series of randomized controlled studies that showed that psychoanalytic therapy was as efficacious as cognitive behavioral therapy. A meta-analysis also showed that psychoanalytically based therapy was as effective in depressive disorders as cognitive behavior therapy (2).

An older meta-analysis that the authors also cite does not even claim to be drawing conclusions about depressive disorders ([6] in the article). A more recent meta-analysis that was published in JAMA in October 2008 found that long term psychodynamic therapy is more efficacious in complex disorders than shorter forms of psychotherapy (3). "Complex disorders" included patients with multiple psychiatric diagnoses, chronic psychological disorders, or personality disorders. A substantial proportion of patients in the real world does not have merely one psychiatric diagnosis but several (3). Long term psychodynamic therapy yielded large and stable therapeutic effects, especially in patients who had primarily complex depressive and anxiety disorders (3).

What is strange is that psychoanalytically based methods are always blamed for a lack of evidence. However, any evidence that is provided is firmly ignored. We cannot find a general recommendation for the treatment of depression in the context of our CME certified article is therefore out of the question. We cannot find a general recommendation against tricyclic antidepressants in our article, and this was not our intention anyway. We do not share the methods are always blamed for a lack of evidence.

Opipramol As Nighttime Medication
The CME article addresses primarily general practitioners and family doctors. As a specialist physician in private practice with many years' experience in collaborating with referring colleagues I wish to draw attention to an option for initial treatment that has been tried and tested in the general practice setting.

No mention was made of prescribing the sedative tricyclic antidepressant opipramol, especially as nighttime medication.

This drug can be used even today, and at very low dosage, to treat early awakening, the particularly tormenting symptom of most forms of depression, with few side effects. Another "tricyclic option" that should have a place in general practice is trimipramine; the fact that it comes in the form of drops makes it particularly suitable when starting treatment.

Following the authors' recommendations would mean that the only antidepressant with the desired sedative effect is the "modern" drug mirtazapine, although this often causes restless leg syndrome in elderly patients.

The highlighted "nonresponder" rate of 30–50% applies for this drug too. There are more than enough patients nowadays—even those of an advanced age—for whom the absolute contraindications of tricyclic antidepressants do not apply and in whom the undesired side effects are limited.

Supported by such medication, even the general practitioner or, in more severe cases, the psychiatrist can prescribe a stimulating antidepressant without having to fear sleep deprivation and inner unrest.

The tricyclic antidepressants and the art of differential therapy should not be altogether sacrificed on the altar of guideline conform medicine (1). This is even more so because in the near future, pharmacogenetics will enable us to predict desirable and undesirable effects even in antidepressants.

REFERENCES

Dr. med. Dr. rer. nat. Ulrich Leutgeb
Bayreuther Str. 15
95500 Heinersreuth, Germany
Ulrich.Leutgeb@kabelmail.de

Conflict of interest statement
The author declares that no conflict of interest exists according to the guidelines of the International Committee of Medical Journal Editors.

In Reply:
Opipramol is licensed merely for the treatment of generalized anxiety disorders and somatoform disorders. A recommendation for the treatment of depression in the context of our CME certified article is therefore out of the question. We cannot find a general recommendation against tricyclic antidepressants in our article, and this was not our intention anyway. We do not share the recommendation by Leutgeb, to use a combination of two antidepressants for primary treatment, especially in elderly patients.

We thank Müller-Oerlinghausen for his additional points.

We welcome Schulz's mention of the new Cochrane review of St John's wort. As stated in Deutsches Ärzteblatt, our manuscript was submitted in June 2008. The Cochrane review was published in October 2008. We object to any accusation of intentional omission.

We thank Schauenburg for his additional explanations. Our article discusses psychotherapy on nearly 1 1/2 pages, so that we cannot quite understand why he has accused...
us of sidelining the subject. The figure is a therapeutic algorithm exclusively for somatotherapy of depression. We agree that this should have been made more explicit in the figure legend. Our article discusses the importance of the therapeutic relationship for psychotherapy in more detail in the section entitled "Psychotherapy." The paragraph selected by Waldmann, however, comes from the section entitled "Basic treatment strategy," where we intended to provide a more general overview.

Leichsenring quotes us incorrectly. Our criticism relating to inclusion of patients with different diagnoses (not only depression) in meta-analyses and review articles on psychoanalytical/psychodynamic psychotherapy relates only to his 2005 article, not, as he claims in his reader’s letter, his 2001 article. His 2005 review includes—in addition to depressive disorders—anxiety disorders, post-traumatic stress disorders, somatoform disorders, bulimia nervosa and anorexia nervosa, borderline personality disorder and other personality disorders, as well as substance dependence and misuse.

REFERENCES


PD Dr. med. Tom Bschor
Jüdisches Krankenhaus Berlin
Abteilung für Psychiatrie und Psychotherapie
Heinz-Galinski-Str. 1
13347 Berlin, Germany
bschor@jb-online.de

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