

## Fitting the biopsychosocial jigsaw together<sup>†</sup>

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Good psychiatry is a blend of science and story – broad diagnostic categories and treatments are brought to bear on individual patients, each with their unique characteristics, emotional life and developmental history. Scientific journals similarly aspire to universality and objectivity, yet each has its own character, style and provenance. The *British Journal of Psychiatry*, published by the Royal College of Psychiatrists, inevitably reflects some of the preoccupations of its parent organisation. The College has a federal structure divided into a number of sub-specialities which include general psychiatry, child and adolescent psychiatry, forensic psychiatry, psychiatry of old age, learning difficulties, liaison psychiatry, rehabilitation psychiatry, substance misuse – and psychotherapy. In an effort to raise the profile of the sub-specialities, a number of special editions of the *Journal* have been planned. It is an honour to have been asked to edit this special section, devoted to psychotherapy.

### SPECIALISM OF PSYCHOTHERAPY

Psychotherapy is unique in that its specialism refers to a mode of treatment rather than to a disorder or a particular group of patients. This is both a strength and a weakness. Psychological treatments ramify into all branches of psychiatry, not excluding psychopharmacology (Kemp & David, 1996). Psychotherapy can legitimately claim a place throughout the psychiatric spectrum and it can be argued that no psychiatrist worth the name should lack psychotherapeutic skills and understanding. On the other hand, generating resources and political momentum is made easier if there is a clear client group for whom responsibility can be claimed. As well as playing their part in psychosocial interventions in psychosis, psychotherapists

could, for example, take prime responsibility for the treatment of people suffering from severe neuroses and borderline personality disorder (Holmes, 1998), as well as for training the mental health workforce in psychological interventions. But in the UK, at least, psychotherapy is – with the exception of learning difficulties – the only sub-speciality in which there has been no net growth in the number of consultants over the past five years (Royal College of Psychiatrists, 1998); meanwhile, in the USA, the era of psychoanalytic hegemony in the universities has long been superseded by biological psychiatry (Kandel, 1999). Unless there is a determined change of direction, there is a real danger that psychiatrists' skills in psychological understanding and treatment will atrophy.

### AMBIVALENCE

The reasons behind this managerial and academic ambivalence about psychotherapy are complex. There have undoubtedly been exciting psychobiological advances in the 'decade of the brain' (Nemeroff *et al*, 1999); psychoanalytic psychotherapy has been slow to embrace the idea of a multi-disciplinary, multi-modal psychological treatment service (Holmes, 1998); and there has been a decline in morale among general psychiatrists in the UK (Deahl & Turner, 1997), so that when resources become available they tend to be used to alleviate the immediate pressure on acute services, rather than flowing into (for example) the longer-term benefits of an effective personality disorder service (Bateman & Fonagy, 2000, this issue) or improved outcomes for other patients which psychotherapy can deliver (Guthrie *et al*, 1999; Bloch & Kissane, 2000, this issue). In addition, psychological treatment skills are not confined to psychiatrists. Since psychiatrically trained psychotherapists are potentially in competition with psychologists and non-medical psychotherapists, it may appear politically

expedient – however shortsighted in undermining credibility and comprehensiveness – for psychiatrists to emphasise areas, such as psychopharmacology and molecular genetics, which are uniquely psychiatric rather than psychological.

### EVIDENCE-BASED PSYCHOTHERAPY

There is also the question of evidence-based medicine. Psychotherapy research has a flourishing tradition (Roth & Fonagy, 1996) and pioneered the method of meta-analysis (Smith & Glass, 1977), for which it is rarely given credit. Yet there remains a lingering myth that few psychological treatments meet the 'gold standard' of the randomised controlled trial, and therefore that they carry less weight than competing disciplines in today's medical market-place. It is true that some aspects of the 'drug metaphor' are problematic for psychotherapy (Shapiro, 1995; Chiesa *et al*, 2000, this issue), which has had to find ways of measuring its impact that take account of its reliance on narrative and the uniqueness of the doctor–patient relationship (Roberts & Holmes, 1998). But, as this special edition shows, psychological treatments are in principle no less capable of being researched and no less demonstrably effective than any other psychiatric intervention. The problem is more that such research is complex, time-consuming and unlikely to be funded by pharmaceutical companies (Aveline & Shapiro, 1995). As a result, the academic base for psychotherapy in the UK is far less robust than it should be, ideally.

Nevertheless, the past decade has seen some remarkable developments in the psychological therapies. Psychotherapy of one sort or another is now an indispensable part of the management of all major psychiatric disorders, including schizophrenia (Turkington & Kingdon, 2000, this issue), manic depression and major depressive disorder (Scott, 1995; Leff *et al*, 2000, this issue), personality disorder (Bateman & Fonagy, 2000, this issue), post-traumatic stress disorder (Adshead, 2000, this issue) and somatisation disorders (Guthrie, 2000, this issue). The challenge is to translate research findings into routine clinical practice – to move from efficacy to effectiveness (Margison *et al*, 2000, this issue).

### CHANGING THE CULTURE

For such a move, a cultural shift is required on the part of both psychotherapists and

<sup>†</sup>See pp. 95–148, this issue.

general psychiatrists. Psychotherapists of all persuasions will have to accept change, both conceptually and in their working practices, and to develop an atmosphere of mutual respect – together they will have to focus more than in the past on severely ill patients, and to take seriously their unique training role. Cognitive therapists must begin to explore their limitations as well as strengths and to argue with third-party funders, whether the state or insurance companies, that new integrative models and long-term therapies are also needed if psychological interventions are to be effective in producing lasting change. Psychoanalysts need to husband the evidence base for their contribution as a ‘third force’ (Temple, 1999), complementary to biological and cognitive approaches, which can help in the understanding and treatment of complex and difficult cases, where individual and institutional transference and counter-transference are so important. Family and marital therapists need to refine the indications for their interventions and spread their skills more widely (Leff *et al*, 2000, this issue). Psychotherapists must listen not just to the public who clamour for “more talk and less pills” (Seligman, 1995), but also to the neglected voices of ethnic minorities (Sue *et al*, 1994), the elderly (Woods & Roth, 1996) and the poor and uneducated, and plan their services accordingly. General psychiatrists must equally widen their training and practice to include psychological therapies, realising that their frustrations and the wish to foster communication skills (Deahl & Turner, 1997) will not be solved simply by improved doctor–patient ratios, important though they are. General psychiatry needs psychotherapy if it is to deliver effective psychosocial interventions to people with psychosis (Turkington & Kingdon, 2000, this issue) and find new ways to combine the prescription of medications with psychotherapeutic interventions; it needs to learn, or re-learn, the principles of therapeutic community (Campling & Haigh, 1999) if it is to improve the culture of its inpatient wards; it needs to support the specialist services for personality disorders, liaison psychiatry and eating disorders, in which psychotherapy plays a decisive part.

## BIOPSYCHOSOCIAL PSYCHIATRY

Western psychiatry continues to pay lip service to the Meyerian ideal of biopsychosocial

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(First received 24 September 1999, final revision 21 October 1999, accepted 27 October 1999)

psychiatry. Until recently the different pieces of the psychological jigsaw have tended to operate in isolation or even in opposition. But as Gabbard (2000, this issue) suggests, thanks to the latest technology in neuroscience, together with more stringent research methods in psychotherapy, we are beginning to understand more clearly ways in which the brain and mind intersect. Similarly, the growth of evolutionary psychiatry (Price & David, 1998) – emphasising how behaviour is shaped by evolutionary forces and is no less ‘biological’ than neurochemistry – underpins both organic and psychotherapeutic psychiatry. Influenced by this new evolutionary thinking, a decade ago Guze (1989) provocatively asked: “Biological psychiatry – is there any other kind?” Today this special edition of the *Journal* justifies the retort: “psychotherapeutic psychiatry – should there be any other sort?”

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