do nothing’ option in response to the clinical vignette of a distressed child running towards a busy road and that the implications of such a response were not commented on by the authors.

Second, although Blower *et al* referred to physical examination in their discussion, the participants do not seem to have been asked about their views on this in either the questionnaire or the telephone interviews. The authors then seemed to downplay the role of physical examination and treatment in child psychiatry, both of which are becoming increasingly important.

Physical examination is essential in the assessment and management of many psychiatric conditions, including attention-deficit hyperactivity disorder, eating disorders and severe depression. Specific syndromes associated with behavioural disorders, particularly those accompanied by learning disability, may be missed without appropriate examination (Devlin, 2003). In addition, physical examination is necessary before initiating drug treatments and in monitoring for adverse effects, particularly when using stimulant drugs or atypical antipsychotics.

Knowledge, understanding and practical experience of the use of physical treatments is required as part of specialist registrar training in child and adolescent psychiatry, alongside the use of other treatments, including the various psychotherapies (Royal College of Psychiatrists, 1999). If trainees or consultants lack confidence or skills in physical examination and treatment, or feel uneasy with the physical contact this requires, it would be appropriate for them to seek further training as part of continuing professional development.

Blower, A., Lander, R., Crawford, A., et al (2006) Views of child psychiatrists on physical contact with patients. *British Journal of Psychiatry*, **188**, 486–487.

Devlin, A. (2003) Paediatric neurological examination. *Advances in Psychiatric Treatment*, **9**, 125–134.

Royal College of Psychiatrists (1999) *Higher Specialist Training Committee, Child and Adolescent Psychiatry Specialist Advisory Committee, Advisory Papers*. London: Royal College of Psychiatrists. <http://www.rcpsych.ac.uk/pdf/advisorypapernov99.pdf>

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Acute and transient psychotic disorders and puerperal psychosis

Marneros (2006) addresses an important issue in his editorial on the concept of acute and transient psychosis, which is a challenge to the Kraepelinian dichotomy. He argues that acute and transient psychoses are separate from schizophrenia, schizoaffective disorder or affective disorder, based on the clinical manifestations, but he did not mention puerperal or post-partum psychosis, which also lacks a consensus of definition (Kohl, 2004). Post-partum psychosis has been described as functional psychosis with good prognosis and clinical presentation similar to acute and transient psychosis (Kendell *et al*, 1987). Despite a varying symptomatology, women with schizophrenia rarely experience arousal of their symptoms after childbirth (Meltzer & Kumar, 1985). Puerperal psychosis appears to occupy a clinical position which is different from schizophrenia and affective disorder.

It is of interest that acute and transient psychosis mainly affects females (Marneros, 2006), and suggests a link between puerperal psychosis and acute and transient psychosis. I therefore suggest that the concept of puerperal psychosis should be included in discussions of the concept of acute and transient psychosis.

Kendell, R. E., Chalmers, C. J. & Platz, C. (1987) Epidemiology of puerperal psychoses. *British Journal of Psychiatry*, **150**, 662–673.

Kohl, C. (2004) Postpartum psychosis: closer to schizophrenia or the affective spectrum? *Current Opinion in Psychiatry*, **17**, 87–90.

Marneros, A. (2006) Beyond the Kraepelinian dichotomy: acute and transient psychotic disorders and the necessity for clinical differentiation. *British Journal of Psychiatry*, **189**, 1–2.

Meltzer, E. S. & Kumar, P. (1985) Puerperal mental illness, clinical features and classification: a study of 142

mother-and-baby admissions. *British Journal of Psychiatry*, **147**, 647–654.

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Author's reply: Dr Lewin is right that puerperal psychoses are of special interest in the context of acute and transient psychoses. To our knowledge there is consensus that post-partum disorders are not distinct nosological entities (Brockington, 2004; Riecher-Rössler & Rohde, 2005) with neither 'post-partum depression' nor 'post-partum psychosis' having specific aetiology. 'Giving birth to a child with all its biological and psychosocial consequences seems to act as a major stressor, which – within a general vulnerability–stress–model – can trigger the outbreak of all classical disorders in predisposed women' (Riecher-Rössler & Rohde, 2005). Hence it is evident that the situation after delivery can be typical for triggering acute and transient psychosis.

Re-evaluation of our own sample of 61 women (Rohde & Marneros, 1993) with first onset of psychosis after delivery showed that according to ICD–10 criteria 18 (29.5%) should be classified as having acute and transient psychosis (Rohde & Marneros, 2000); all other diagnostic categories were also present (schizoaffective and affective disorders, schizophrenic and organic psychoses). In our sample the frequency of acute and transient psychoses was much higher than expected from the general prevalence. This might be a reason for the frequent observation that puerperal psychoses are mainly very acute, short episodes with a 'colourful' psychopathology and good prognosis.

Considering the few available studies we conclude that in the post-partum period acute and transient psychoses represent a disorder that is different from other psychiatric disorders but is part of a psychotic continuum.

Brockington, I. (2004) Postpartum psychiatric disorders. *Lancet*, **363**, 303–310.

Riecher-Rössler, A. & Rohde, A. (2005) Diagnostic classification of perinatal mood disorders. In *Perinatal Stress, Mood and Anxiety Disorders From Bench to Bedside*. Bibliotheka Psychiatrica, Vol. 1 (eds A. Riecher-Rössler & M. Steiner), pp. 6–27. Basel: Karger.

Rohde, A. & Marneros, A. (1993) Postpartum psychoses: onset and long-term course. *Psychopathology*, **26**, 203–209.

Rohde, A. & Marneros, A. (2000) Bipolar disorders during pregnancy. In *Bipolar Disorders 100 Years After Manic Depressive Insanity* (eds A. Marneros & J. Angst), pp. 127–137. Dordrecht: Kluwer Academic Publishers.

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Cognitive impairment in euthymic patients with bipolar disorder

By prospectively verifying euthymia and controlling for the effect of residual affective symptoms Goswami *et al* (2006) make a significant contribution to the existing evidence on cognitive impairments in euthymic patients with bipolar disorder. However, they did not define euthymia and the diagnosis of DSM–IV bipolar I disorder, verification of euthymia and exclusion of current and past psychiatric illness or substance use disorders in patients and controls were made without structured assessments. Controls were relatives of participating patients. In addition, exclusion criteria make no mention of birth injuries, the handedness of patients and whether patients had received electroconvulsive therapy. All these factors influence results of tests for cognitive function (Ferrier & Thompson, 2002).

As the Schedule for Assessment of Psychiatric Disability assesses marital and occupational functioning, details of the patients' marital or occupational status would have helped to better interpret the data. There is also no mention of the duration of illness (in Table 1, p. 368, duration spent in episodes is erroneously labelled as duration of illness). This variable has implications for the generalisability of findings.

A measure of the reliability and validity of the modified Kolakowska battery is not provided. The use of more systematic and better-validated instruments such as the Cambridge Neurological Inventory (Chen *et al*, 1995) and more than one rater to reduce assessment bias would have allowed better characterisation of neurological soft signs. About 92% of healthy controls in the current study had neurological soft signs. This unusually high prevalence could