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Highlights of this issue

By Derek K. Tracy

Something old, some things new

Jon Ronson said 'ever since I first learned about confirmation bias, I've been seeing it everywhere'; undoubtedly true, but there does seem to have been an enormous growth in mindfulness in mental health. It has existed in various forms for millennia, with mindfulness-based cognitive therapy (MBCT) a variation on this, adding cognitive elements to mindfulness-based stress reduction. Kaleidoscope (pp. 90–91) notes a meta-analysis supporting efficacy of MBCT in relapse prevention in depression – including superiority over antidepressants – and Wong *et al* (pp. 68–75) report on the first large randomised controlled trial (RCT) in generalised anxiety disorder (GAD). This latter study randomised participants with GAD to 8 weeks of MBCT, CBT-based psychoeducation, or treatment as usual, and followed them up over 6 months. Both active interventions demonstrated approximately equivalent benefit over ordinary care. Against expectation, psychoeducation was deemed more acceptable; the authors put forth an interesting hypothesis that for the tested participants in Hong Kong – most of whom were speculated to be culturally familiar with meditative processes – the psychoeducation may have appeared more 'Western' and 'scientific'.

Psychological interventions in tic disorders traditionally focus on habit reversal training, but O'Connor *et al* (pp. 76–83) detail a novel intervention: cognitive psychophysiological therapy. The principle is that rather than address the tic in isolation, one alters the background activity against which it occurs, modifying planning and inhibiting central and peripheral motor action to prevent tic onset. Effect sizes were large both in those with Tourette syndrome and in those with chronic tics by the end of the 10-week open programme, with benefits maintained to the 6-month end-point. Freeman and colleagues (pp. 62–67) show the utility of a virtual reality-based cognitive therapy that allowed testing of persecutory delusions and produced significant reductions in distress and delusional conviction. It's not often that a virtual reality trial doesn't qualify as the most boundary-pushing item in a volume of the *BJPsych*, but Kaleidoscope (pp. 90–91) also notes an RCT on the fantastical-sounding intervention of whole-body hyperthermia for depression.

Social care

What does recovery look like, and what helps people get there? Sam Harvey's team (Modini *et al*, pp. 14–22) took on the critical issue of employment: we know that far too few individuals with psychosis attain paid employment, yet it has well-evidenced benefits in terms of general well-being and self-esteem, reduced psychopathology, and enhanced social contact and finances. They meta-analysed a specific type of intervention – individual placement and support – and found it more effective than traditional vocational rehabilitation. Interestingly, and importantly, the findings held in studies across different jurisdictions that had varying employment frameworks and base rates of unemployment. This fits well with Law *et al*'s (pp. 48–53) longitudinal investigation of predictors of recovery in individuals with psychosis. Although recovery is a unique personal perspective, subjective senses of attaining this were found to be most associated with psychosocial factors and negative emotion, not psychiatric symptoms. All of which adds succour to the editorial by Ventriglio and colleagues (pp. 1–2) which argues that as we are social animals, the external framework of our environment and relationship networks should form the basis of psychiatry, rather than a predominating preoccupation with 'internal' symptoms. It's an interesting journey insofar as psychiatry has an unhappy tradition – or, perhaps more accurately, traditional criticism – of policing and enforcing digressions against perceived social norms.

Co-design: language matters

Among the core findings of the Francis report was the variation between patient and staff perceptions of care, and the need to understand the factors that drove this. Csipke *et al* (pp. 35–39) evaluated this issue in in-patient units over 18 months; their findings are sobering, with a significant deterioration in experiences of both patients and staff across the trial. Ward systems of care did not improve patient experience, and triage units were found to be potentially detrimental to staff well-being. It's difficult to square all of this, in what is the first such study of its kind. The authors reasonably look to broader trends of National Health Service budget reductions and increased demand on throughput. This is probably also a reflexive initial response for many of us who work in pressurised and stressed in-patient services. How to improve patient experience? More work is needed, the issue is critical; Stovell *et al* (pp. 23–28) reviewed the effects of shared decision-making with individuals with psychosis, something the majority say does not happen in their interactions with professionals. While such joint working did produce a greater sense of empowerment – and a reduction in compulsory treatment – the effect sizes were disappointingly smaller than one might predict (or hope for).

Which segues nicely into the hoary patient/service user/client argument. Does the phrasing matter? Empowerment, respect, or just new-speak? We've been here before, but the argument never seems to have a single or final answer. In the context of the College deciding upon 'patient' as the way forward, David Christmas and Angela Sweeney debate the issue (pp. 9–13); will their arguments sway your preconceptions or choice of word? There will probably be more agreement on the importance of nuance in *how* we speak to each other in clinical interactions, though it's been a scientifically rather unexplored issue. Thompson and colleagues (pp. 40–47) classified questions across a range of out-patient clinic consultations, and found that we tend to regularly use only four of ten possible question types, with only *declarative questions* predicting better adherence and perceptions of the therapeutic relationships. So, that's clear to you now?

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