We agree with this analysis. Nevertheless, the continued year-on-year rise in antidepressant use in the study period does indicate a wider population of individuals, presumably some of whom are at risk of suicide, being treated by these drugs.

Our assessment of suicide and antidepressant prescribing in the Nordic countries was more comprehensive than Isacsson's original analysis and in our view provides weaker evidence than that originally presented (Isacsson, 2000). Nevertheless the most comprehensive assessment of the ecological data to date (Ludwig & Marcotte, 2005) does support Isacsson's view. In an area where the influence of the pharmaceutical industry is widespread we favour a more cautious interpretation of the ecological data.

Declaration of interest

D.G. was an independent advisor to the Medicines and Healthcare Products Regulatory Agency Expert Working Group on the Safety of SSRIs, receiving expenses and an attendance fee.

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S. Reseland KD-G Consulting, Hosletoppen 56, 1362 Hosle, Norway. Email: sreselan@online.no

I. Bray, D. Gunnell Department of Social Medicine, University of Bristol, Bristol, UK.

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Cognitive–behavioural therapy for avoidant personality disorder

Emmelkamp *et al* (2006) reported that cognitive–behavioural therapy (CBT) was more effective than brief dynamic therapy (BDT) for the treatment of avoidant personality disorder. However, the study has several methodological shortcomings.

In the BDT group it is not clear whether and to what extent a manualised treatment was realised. The article includes non-specific references to several psychodynamic manuals and it is not clear what therapeutic procedures were actually carried out. Furthermore, no disorder-specific treatment manual was used. In contrast, in the CBT group the manual of Beck & Freeman (1990) for avoidant personality disorder was applied. No data with regard to adherence and competence were reported and thus it is not clear whether both treatments were carried out with equal competence.

Besides the presence or absence of the diagnosis according to the Structural Clinical Interview for DSM–IV Axis II Disorders (SCID–II) several self-report measures were applied as 'primary outcome measures'. However, the authors focus on a specific measure that they regarded as primary. In addition to other outcome measures, Emmelkamp *et al* used the Personality Disorder Belief Questionnaire (PDBQ; Arntz *et al*, 2004). Arntz *et al* (2004) explicitly included items from Beck & Freeman (1990) and hence the PDBQ is specifically tailored to the effects of CBT. Possibly the most convincing difference between CBT and BDT was found with regard to the number of patients still fulfilling the SCID–II criteria at follow-up (9 *v.* 36%). However, it is not clear whether the 'independent assessor' was masked to the treatment group.

In two outcome measures that refer more specifically to the features of avoidant personality disorder, the Social Phobia Anxiety Inventory (SPAI) and the Avoidance Scale, another measure developed by the authors (Emmelkamp, 1982), both CBT and BDT achieved large and nearly identical pre-/post-treatment effect sizes: 0.92 *v.* 0.82 (SPAI) and 1.88 *v.* 1.75 (Avoidance Scale). Emmelkamp *et al* reported that 'CBT was significantly superior on all primary outcome measures.' However, for the difference between the CBT and BDT groups in SPAI score the P was 0.09, which is not significant at the level of α=0.01 set by the authors. Furthermore, at follow-up, there were no differences between CBT and BDT groups in SPAI and Avoidance Scale scores. Differences were only reported for the PDBQ and for two scales that refer to other personality disorders. For BDT, 'no significant difference was found between BDT and control' but no data are reported. Compared with the waiting list control, CBT was only superior in two of six measures but the sample size of the waiting list control was small (n=15 *v.* 26 for CBT and 28 for BDT post-treatment). The fact that almost no differences were found between the waiting-list control and both BDT and CBT is (at least in part) a result of the insufficient sample size. Furthermore, at least in some measures, the waiting-list group achieved medium or even large effect sizes.

The results reported by Emmelkamp *et al* (2006) are at variance with those reported by Svartberg *et al* (2004), who found BDT and CBT to be equally effective for cluster C personality disorders.

Overall, the design, statistical analyses and reporting of the results raise serious concerns about an investigator allegiance effect (Luborsky *et al*, 1999).

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F. Leichsenring Centre for Psychosocial Medicine, von-Siebold-Strasse 5, D-37075 Göttingen, Germany. Email: Fleichs@gwdg.de

E. Leibing Centre for Psychosocial Medicine, Göttingen, Germany.

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Author's reply: Our study was designed in close cooperation with full-time clinicians and in both groups (CBT and BDT) application of manuals was highly flexible to be representative of the respective therapies as they are carried out in clinical practice and to enhance the external validity of the study. Sessions were audiotaped and scored using the Coding System of Therapeutic Focus on Action and Insight (CFAI; Samoilov *et al*, 2000) by two independent raters who were masked to the treatment group (interrater reliability (Kendall's W) ranged from 0.86 to 0.91). In general, results revealed that therapists adhered to the respective therapies (Emmelkamp *et al*, 2004).

To the best of our knowledge there are no measures of 'psychodynamic origin' specifically related to avoidant personality disorder and hence we used the PDBQ. Furthermore, it was not feasible to keep the independent assessors who completed the SCID–II unaware of the treatment group in a number of instances.

Post-treatment CBT was significantly superior to BDT on all 'primary' outcome measures. A significance level of $\alpha=0.1$ set rather than 0.01 as claimed by Leichsenring & Leibing. Even if we exclude the SPAI scores ($P=0.09$), this still leaves superior outcome for CBT on three out of four outcome variables. The lack of power to detect differences between the waiting-list control group and the active treatments is acknowledged as a limitation.

There are important differences between our study and that of Svartberg *et al* (2004). Svartberg *et al* included all types of cluster C and self-defeating personality disorders, rather than limiting their study to avoidant personality disorder. Two-fifths of their sample did not fulfil criteria for avoidant personality disorder treatment and treatment consisted of 40 rather than of 20 sessions. Furthermore, outcome with respect to personality disorders (sic) was only assessed with the Millon Clinical Multiaxial Inventory (Millon, 1994), rather than with the gold standard SCID–II. Finally, the lack of a control group in the study of Svartberg *et al* renders the results difficult to interpret.

In contrast to most other psychotherapy studies, we did our utmost to prevent an effect of investigator allegiance. The study was designed in close cooperation with two psychodynamic therapists (G.F. and H.K.) and two cognitive–behavioural therapists (A.B. and A.K.), who all fully participated in the design of the study, selection of measures, treatment manuals (including degree of flexibility) and therapists.

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P. M. G. Emmelkamp Department of Clinical Psychology, University of Amsterdam, Roetersstraat 15, 1018 WB Amsterdam, The Netherlands. Email: P.M.G.Emmelkamp@uva.nl

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Anti-phospholipid antibodies, neuroleptic treatment and cardiovascular morbidity

Joukamaa *et al* (2006) reported a clear relationship between the number of neuroleptic drugs prescribed and mortality of people with schizophrenia. The more important causes of death were cardiovascular disease and unspecified respiratory disease. Moreover, the authors postulated that overlooked venous thrombosis or pulmonary embolism accounted for some respiratory deaths.

Oomen *et al* (1995) documented increased vascular morbidity at 2-year follow-up in patients with anti-phospholipid antibodies who were newly admitted for psychiatric treatment. These patients showed a range of cardiovascular accidents (arterial or venous thrombosis, pulmonary embolism and myocardial infarction). The negative control group without anti-phospholipid antibodies had no vascular complications during follow-up.

Vascular events associated with such autoantibodies range from superficial to life-threatening multiple organ thrombosis developing over a short period ('catastrophic' anti-phospholipid syndrome). Thrombosis in anti-phospholipid syndrome appears to be a 'two-hit' phenomenon. Autoantibodies (the first 'hit') are continually present in the circulation, yet a local trigger (the second 'hit') is required to induce thrombus formation. Erkan & Lockshin (2006) recently suggested the elimination of reversible thrombosis risk factors and heparin prophylaxis during high-risk periods in people with persistent anti-phospholipid antibodies. Chengappa *et al* (1991) and Schwartz *et al* (1998) demonstrated a high prevalence of anti-phospholipid antibodies (about 30%) in patients. A prospective study is ongoing in our departments to confirm the prevalence of anti-phospholipid antibodies with a first episode of acute psychosis before and after neuroleptic treatment. If historical data are confirmed, more attention should be paid to the fact that up to one-third of patients presenting with psychosis have anti-phospholipid antibodies and are at risk of cardiovascular or respiratory morbidity/mortality when neuroleptic treatment or physical restraint are used.

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E. Leuci Psychiatry Department, Parma, Fidenza, Italy.

L. Manenti Psychiatry Department, Fidenza District, ASL Parma, Via Berenini 151, Fidenza (PR), 43100 Italy. Email: lucio.manenti@aod.it

C. Maggini Psychiatry Department, Parma, Fidenza, Italy.

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Letters to the Editor

In order to speed up the publication of correspondence and to encourage debate among our readers and authors, all letters to the Editor must from now on be submitted online as eLetters. Hard-copy submissions will no longer be considered. To submit an eLetter, click 'submit a response' in the box at the top right of the screen when viewing online an article on which you wish to comment. If your letter is a general one, and not in response to a specific article, please 'submit a response' to this letter (you can also submit a general letter from the eLetters home page). We aim to publish eLetters online, if accepted, within 10 days of submission. A selection of these letters will be included in subsequent printed issues.

Correspondence Editors

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