

**Declaration of interest**

D.K. has published books and gives workshops on cognitive-behavioural therapy for schizophrenia.

**Drury, V., Birchwood, M., Cochrane, R., et al (1996)** Cognitive therapy and recovery from acute psychosis: a controlled trial. II. Impact on recovery time. *British Journal of Psychiatry*, **169**, 602–607.

**Durham, R. C., Guthrie, M., Morton, R. V., et al (2003)** Tayside–Fife clinical trial of cognitive-behavioural therapy for medication-resistant psychotic symptoms: results to 3-month follow-up. *British Journal of Psychiatry*, **182**, 303–311.

**Lewis, S., Terrier, N., Haddock, G., et al (2002)** Randomised controlled trial of cognitive-behavioural therapy in early schizophrenia: acute-phase outcomes. *British Journal of Psychiatry*, **181** (suppl. 43), s91–s97.

**Pilling, S., Bebbington, P., Kuipers, E., et al (2002)** Psychological treatments in schizophrenia: I. Meta-analysis of family intervention and cognitive behaviour therapy. *Psychological Medicine*, **32**, 763–782.

**Sensky, T., Turkington, D., Kingdon, D., et al (2000)** A randomized controlled trial of cognitive-behavioural therapy for persistent symptoms in schizophrenia resistant to medication. *Archives of General Psychiatry*, **57**, 165–172.

**Turkington, D./McKenna, P. J. (2003)** Is cognitive-behavioural therapy a worthwhile treatment for psychosis? (debate). *British Journal of Psychiatry*, **182**, 477–479.

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**Author's reply:** Actually, the study of Durham *et al* (2003) which was carried out under blind conditions failed to find a significant advantage for cognitive therapy over active placebo. The authors state that 'Repeated measures analyses of variance were first conducted with three levels of treatment (CBT *v.* SPT *v.* TAU) and three time points (baseline, post-treatment, follow-up). There were significant effects for time for all variables except the GAS but no significant time  $\times$  treatment interaction effects or contrasts for any of the measures'. This was for 'Changes in severity from baseline', with an essentially similar finding for 'Clinically significant improvement'.

**Durham, R. C., Guthrie, M., Morton, R. V., et al (2003)** Tayside–Fife clinical trial of cognitive-behavioural therapy for medication-resistant psychotic symptoms. Results to 3-month follow-up. *British Journal of Psychiatry*, **182**, 303–311.

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**Personality assessment**

In their description of the Standardised Assessment of Personality – Abbreviated Scale (SAPAS) Moran *et al* (2003) write that, to the best of their knowledge, only two other interviewer-administered screens for personality disorder have been published. I would like to draw attention to a third, the Personality Structure Questionnaire (PSQ) (Pollock *et al*, 2001), which consists of eight bipolar items scored 1–5 and is similarly quick to administer and to score. The scores of four clinical and four non-clinical samples are reported in the paper. Two samples of patients meeting diagnostic criteria for borderline personality disorder had mean scores of over 30, whereas the non-clinical samples scored between 19.7 and 23.3. Scores on the PSQ were shown to correlate with a number of measures of multiplicity, dissociation and identity disturbance.

Most of the items on the questionnaire describe the respondent's awareness of a discontinuous sense of self. This reflects the multiple self states model of borderline personality disorder (Ryle, 1997a), in which alternations in the operation of recognisable, discrete self states, each with a characteristic mood, sense of self and mode of relating to others, are seen to account for much of the experience and confusion of patients and of those treating them. The PSQ is similar to the SAPAS in being a screening, not a diagnostic instrument. It differs in that it focuses on the specific feature of self state instability typical of Cluster B disorders. This can be an advantage in that these patients present the greatest difficulty to clinicians. By drawing attention to this characteristic the PSQ can initiate further enquiry leading to the detailed description of an individual's self states and state switches, which can provide a basis for management and treatment directed towards personality integration (Ryle 1997b).

**Moran, P., Leese, M., Lee, T., et al (2003)** Standardised Assessment of Personality – Abbreviated Scale (SAPAS): preliminary validation of a brief screen for personality disorder. *British Journal of Psychiatry*, **183**, 228–232.

**Pollock, P., Broadbent, M., Clarke, S., et al (2001)** The Personality Structure Questionnaire (PSQ): a measure of the multiple self states model of identity disturbance in cognitive analytic therapy. *Clinical Psychology and Psychotherapy*, **8**, 59–72.

**Ryle, A. (1997a)** The structure and development of borderline personality disorder: a proposed model. *British Journal of Psychiatry*, **170**, 82–87.

**Ryle, A. (1997b)** *Cognitive Analytic Therapy and Borderline Personality Disorder: the Model and the Method*. Chichester: J. Wiley & Sons.

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**Management of post-concussion syndrome**

In his editorial King (2003) gave an excellent overview of the post-concussion syndrome, an area of neuropsychology and psychiatry that is fraught with difficulty and controversy. King pointed out that both biological and psychological factors are at play in post-concussion syndrome. Of great importance was his integration of time since injury into a model and outlining 'windows of vulnerability' for the development of symptoms. It is likely that most clinicians treating patients with post-concussion syndrome will find this model of real value for understanding and possibly preventing some of the difficulties resulting from the syndrome.

King rightly pointed out the need for studies investigating treatment and management of post-concussion syndrome. New and future research findings now need to be incorporated into King's model. For example, Ponsford *et al* (2002) in a randomised controlled trial found that the provision 1 week post-injury of an information booklet to patients who suffered a mild head injury reduced anxiety and reporting of ongoing problems at 3 months post-injury. Against a background of 'windows of vulnerability' for the development and maintenance of symptoms, providing written information to patients in addition to the early interventions reviewed by King can further improve outcome in post-concussion syndrome.

A recent example identifying a potential lack of evidence for an intervention perhaps also needs mentioning. De Kruijk *et al* (2002) investigated the effect of bed rest on outcome following mild traumatic brain injury. Bed rest has been recommended as an intervention to improve outcome following head injury; however, the effectiveness of this intervention has not been investigated. De Kruijk and colleagues did not find significant differences in outcome between their

bed rest and no bed rest groups at 3 months post injury. However, they concluded that bed rest might have some palliative effect during the initial weeks following injury.

New and future research findings on management, integrated into King's model, can potentially enhance the prevention of chronic symptomatology developing in

post-concussion syndrome. This might also inform our understanding of cases where post-concussion symptoms persist beyond 1 year following injury.

**De Kruijk, J. R., Leffers, P., Meerhof, S., et al (2002)** Effectiveness of bed rest after mild traumatic brain injury: a randomised trial of no versus six days of bed rest. *Journal of Neurology, Neurosurgery and Psychiatry*, **73**, 167–172.

**King, N. S. (2003)** Post-concussion syndrome: clarity amid the controversy? *British Journal of Psychiatry*, **183**, 276–278.

**Ponsford, J., Willmott, C., Rothwell, A., et al (2002)** Impact of early intervention on outcome following mild head injury in adults. *Journal of Neurology, Neurosurgery and Psychiatry*, **73**, 330–332.

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## One hundred years ago

### Review of *Hypnotism, its History, Practice, and Theory*.

By J. Milne Bramwell, MB, CM, Edin., author of numerous articles on the Practice and Theory of Hypnotism. London: Grant Richards. 1903. Pp. 477. Price 18s. net.

"The author" of this book, we are told by the publisher, "has devoted the last 12 years to hypnotic practice and research and his personal observations of the practical work done in France, Germany, Sweden, Holland, Switzerland, and Belgium should also make the volume a valuable addition to the science of a subject which is exciting much interest at the present time." In the introductory chapter the author tells us that in the course of the volume he proposes "to refer not only to his own hypnotic 12 years' practice and research but also to give such a general account of the subject as can be brought within reasonable compass." Examining Dr. Bramwell's book in the light of his own account of his intentions we doubt if he has fulfilled the promises made. One chapter is devoted to the early history of hypnotism; it is short and very incomplete; for example, the account given of Mesmer is fragmentary. The work

of Elliotson, of Esdaile, and of Braid is more fully treated. The section on the later History of Hypnotism contains an account of the practice of Dr. A. A. Liebeault of Nancy. A section follows entitled "History of My Own Practice." The remaining part of the book is devoted to dissertations on the methods of inducing and terminating hypnosis, susceptibility to hypnosis and the causes which influence it, the experimental phenomena of hypnosis, and the management of hypnotic experiments and an account of the "different stages of hypnosis." The therapeutic use of hypnotism is dealt with in chapters on hypnotism in medicine and surgery and in one on the management of medical and surgical cases. This is followed by a disquisition on hypnotic theories which occupies 150 pages, or nearly a third of the whole work. A chapter is devoted to "the so-called dangers of hypnotism" and this is followed by a summary, conclusion, and list of references. Of the two appendices one is the late Dr. Williamson's account of the origin of Braid's work and the other is a note on spiritualism, clairvoyance, and telepathy.

The general effect produced by this book is a feeling of wonder that such a

subject, with all its suggestions of mystery and occultism bred of our imperfect knowledge, can have led to the production of so unstimulating a book. Doubtless Dr. Bramwell was particularly right to treat his subject very seriously, but he might have taken more steps to arouse and to hold our interest. The work would gain much if it were rearranged and rewritten so that the history of the subject and the theories of its various exponents were placed together. For example, the life of Esdaile is given in one place, while his theories will be found in another. The author's views naturally pervade the book, but while lessons from personal experience are of the utmost value in all medical treatises, an author should beware lest the actors of the past should appear merely as puppets in his play. Dr. Bramwell is, we are sure, unaware how strongly the impression is produced that views contrary to his own are erroneous and misleading.

### REFERENCE

*Lancet*, 2 January 1904, 30.

Researched by Henry Rollin, Emeritus Consultant Psychiatrist, Horton Hospital, Epsom, Surrey.

## Corrigendum

Disintegration of the components of language as the path to a revision of Bleuler's and Schneider's concepts of schizophrenia. Linguistic disturbances compared with first-rank symptoms in acute psychosis.

*BJP*, **182**, 233–240. Summary (p.233), Results should read: Strong positive correlations were found between the CLANG factor 'poverty' and first-rank delusions of control and between semantic/phonemic

paraphasias and verbal auditory hallucinations. Language disturbances were superior to nuclear symptoms in discriminating ICD-10 schizophrenia from other psychoses.