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# From the Editor's desk

By Peter Tyrer

## Psychotherapy made perfect

In their recent assault on the technological paraphernalia of psychiatric interventions Bracken *et al*[1] asserted confidently that (in psychotherapy) 'the evidence that non-specific factors, as opposed to specific techniques, account for nearly all the change in therapy is overwhelming' (p. 431). I am not sure that many would disagree strongly with this in our present state of knowledge; the qualities of the therapist are more important than specific technical skills. But both are desirable, and anyone involved in psychotherapy research will be aware of the literature that good fidelity to treatment leads to better outcome than poor fidelity.[2–4] When I was a postgraduate trainee our group carried out a little exercise in assessing which of the many glitterati adorning the consultant staff of the Maudsley and Bethlem Royal Hospitals we would choose to consult if we had a psychiatric illness. The winner by a country mile was not a world leader in research, policy or practice, but a well-rounded, modest, compassionate and approachable consultant whom all of us felt we could go to comfortably and confidently with our problems. He did not claim any special expertise in psychotherapy or any other branch of psychiatry, but few of us felt this mattered; it was the human qualities that counted.

In this issue we have many reminders of the importance of humanised skilled psychotherapy. From what I have heard, the Dorset service for personality disorders is well-regarded, and seen as flexible and facilitatory, but Clarke *et al* (pp. 129–134) in describing the benefits of cognitive analytic therapy in the treatment of this group of disorders cannot properly address this non-specific element. But by not confining their study to those with borderline personality disorder and by ensuring that all their therapists reached minimum levels of competence, they were setting a benchmark for the training of others. Their results are encouraging but practitioners will know of many other therapies in the field that employ similar techniques (Mulder & Chanen, pp. 89–90) and which may be equally good[5] – what is most interesting in this area is that there are so few head-to-head comparisons of different psychotherapies and it seems likely that even when these are carried out[6,7] the allegiance of the therapist to the treatment[3,8] has the tendency to distort the interpretation of the findings.

Where we are still remarkably ignorant is predicting how much psychotherapy is needed for an individual patient, and this is where the criticisms of Bracken *et al* carry some weight. It is pointless for a therapist to treat a patient for 10 sessions because this is set down in policy somewhere, when clinical common sense screams 'add a few more' to complete the job, and for many interventions we would be arrogant to specify how many sessions are going to be needed.[9–11] What is encouraging is that psychotherapy in all its forms is now available to a large number of people who require this treatment, at least in high-income countries, as Jokela *et al* (pp. 115–120) and Meadows & Tylee (pp. 86–88) indicate. Technology has also enabled computerised therapy to replace, or add to, face-to-face contact but we still need to be reminded that this can never replace other treatments entirely, as Wagner *et al* (pp. 135–141) have shown in the treatment of bulimia nervosa. Jeste & Palmer (pp. 81–83) also emphasise the psychotherapeutic aspects in a model of positive old age psychiatry, and remind us that basic psychotherapy is an essential component of all good psychiatric care. Even the study by Van der Schaaf *et al* (pp. 142–149), in examining the need for seclusion, demonstrates the importance of psychotherapy. One of my patients, who dreaded her stays in hospital, initiated a campaign to change the direction of the cameras in the nursing office – to point inwards rather than outwards – as her claim was that this would demonstrate the staff were spending almost all their time in the office rather than interacting with patients. Not a bad hypothesis, and even the critics of psychiatric technology might see some value here to reinforce their cause.

## Hamid Ghodse

Professor Hamid Ghodse, Editor of our sister journal, *International Psychiatry*, died suddenly on 27 December at the age of 74. Many may have heard of Hamid, but only a few could appreciate the breadth and vision of this extraordinary man, starting his career as a lieutenant in the Iranian Health Corps and ending in a constellation of starring world roles, including President of the International Narcotics Control Board. But Hamid was a ground-breaker in so many fields, an excellent exemplar of the Chinese proverb, 'a leader is best when people barely know he exists, when his work is done, his aim fulfilled, they will say: we did it ourselves'. I often said to Hamid that he was in the wrong profession, as his ability to change conflict into compromise was demonstrated over and over again in so many ways, that he could have emulated Kemal Ataturk's achievements in Turkey by resolving Iran's relationship with the rest of the world. But that was not to be, and we in psychiatry were the grateful beneficiaries. And I do not think Hamid would have minded if I ended with part of my Editor's Report delivered in Liverpool in 2009, but never published as it was entirely in verse, and to some this would have looked unseemly:

And across the world we take our odyssey
On the camel train led by Hamid Ghodse
For it is he who with passion shall
Make our Journal International

Safe journey, Hamid.


1 Bracken P, Thomas P, Timimi S, Asen E, Behr G, Beuster C, et al. Psychiatry beyond the current paradigm. *Br J Psychiatry* 2012: **201**: 430–4.

2 Kingdon D, Tyrer P, Seivewright N, Ferguson B, Murphy S. The Nottingham Study of Neurotic Disorder: influence of cognitive therapists on outcome. *Br J Psychiatry* 1996; **169**: 93–7.

3 Godfrey E, Chalder T, Ridsdale L, Seed P, Ogden J. Investigating the active ingredients of cognitive behaviour therapy and counselling for patients with chronic fatigue in primary care: developing a new process measure to assess treatment fidelity and predict outcome. *Br J Clin Psychol* 2007; **46**: 253–72.

4 Erkkilä J, Punkanen M, Fachner J, Ala-Ruona E, Pöntiö I, Tervaniemi M, et al. Individual music therapy for depression: randomised controlled trial. *Br J Psychiatry* 2011; **199**: 132–9.

5 Bateman AW. Treating borderline personality disorder in clinical practice. *Am J Psychiatry* 2012; **169**: 560–3.

6 Giesen-Bloo J, van Dyck R, Spinhoven P, van Tilburg W, Dirksen C, van Asselt T, et al. Outpatient psychotherapy for borderline personality disorder: randomized trial of schema-focused therapy vs transference-focused psychotherapy. *Arch Gen Psychiatry* 2006; **63**: 649–58.

7 Doering S, Hörz S, Rentrop M, Fischer-Kern M, Schuster P, Benecke C, et al. Transference-focused psychotherapy v. treatment by community psychotherapists for borderline personality disorder: randomised controlled trial. *Br J Psychiatry* 2010; **196**: 389–95.

8 Luborsky L, Diguer L, Seligman DA, Rosenthal R, Krause ED, Johnson S, et al. The researcher's own allegiances: 'wild' card in comparison of treatment efficacy. *Clin Psychol Sci Pract* 1999; **6**: 95–106.

9 Leichsenring F, Rabung S. Long-term psychodynamic psychotherapy in complex mental disorders: update of a meta-analysis. *Br J Psychiatry* 2011; **199**: 15–22.

10 Leamy M, Bird V, Le Boutillier C, Williams J, Slade M. Conceptual framework for personal recovery in mental health: systematic review and narrative synthesis. *Br J Psychiatry* 2011; **199**: 445–52.

11 Holmes, J. Psychodynamic psychiatry's green shoots. *Br J Psychiatry* 2012; **200**: 439–41.