

From the Editor's desk

By Peter Tyrer

Choice, guidelines and guidebinds

Choice, uncertainty and ambivalence all run in parallel, and as a monozygotic twin I am constantly aware of this. Since the age of consciousness I have had the luxury of choosing either to let people know who I am or to keep them guessing. Geneticists, please note: this is a unique feature of monozygosity that may explain some otherwise unusual findings.¹ So I and my co-twin have taken opportunities to masquerade as the other twin from the time we were at school to presentations at international conferences, and when things go wrong each of us could claim the other was responsible. But this is merely mischief. The exercise of proper choice carries with it the transfer of power and responsibility and is currently going through a radical change, with the views of patients and carers taken into account in both decision-making and research.^{2,3} But the transfer of choice has another consequence: less is now exercised by the person who in former days had total control, the psychiatrist. This is exemplified by the review of an old treatment, abreaction for conversion disorder (Poole *et al*, pp.91–95), whose history demonstrates the very different distribution of power in past patient–doctor relationships. Now not only do patients make their voices and choices heard, but clinicians are assailed by guidelines from all sides, even on subjects where there is little or no evidence available.⁴ Some guidelines are good, but they can emasculate the practitioner by taking choice away. But clinicians are specially trained to choose, to use skills that allow them to select treatments, and many colleagues regard this as an essential role of the psychiatrist that is in danger of disappearing.⁵

This other element of choice is seldom recognised in formal clinical trials – randomisation is the antithesis of choice – but in this issue we publish the first double single-blind trial in our history in which two randomisations took place, first to a process of either systematic treatment selection (good old-fashioned clinical choice), or random treatment selection of cognitive–behavioural therapy or psychodynamic psychotherapy. This is rather like testing the satisfaction of a group of diners at a restaurant, where some of whom are allowed to select one of two menus and the rest randomised to them. One might have thought that the selected group would be happier; they were, but only in those selected for the psychodynamic option. Cognitive–behavioural therapy, like a meal made with the confidence of a chef at his peak, impresses equally even if it has not been chosen. So a change is needed; as Fonagy (pp.83–85) concludes, ‘uncritically implemented parameters of therapeutic psychodynamic practice inherited from the past century can yield disappointing results’. It is clear from other papers in this issue that the clinical skills of the psychiatrist should still be valued and that guidelines should never be guidebinds. Treloar *et al* (pp.88–90) make this very clear in their impassioned plea for common sense to be applied in the treatment of behaviour symptoms in dementia, and Leone (pp.86–87) and Ball *et al*

(pp.106–113) illustrate that preoccupation with specific treatments for fatigue and depression may obfuscate the broader clinical problems which need addressing when both occur together. The exercise of choice also depends on having resources to implement them. The cycle of financial disadvantage created by mental disorder in all forms is spelt out clearly in two of our papers (Levinson *et al*, pp.114–121; Gibb *et al*, pp.122–127) and these reinforce the need for controlled evaluation of the long-term economic impact of new initiatives⁶ that could have the joint benefit of better mental health and increased earnings.

I should add a caveat about the attraction of dissociative identity choice in monozygosity. It has a downside. Once I attended a meeting and noticed someone who at first seemed to recognise me and then gave me increasingly hostile looks. After a little time I cottoned on. I went over to him and started to explain, ‘I think you think you know me but you don’t.’ I wanted to continue to explain my genetic status but he would have none of it. ‘Nonsense’, he expostulated, ‘don’t you know you were best man at my wedding?’ Perhaps I was, as my genes certainly were.

Making more impact

Although I am among many who are keen on getting a better measure of merit for journals than the impact factor,⁷ it is still heartening to note that this alleged record of esteem has now risen to 5.78 for the *British Journal of Psychiatry*, its highest ever, and that the cited half-life (a measure of long-term impact) remains over 10 years. In my own personal league table the impact factor has to jostle to find its place among the ‘eclectic mix of original articles, reviews, editorials, reappraisals, comment, opinion and extras, the latter including poetry, short summaries, literature and psychiatry, and a touch of humour’⁸ that constitute our journal and if it is squeezed into secondary importance at times it is better than regarding it, in the paraphrased words of John Keats, as the absolute fount of excellence:

‘The impact factor shalt remain, in midst of other woe
Than ours, a friend to man, to whom thou say’st,
‘Beauty is truth, truth beauty, – that is all
Ye know on earth, and all ye need to know.’

- 1 Ball HA, Sumathipala A, Siribaddana SH, Kovas Y, Glozier N, McGuffin P, et al. Genetic and environmental contributions to depression in Sri Lanka. *Br J Psychiatry* 2009; **195**: 504–9.
- 2 Waddell L, Taylor M. Attitudes of patients and mental health staff to antipsychotic long-acting injections: systematic review. *Br J Psychiatry* 2009; **195** (suppl 52): s43–50.
- 3 Lawrence V, Murray J, Samsi K, Banerjee S. Attitudes and support needs of Black Caribbean, south Asian and White British carers of people with dementia in the UK. *Br J Psychiatry* 2008; **193**: 240–6.
- 4 Kane JM, Garcia-Ribera C. Clinical guideline recommendations for antipsychotic long-acting injections. *Br J Psychiatry* 2009; **195**: s63–7.
- 5 Craddock N, Antebi D, Attenburrow M-J, Bailey A, Carson A, Cowen P, et al. Wake-up call for British psychiatry. *Br J Psychiatry* 2008; **193**: 6–9.
- 6 Clark DM, Layard R, Smithies R, Richards DA, Suckling R, Wright B. Improving access to psychological therapy: initial evaluation of two UK demonstration sites. *Behav Res Ther* 2009; **47**: 910–20.
- 7 Bloch S, Walter G. The impact factor: time for a change. *Aust N Z J Psychiatry* 2001; **35**: 563–8.
- 8 Tyrer P. The place of the *British Journal of Psychiatry* in the mental health league. *Epidemiol Psychiatr Soc* 2010 (in press).