therapy in family practice: a controlled prospective intervention trial" (*Journal,* July 1983, **143,** 11–19) raises two points worthy of comment.

1. The authors found no difference between psychotherapy, general practitioner treatment and the control condition. However, they observe that the research design was "vulnerable" because, among other reasons, "the small number of subjects completing treatment increases the possibility of Type II error". They go on to say that "this possibility seems remote as there was not even a tendency towards a differential effect between the treatment groups".

   In fact, the possibility of Type II error (i.e., failure of an experiment, test or study to detect a difference that does in fact exist) in their study is not at all remote. Considering only the comparison between psychotherapy and control groups, and applying the average effect size obtained by Smith and Glass (1977) from their meta-analysis of 96 treatment trials of dynamic psychotherapy to the SCL-90 scores given by Brodaty and Andrews, it can be shown, using formulae available in standard medical statistics texts (e.g., Armitage, 1971), that the probability of type II error is in the region of 25 per cent. It can also be shown that in order to have a 95 per cent chance of detecting a psychotherapy/control difference similar to that derived from the 96 outcome studies assessed by Smith and Glass (1977), about 75 patients in each group would be needed.

2. Brodaty and Andrews screened 1510 consecutive family practice attenders: of these, 700 had high General Health Questionnaire scores and of these, 48 were thought suitable for and accepted specific treatment (i.e., not controls) within the context of the trial. Thus, at best, the results of such a study are applicable to only 7 per cent of those patients with significant psychiatric morbidity who present to general practitioners, and thus of limited relevance to the practical management of psychiatric disorder in general practice.

   Similarly, the MRC trial of dynamic psychotherapy found (Candy *et al,* 1972) that only 7 per cent of referred patients were considered suitable for entry into the trial. Such findings support the observation of Cawley (1971), that "the controlled therapeutic trial is not the only, or necessarily the best, way of examining the case for dynamic psychotherapy".

   The role and value of a psychodynamic approach in primary health care seems *par excellence* an issue which could usefully be studied by alternative approaches. Among such alternatives, techniques designed for the evaluation of health care delivery (see Illsey, 1980) merit serious consideration. Such techniques have been applied, in a series of studies by workers in the General Practice Research Unit at the Institute of Psychiatry, to a similar problem, *viz.*, the evaluation of social casework in the primary care setting.

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References

ARMITAGE, P. (1971) *Statistical Methods in Medical Research.* Oxford: Blackwell.

CANDY, J., BALFOUR, F. H. G., CAWLEY, R. H., HILDEBRAND, M. P., MALAN, D. H., MARKS, I. M. & WILSON, J. (1972) A feasibility study for a controlled trial of formal psychotherapy. *Psychological Medicine,* **2,** 245–62.

CAWLEY, R. H. (1971) Evaluation of psychotherapy. *Psychological Medicine,* **1,** 101–3.

ILLSEY, R. (1980) *Professional or Public Health.* London: Nuffield Provincial Hospitals Trust.

SMITH, M. L. & GLASS, G. V. (1977) Meta-analysis of psychotherapy outcome studies. *American Psychologist,* **32,** 752–60.

CORRECTION

The first sentence in the summary "Are there Anticompulsive or Antiphobic Drugs?" by Isaac Marks (*Journal,* October, 1983, **143,** 338–47) should read "19 controlled studies" not "19 uncontrolled studies".

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