Definition of depression is questionable

EDITOR,—Mynors-Wallis and colleagues claim that problem solving treatment and amitriptyline are equally effective in major depressive disorder.[1] Even though they required their patients to meet the research diagnostic criteria for depression, just how severely depressed they were comes into question. To be eligible to take part in the study patients had to score just 13 on the Hamilton depression rating scale. Drug licensing authorities, such as the Committee on Safety of Medicines and the Food and Drug Administration, and most investigators would regard a score of 18 as being the minimum required for entry into any trial.

Older tricyclic antidepressants such as amitriptyline are associated with a plethora of adverse effects and may not have been the most appropriate choice of agent. Newer tricyclic drugs such as lofepramine, selective serotonin reuptake inhibitors, or even the recently introduced selective noradrenaline reuptake inhibitors might have been a better choice as they have a more favourable profile of side effects, resulting in greater compliance. An average dose of 139 mg of amitriptyline was taken, as calculated from tablet counts. It is generally accepted that the minimum effective dose of amitriptyline is 150 mg a day. Clearly, the patients in the group given active somatic treatment were receiving a subtherapeutic dose.

To recommend in the key messages box that the need for psychological treatment exists because antidepressants are associated with poor compliance is clearly incorrect. The need for psychological treatment exists in its own right, and such treatment should be used in combination with somatic treatment. All types of treatment for depression, be they somatic or psychological, are associated with a certain degree of non-compliance. To date, no particular mode of treatment has been proved to be more efficacious or associated with better compliance than others.

JOGIN H THAKORE
Lecturer in psychological medicine

Department of Psychological Medicine,
St Bartholomew's Hospital,
London EC1A 7BE

1 Mynors-Wallis LM, Gath DH, Lloyd-Thomas AR, Tomlinson D. Randomised controlled trial comparing problem solving treatment with amitriptyline and placebo for major depression in primary care. *BMJ* 1995;310:441-5. (18 February.)

Placebo treatment was meaningless

EDITOR,—Describing the design of their study, L M Mynors-Wallis and colleagues state that they compared "(*a*) problem solving; (*b*) amitriptyline with standard clinical management; and (*c*) drug placebo with standard clinical management."[1] The patients in the second two groups, however, were seen by therapists who were under strict instructions with regard to the type of interventions they could make. The therapists were instructed to avoid specific psychological interventions, in particular problem solving treatment. If patients raised a problem it was to be listened to sympathetically, but no advice could be given on how to manage the problem. It is difficult to believe that this would constitute any therapist's or doctor's standard clinical management. The fact that problem solving treatment compared favourably with such abnormally restricted treatments is of little clinical use.

To compound this error, the three therapists were all authors of the paper. They carried out both the problem solving treatment and the standard clinical management. In this situation, bias against the groups given standard management would have been difficult to avoid and impossible to compensate for.

I also wish to raise the ethical issue of randomisation. Most patients with major depression show a good response to antidepressants,[2] and cognitive therapy has also been shown to be effective.[3] In Mynors-Wallis and colleagues' study one group of patients was allocated to a placebo drug and a highly restricted psychological treatment of unknown benefit. Altogether 60% of patients in this group had dropped out at three months, most (eight of 14) because they were not getting better. These patients were effectively denied access to treatment of known benefit. As Gore and Altman have pointed out, too many studies compare a new treatment with a placebo rather than an existing proved treatment.[4] This process is both ethically suspect and likely to yield results of no practical importance.

Problem solving treatment could potentially be a useful addition to the treatments available for depression. I suggest, however, that a trial should be carried out to compare problem solving treatment with "treatment as usual by the general practitioner" (in most cases consisting of antidepressants or supportive counselling, or both). This would avoid the ethical problems associated with placebo treatment and would yield a far more useful result.

LIAM SMEETH
Senior house officer

Department of Obstetrics and Gynaecology,
Royal Free Hospital,
London NW3 2QG

1 Mynors-Wallis LM, Gath DH, Lloyd-Thomas AR, Tomlinson D. Randomised controlled trial comparing problem solving treatment with amitriptyline and placebo for major depression in primary care. *BMJ* 1995;310:441-5. (18 February.)
2 Paykel ES, Priest RG. Recognition and management of depression in general practice: consensus statement. *BMJ* 1992;305: 1198-202.
3 Ross M, Scott M. An evaluation of the effectiveness of individual and group cognitive therapy in the treatment of depressed patients in an inner-city health centre. *J R Coll Gen Pract* 1985;35:239-42.
4 Gore SM, Altman DG. *Statistics in practice.* London: BMJ, 1982.

Diagnosis of major depression is too broad

EDITOR,—Although depressive neurosis is equated with dysthymic disorder in the *Diagnostic and Statistical Manual of Mental Disorders*, owing to personal circumstances it can be severe enough to be equated with major depression. L M Mynors-Wallis and colleagues do not take this into account when measuring the efficacy of problem solving treatment in major depression in primary care.[1]

The implication of the finding that problem solving treatment is "effective, feasible, and acceptable" in patients with major depression is that this treatment is helpful to all such patients. What the authors have failed to examine is whether the subgroup of patients with environmental problems is more responsive than the subgroup with biological causes of their depression.

J WATT
Locum consultant psychiatrist

Mental Health Directorate (Inverclyde),
Ravenscraig Hospital,
Greenock PA16 9HA

1 Mynors-Wallis LM, Gath DH, Lloyd-Thomas AR, Tomlinson D. Randomised controlled trial comparing problem solving treatment with amitriptyline and placebo for major depression in primary care. *BMJ* 1995;310:441-5. (18 February.)

There is a place for a combined treatment approach

EDITOR,—Primary care is assuming an increasing role in community psychiatry, and L M Mynors-Wallis and colleagues' study of problem solving treatment has implications for the treatment of major depression in this setting.[1] The approach, however, adheres strictly to an either/or model of biological or psychosocial approaches to treatment. The authors' reference to traditional treatment dates from 1978 and is not one that reflects the conventional psychiatric model of depression as being biopsychosocial (aetiologically and therapeutically). Most referral letters from general practitioners reference the complicated but relevant range of such issues, which suggests that "drugs and reassurance" are an inaccurate reflection of primary care treatment. The face validity of the biopsychosocial model is inadvertently endorsed by the results of the study. The reductionist approach would leave 48% (drugs) and 40% (problem solving) of treated patients not recovered. Would such patients be referred to specialist care for treatment for persistent depression? It is surprising that the place for a combined or adjunctive treatment approach is not discussed.

MARCELINO G SMYTH
Senior registrar

Queen Elizabeth Psychiatric Hospital,
Birmingham B15 2QZ

1 Mynors-Wallis LM, Gath DH, Lloyd-Thomas AR, Tomlinson D. Randomised controlled trial comparing problem solving treatment with amitriptyline and placebo for major depression in primary care. *BMJ* 1995;310:441-5. (18 February.)

Authors' reply

EDITOR,—In response to Jogin H Thakore's comments about the severity of depression, it is important to emphasise that our trial was carried out in primary care. We selected depressed patients with a score of 13 or more on the Hamilton depression rating scale because Paykel *et al* found in general practice that depression at this level and above responded to amitriptyline but not placebo.[1] Thakore states that most investigators would regard a Hamilton score of over 18 as the minimum score for entry into a trial, but trials comparing psychological with drug treatments generally admit patients with less severe depression. Despite the common belief that the minimum effective dose of amitriptyline for depressive disorders is 150 mg a day, there is little evidence to support this contention in primary care. There is no evidence of a difference in efficacy between the standard dose of 150 mg and the mean dose achieved in this study (139 mg).

In our trial all the treatments were specified in a standardised manual, which was based on the manual used in the National Institute of Mental Health's treatment of depression collaborative research programme.[2] The purpose of having a clearly defined placebo treatment was to answer an important question: whether there is a specific treatment factor in problem solving apart from simply spending time with the patient. Patients with depressive disorders may receive a large amount of unstructured treatment time, but our trial has shown that such time is less effective than problem solving treatment. In general practice most antidepressant drugs would be given in far less time, so it is inappropriate to call the drug treatment abnormally restrictive. We emphasise that the problem solving treatment was compared not only with placebo treatment but also with antidepressant treatment, and the placebo treatment was not just "no treatment" but both drug placebo and psychological placebo.

We do not suggest that problem solving treatment is helpful for all patients. As we pointed out, 40% of the patients did not meet the criteria for recovery at the end of 12 weeks of treatment. It is clearly important to be able to identify patients for whom problem solving treatment would be particularly helpful. Our initial analyses do not suggest a clear subgroup of patients for whom this is the case.

It is also important to determine whether combined drug and psychological treatment would be better than either treatment alone. It seemed to us important to determine whether problem solving treatment was effective in its own right before seeking to determine whether it would be more effective when combined with drug treatment. We are carrying out a further randomised controlled