BJPsych The British Journal of Psychiatry (2016) 209, 270. doi: 10.1192/bjp.209.3.270

From the Editor's desk

By Kamaldeep Bhui

Biosocial interventions in psychological medicine

Mental illness continues to challenge governments, policy makers and practitioners around the world, with greater recognition now of disabilities and impacts on economic growth. To promote global mental health, cooperation and trust are needed across a broad range of constituencies, to encourage learning between low- and high-income countries, but also between countries that share a context of poor resourcing of services.[1] Given the shortfalls, creative solutions are needed and scientific advances are at the heart of how to intervene more effectively – one of the themes exemplified by the impressive lifetime of work by the late Professor Michele Tansella.[2] This does require us to rethink our conventional approaches to professional identities and inflexible ways of intervention, taking account of societal and biological aetiologies and impacts that are inextricably intertwined. There is no conscious mind without biology, nor mental illness without biological correlates and pathophysiology. Similarly, psychotherapeutic interventions are effective in both addressing societal adversity and adapting to and surviving disease affecting biological functions, for example, in psychiatric research about the treatment of addictions,[3] brain imaging studies,[4] and studies on the treatment of cardiac disease[5] and cancers.[6] Scientific endeavours are now revealing more complex models of disease that reflect staged life-course adversity interacting with individual and group-level cumulative genetic and biological vulnerabilities, ultimately manifesting as illness experiences that relate to both dysfunction and social maladies. For example, social environment, including deprivation, social support and protections against violence all shape future risk trajectories. The interventions we offer should be cognisant of the patient's priorities and the range of concerns they bring, rather than only seeking round hole (disease) specialists and treatments for round hole diseases and square hole specialists for square hole diseases.[a] The intersectional and interactive nature of the causes of and remedies for mental illnesses demand a rethink. Knowledge silos prevent us from harnessing the evidence base, and overlook the shared essential ingredients of a therapeutic alliance including trust, confidence, competence, and commitment to shared goals. To break down the silos, specialists will need to become generalists, and marshal a wider array of interventions, so breaking down disciplinary territorial, geographical and attitudinal boundaries. Scientific journals play an important role in connecting people across disciplines, countries and traditions of intervention. Vivekanantham *et al* (pp. 257–261) show that medical journals tend not to publish psychiatric research as much as might be expected, given the close relationship between aetiologies and treatments for medical disorders of body and mind. Indeed, premature mortality in people with severe mental illness is a major and unremitting concern; Black and minority groups at high risk of mental illness may be vulnerable to even greater mortality rates (see Das-Munshi *et al*, pp. 183–185), yet insufficient research compounds the lack of action to reduce premature mortality.

Treatments

Studies by Ingman *et al* (pp. 251–256) and Sanatinia *et al* (pp. 244–250) show the effectiveness of psychotherapy treatments for, respectively, chronic fatigue in Black and minority ethnic patients, and health anxiety in people with personality difficulties. The negative finding from Coleman *et al*'s innovative 'therapy-genetic' investigation (pp. 236–243) recommend larger samples to realise a future practical benefit if there are important genetic influences on benefits gained from psychotherapy. Anxiety is a disabling illness associated with significantly increased mortality risk (Meier *et al*, pp. 216–221). Gingnell *et al* (pp. 229–235) show that addition of an antidepressant to internet-based cognitive–behavioural therapy improves outcomes of social anxiety disorder, and the improvements correlate with diminished activity in the amygdala. Diefenbach *et al*'s report (pp. 222–228) of improved anxiety, worry and depressive symptoms following repetitive transcranial magnetic stimulation also highlighted activation of the dorsolateral prefrontal cortex in the intervention group, and that this activation correlated with improvements in worry symptoms. Omega fatty acids improve depressive symptoms among patients with a clear diagnosis of depression, but not in the general population (Hallahan *et al*, pp. 192–201), reminding practitioners of the importance of careful targeting of interventions.

Classification and diagnosis

To help us avoid round and square hole psychiatry, several studies this month tackle classification and diagnosis. Although there is often confusion in practice between borderline personality disorder and bipolar disorder,[7] Parker *et al* (pp. 209–215) show that patients with bipolar disorder differed from those with comorbid borderline personality disorder on demographic, illness and personality variables. De Jong *et al*'s (pp. 202–208) study of gene expression in peripheral blood, in patients with psychiatric disorders and healthy controls, identified both cross-disorder and disorder-specific signatures for adult attention-deficit hyperactivity disorder and major depressive disorder, suggesting new pathways for the co-expression of risks. Salekin's editorial (pp. 189–191) draws attention to the importance of psychopathology, especially to better understand psychopathy in childhood and not let this severe condition be lost in a rather overinclusive diagnosis of conduct disorder in which the role of impulsivity may be unnoticed.

1 Collins PY, Saxena S. Action on mental health needs global cooperation. *Nature* 2016; **532**: 25–7.

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3 Feldstein Ewing SW, Chung T. Neuroimaging mechanisms of change in psychotherapy for addictive behaviors: emerging translational approaches that bridge biology and behavior. *Psychol Addict Behav* 2013; **27**: 329–35.

4 Marano G, Traversi G, Nannarelli C, Pitrelli S, Mazza S, Mazza M. Functional neuroimaging: points of intersection between biology and psychotherapy. *Clin Ter* 2012; **163**: e443–56.

5 Tan MP, Morgan K. Psychological interventions in cardiovascular disease: an update. *Curr Opin Psychiatry* 2015; **28**: 371–7.

6 Spiegel D. Minding the body: psychotherapy and cancer survival. *Br J Health Psychol* 2014; **19**: 465–85.

7 Bayes AJ, McClure G, Fletcher K, Roman Ruiz Del Moral YE, Hadzi-Pavlovic D, Stevenson JL, et al. Differentiating the bipolar disorders from borderline personality disorder. *Acta Psychiatr Scand* 2016; **133**: 187–95.

[a] I owe a debt of gratitude for this phrase and much more, to my mentor, the remarkable Professor Jim Watson, who sadly passed away in August 2016.

https://doi.org/10.1192/bjp.209.3.270 Published online by Cambridge University Press