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Editorial

Welcome to this psychological therapies special issue of Mental Health and Learning Disabilities Research and Practice. Authors were invited to submit papers that addressed current concerns about the accessibility of psychological therapies. While the question of access to therapy has a particular United Kingdom and National Health Service focus, the question of how to provide more good quality psychological therapy is of international interest and this is reflected in the papers in this issue.

The prospect of an increase in service provision, although generally welcomed, brings with it concerns about the best way forward. Politics, where “a week is a long time”, and science move to different rhythms. It is understandable that politicians are impatient with the time it takes scientists to come up with definitive answers to their questions, while scientists fear that decisions are made hastily on the basis of insufficient evidence.

Within the scientific and clinical communities, there can also be a tension between “facts” as they are established in laboratory conditions and those apparent from clinical experience and observation. Where formerly researchers tended to see the divide between research evidence and clinical practice as a failure to implement knowledge, a more reflective and philosophically sophisticated debate is now emerging.

Leichsenring and Rabung explore the theme of the appropriate paradigm for psychotherapy research in depth (pp. 125-144). They describe the current requirement that evidence be based on Randomised Controlled Trials (RCTs) and the many reasons why evidence gained in such a way may not apply to usual clinical practice. They offer a philosophical understanding of a phenomenon well known to therapists; which is that RCTs study what may be termed “laboratory therapies” under laboratory conditions and then draw unwarranted conclusions about what therapies will be effective in service settings. They argue that RCTs and effectiveness studies do not fundamentally differ in their internal or external validity, and RCTs do not necessarily provide higher-level evidence than effectiveness studies. **Stratton** (pp. 83-98) addresses “the persisting dominance of the competitive outcome question despite its long history of relative failure in mental health”. He offers a critique of the RCT research paradigm, research funding and the medical model of anxiety and depression.

The debate over the most appropriate approach to measuring psychotherapy outcome is important but is not the only debate in psychotherapy research. **Sales et al.** discuss the use of an idiographic measure, the Personal Questionnaire, and a process measure, Helpful Aspects of Therapy. These measures in different ways contribute to a greater understanding of the processes of therapy and the particular impacts it makes on individuals. This approach to tracking the progress of psychotherapy may lead to a clearer understanding of what is helpful to particular individuals in cases where outcome data is insufficiently sensitive.

The paradigm of psychological therapy selection determines what psychological therapies are chosen and is felt by some authors to favour one particular mode of therapy, i.e. cognitive behavioural therapy (CBT). Several authors address the question whether CBT should predominate and/or exclude other approaches. **Winter** (pp. 73-82) asks if CBT is always the best therapy. He argues that the case for the superiority of CBT is not clear-cut and for the selection of therapies based on the personal style of the client. **Stratton** offers the alternative of recognising that a person's psychological condition is a function of their context and their relationships. He points to the effectiveness of systemic interventions, variations in effectiveness among therapists and the central role of the therapeutic alliance. **Ahmed et al.** (pp. 175-188) describe a model of working incorporating ideas from CBT but presented in a less complex manner making them accessible to less highly trained professionals.

Access to psychological therapies depends on how individuals seek therapy and how the therapy is organised and delivered. The former question is addressed by **Saunders and Bowersox** (pp. 99-124), who offer a model of help seeking that describes the processes that individuals engage in before asking for professional help. They remind us that people suffering with mental health problems are actively making decisions, wise and unwise, about their lives that have positive or negative effects on the resolution of these problems. They suggest that improving access to psychological therapies will require attention to the entire process of help seeking rather than simply concentrating on availability of resources.

Butler et al. (pp. 161-174) address service delivery. They offer a practical account of how drawing, previously separate and poorly communicating, services together within a psychological therapies managed structure and developing a rational allocation system has reduced waiting times.

Psychological Therapies of any type depend on the existence, recognition and organisation of professionals competent to deliver them. The articles by **Kinderman and Tai** (pp. 189-203), **Ng** (pp. 205-217) and **Schulte** (pp. 219-230) describe professional issues in three countries. Kinderman and Tai emphasise the wide range of skills and activities offered by clinical psychologists. They see CBT as evidence based and useful but only one of several evidence based and useful therapies and formulation rather than a particular therapy as the basis for intervention. Ng provides an account of psychotherapy in Malaysia. He describes some of the difficulties of applying western therapies in a country with diverse languages, religions and cultural norms. The success of incorporating Islamic and socio-cultural elements in cognitive therapy illustrates an adaptation of western approaches to meet local need that may have application in other cultural

settings. Schulte describes the impacts of the introduction in 1999 of a new law creating the new professions of “Psychological Psychotherapist“and “Child and adolescent psychotherapist” in Germany.

Rowe (pp. 231-237) offers a historical perspective reminding us of the few years that have passed since models of depression were predominantly medical and biological. She distinguishes models of human beings that see them as puppets or agents. She argues that although the accounts of the factors leading to mental illness have become more sophisticated they still imply that individuals are caused to be depressed by external factors rather than their way of interpreting these factors.

The possibility of increased funding for psychological therapies brings with it an urgency to fund a programme of research that will begin to fill the gaps in our knowledge. Some of these gaps, illuminated by the papers in this issue, are summarised below:

Existing Research	**Research Needed**
Research Clinics	Service Settings
Single diagnosis, low severity, acute	Multiple diagnosis, high severity, long term
Restricted range of “pure” therapies	Including eclectic and integrative approaches
Randomised Controlled Trials	Effectiveness Studies
First Interventions received by client	Following failed interventions
Outcome	Process and Outcome
Therapist variation ignored	Therapist variation a finding

As the Secretary of State for Health demands “an NHS which is clinically led and locally driven”, it may be appropriate to foster research that is service based and naturalistic. This does not mean ignoring or abandoning traditional efficacy research but rather accepting that knowledge derives from a variety of paradigms. A research programme that actively engages the perspectives of clinicians and service users as well as academics presents a challenge to traditional approaches to organising and funding research. The potential reward is far more clinically meaningful research and more informed change in clinical practice.

The need to tackle human misery and the appropriateness of talking therapies for the task are not new discoveries. What is new is a consensus among politicians, economists, clinicians and the public that we need to move ahead and the debate is about how. We believe that this issue informs that debate.

Jeremy Halstead– Editorial lead.

SPECIAL ISSUE - DEDICATED TO THE MEMORY OF TIM LISTER

This issue is dedicated to Dr Timothy Lister, who died just before we went to press after a long, brave battle with lymphoma. Tim was a wonderful colleague and friend who was in at the planning stage of this journal and who has been a dedicated member of the Editorial Board ever since. As with all his work, Tim contributed a lot of energy and careful thought into the development of the journal. He was committed to making the journal available to people who would not read the usual scientific journals and pioneered the use of non-scientific, accessible language, reflected in his own article for the journal, published in our second issue ("What does cognitive therapy change? It makes you think more carefully about the bad stuff"). He defended this lay-friendly language at the Editorial Board meetings, as long as it didn't imply poor science. As well as planning, Tim worked hard with authors and peer reviewers, helping to turn articles into reports that would be scientifically rigorous but as accessible as possible to all readers.

Tim worked as a therapist in Halifax, West Yorkshire, having trained as a clinical psychologist, with further specialist training in cognitive behaviour therapy (CBT) and eye movement desensitisation and reprocessing (EMDR). He had an inquiring mind, whether he was with clients or doing research. What came across to clients and colleagues alike was a man who was extremely modest, underestimating his own considerable ability, but always using his own uncertainties to think things through in ways that would help others most effectively.

Tim was also very dedicated to his family, his wife Karen and his two children Ewan and Amber. Everyone whose lives he touched will miss him a great deal.