As you have hinted, personal sacrifices are necessary. It is a tough, and occasionally dangerous profession. It is not too hard academically, but it is challenging at a deeply personal level. Compassion – 'suffering with' one's patients and their carers, also one's colleagues – means feeling and sharing the emotional pain and distress of others. As I have written about extensively elsewhere,[6] it is this very suffering, acting as a kind of medicine, which affords the best opportunity to initiate healing from life's inevitable psychological traumas, threats and losses, resulting in the deepest satisfaction that human experience can offer, inherent in personal growth. To become wiser, kinder, humbler, more truthful and tolerant, enjoying lower levels of anxiety, anger, sorrow, doubt, confusion, and greater levels of equanimity and self-esteem, accompanied most often by the heartfelt esteem of others, are among the inestimable rewards to be garnered. This is undoubtedly what I have gained from becoming and working as a psychiatrist.

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Larry Culliford, Independent Author - Retired Consultant Psychiatrist, 18, Penlands Rise, Steyning BN44 3PJ, West Sussex. Email: larry@ldc52.co.uk

doi:10.1192/bjp.2018.134

Rethinking rebranding

Recruiting sufficient psychiatrists in the UK apparently resists straightforward remedy. Crabb *et al*'s recent editorial *Shrink rethink: rebranding psychiatry* is a welcome contribution on this subject.[1] Innovative and provocative in turn, it urges that the psychiatric profession draw on expertise from the fields of advertising and public relations. We should engage with potential recruits by thinking of psychiatry as a 'brand'.

But brands are ethereal things. Their existence is championed by some,[2] whereas others have written about the negative impact of brand-oriented corporate activity.[3] Marketing psychiatry as a brand certainly has an attractive simplicity. Yet doing so situates the practice of psychiatry in the realm of things that are bought and sold, where it sits only uncomfortably.

The ubiquity of some brands is a marketing triumph, but emulating their tactics is not necessarily desirable. The advertising of brands seeks to sow discontent; to demonstrate to customers a gap in their life experience that a product can fill. Attempts to promote brands and products by association with certain desirable lifestyles may be effective, but also disingenuous. This approach may be acceptable for a soft drink but should be approached with caution by the medical profession.

In addition, the management priorities of the corporations that own many brands only faintly resemble psychiatry's governance structures. Psychiatry's relationship with its 'competitors' is more complex. If one company enters administration as a result of the crushing success of a rival, then that is capitalism 'working'. But if by increasing psychiatry's share of trainee recruitment we substantially weaken a fellow specialty, this success is equivocal.

Arguably, acknowledged or not, psychiatry is a brand of sorts. Doctors making career decisions may be accustomed to thinking of themselves as consumers and consider their options in a transactional way. In this case the explicit branding of psychiatry makes some sense, and in recognising this possibility Crabb *et al* provide a valuable insight. But promoting psychiatry as a brand may mean that other ways of understanding how our specialty might appeal are overlooked. What I hope is not lost is the notion of the new recruits to psychiatry's ranks as engaged citizens, drawn to this specialty as an expression of deeply held values and as a demonstration of commitment to their community and to wider society.

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Stephen Ginn, Consultant Psychiatrist, Camden and Islington Foundation NHS Trust, UK. Email: stephen.ginn@candi.nhs.uk

doi:10.1192/bjp.2018.135

Cognitive–behavioural therapy for chronic fatigue syndrome: neither efficacious nor safe

Janse *et al* investigated the effect of two variants of internet-based cognitive–behavioural therapy (iCBT) for chronic fatigue syndrome (CFS): iCBT with protocol-driven feedback and iCBT with feedback on demand.[1]

First, it should be acknowledged that CBT trials for participants with CFS have a high preselection bias, i.e. self-selection, since, according to another study by two of the authors of Janse *et al*, patients seem to be sceptical about psychological interventions.[2] Janse *et al*'s study reported 'clinically relevant depressive symptoms' in both iCBT groups (protocol-driven feedback iCBT group 31%, feedback-on-demand iCBT group 29%), while depression and other psychological conditions that could explain 'chronic fatigue' exclude the diagnosis CFS.[2] It is feasible that many patients who improved had depression, not CFS.

Comparing the number of patients working full-time in this study[1] with other studies, for example Sunnquist *et al*,[3] the CFS (?) patients can be classified as 'mild cases'.[2] Since CFS is a heterogeneous condition, the results of this study[1] cannot be generalised to CFS.

Drop-out rates are not reported but the authors assumed a drop-out rate of 15% when deciding on sample size[1] and other studies by the same group have reported even higher drop-out rates.[2] They state 'a substantial number of patients did not fully adhere to the interventions'.[1] One could also question whether accessing treatment modules and email contact are 'strict criteria' to guarantee adherence to the graded activity protocol. Although the authors state that 'The treatment is tailored to a patient's current activity pattern as assessed with actigraphy', (increased) activity levels was not included in the adherence criteria.

According to the authors, both iCBT conditions are efficacious, since 29/80 (36%) in the protocol-driven feedback iCBT group and 34/80 (43%) in the feedback-on-demand iCBT achieved the 'normal range' for Checklist Individual Strength fatigue severity, compared with 12/80 (15%) in the waiting list group.[1] However, the treatment effects of the protocol-driven feedback iCBT and feedback-on-demand iCBT in the study are by far insufficient to achieve 'normal levels of fatigue' (Checklist Individual Strength fatigue severity $\leq$27) as defined in another study by two of the

https://doi.org/10.1192/bjp.2018.136 Published online by Cambridge University Press

authors of Janse *et al*.[2] Looking at the Sickness Impact Profile 8 and Medical Outcomes Survey Short Form-36 physical functioning scores after the intervention at the group level (scores at the individual level are not reported), both iCBT groups would still be qualified as 'severely disabled'.

The effect of protocol-driven feedback iCBT and feedback-on-demand iCBT on objective measures are not reported, but other studies by the research group have shown that a CBT protocol has no effect on (low) physical activity levels, number of hours worked or cognitive test scores.[2]

The authors label their intervention CBT.[1] However, looking at the protocol, the intervention investigated not only incorporated CBT, aimed at 'behaviours and beliefs' perpetuating 'fatigue and impairment', but also included a graded activity programme, known as graded exercise therapy (GET). Several large-scale patient surveys and studies, for example Cheshire *et al*,[4] indicate that CBT, especially when combined with GET, can cause iatrogenic harm and is not safe.[5]

In conclusion, the study does not substantiate the claim that iCBT/GET for CFS is efficacious, while there are several indications CBT/GET is not a safe therapy.

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Frank Twisk, researcher, ME-de-patiënten Foundation, the Netherlands; **Lou Corsius**, researcher, the Netherlands. Email: frank.twisk@hetnet.nl

doi:10.1192/bjp.2018.136

https://doi.org/10.1192/bjp.2018.136 Published online by Cambridge University Press