Declaration of interest

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

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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 × 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, 1997*a*), 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 1997*b*).

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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

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