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From the Editor's desk

By Peter Tyrer

The quintessence of fact

In the parched desert of ignorance and prejudice every established fact becomes an oasis. By 'established fact' I mean one that defines the field, the one that all the related and restlessly inchoate facts gather round and say 'I belong here', and then fall into line behind it. Every editor likes to feel they can identify these established facts as they peruse the manuscripts that flood into every journal office nowadays. Here are some from this month's issue.

1. Abortion is bad for your mental health.
2. Olanzapine is of no value for people with borderline personality disorder.
3. Cornelia de Lange syndrome is clinically an autistic-spectrum disorder.
4. Untreated phenylketonuria leads to apparently permanent and severe disability.
5. CD–ROM interventions alone are limited in value for eating disorders.

Why are these likely to be strong enough to become established facts? Fergusson *et al* (pp. 444–451) provide prospective data in an unselected population that mental disorder is 30% higher in those who have had abortions. He and his colleagues have no ideological axe to grind; their data dictate their paper and, after looking hard and long at all other possible confounders, they cannot account for their data in any other way. Of course, how one interprets this fact is quite a different matter, and Dingle *et al* (pp. 455–460) add more grist to the mill, but despite the wide variation shown in our commentaries (Casey/Oates *et al*, pp. 452–454) none disputes the essential science and the results. Olanzapine is an atypical antipsychotic drug now showing evidence of efficacy in a very large range of psychiatric disorders, not only schizophrenia and schizoaffective disorder,[1] those at risk of schizophrenia,[2] bipolar and other mood disorders,[3] and anxiety disorders.[4] It might therefore be expected that borderline personality disorder, which manifests features of all the above conditions, would respond to this drug. But it doesn't, and please note that this publication includes many authors from a pharmaceutical company, whose contribution normally is associated with studies showing positive efficacy.[5] So I judge this study to convey another essential fact that may help to put other studies into a better diagnostic and treatment perspective,[6,7] as well as pointing our attention to the potential value of psychological treatments, including cognitive analytic therapy, the first randomised trial of which is reported by Chanen *et al* (pp. 477–484).

Cornelia de Lange syndrome, a condition associated with chromosome abnormalities, was identified as having some overlap with autistic disorders many years ago[8] but Oliver *et al* (pp. 466–470) show clearly that it is right in the middle of this spectrum with particularly marked compulsive features, a characteristic that separates it from some disorders showing lesser handicap.[9] One of the preventable forms of severe intellectual disability, phenylketonuria, has disappeared from many people's view since the recognition of the value of phenylalanine-restricted diets, and Murphy *et al* (pp. 501–502) have done us a service in showing that those with the condition that preceded this advance – many fewer than they thought – are still severely handicapped despite living longer[10] and deserve the opportunity of the randomised trial they are suggesting. And so we move on to my last established fact, now becoming clearer with every succeeding study. We are increasingly enchanted with the notion of computer as therapist in a world of exciting new technology and nearly one in five people use it for medical purposes.[11] But computers are never personal; even their screen messages give the impression of being produced by aggressive Daleks, and it is a sad established fact that the most effective of treatments does not quite live up to its potential when given by an inanimate program. Schmidt *et al* (pp. 493–500) confirm what we have suspected for some time:[12] without the human touch psychological treatments go sadly awry and lose their edge.

The primrose comic

As we come to the end of our first year of the new-look *Journal* it is a good time to reflect on the reaction to our revised cover and contents. I have taken the trouble to canvas as much opinion as possible and, although it may not be completely representative, here are my findings. At one extreme, some people have reacted with a sense of shock to the loss of a well-loved friend and do not like its replacement one little bit. 'It just looks like a copy of *Vogue*' said one of my colleagues, and while I am not quite sure if this should be interpreted as a compliment or an insult to either journal, it does tilt towards the negative. Others have embraced it with enthusiasm and excitement and regard the change as an advance. There is also a split in opinion by age. I was made aware of this at a dinner for honorary Fellows of the College recently when a surprisingly large number came up with comments about the new look that could be summarised in the cantankerous words of Victor Meldrew in the series *One Foot in the Grave*, 'I cannot believe it'. Well, sorry, it looks as though it will be with us for some time yet.

Some years ago one of my correspondents from Australia informed me that there the *British Journal of Psychiatry* is often referred to as 'the primrose comic'. I've always quite liked this. So why not celebrate our journal as the epitome of *Primula vulgaris*:

What is wrong with the primrose comic
Part content unashamed and plain
Mixed with the mildly histrionic
To joint explain and entertain?

1 Keks NA, Ingham M, Khan A, Karcher K. Long-acting injectable risperidone *v.* olanzapine tablets for schizophrenia or schizoaffective disorder. Randomised, controlled, open-label study. *Br J Psychiatry* 2007; **191:** 131–9.

2 Hoffman RE, Woods SW, Hawkins KA, Pittman B, Tohen M, Preda A, Breier A, Glist J, Addington J, Perkins DO, McGlashan TH. Extracting spurious messages from noise and risk of schizophrenia-spectrum disorders in a prodromal population. *Br J Psychiatry* 2007; **191**: 355–6.

3 Derry S, Moore RA. Atypical antipsychotics in bipolar disorder: systematic review of randomized trials. *BMC Psychiatry* 2007; **7**, 40.

4 Gao K, Muzina D, Gaiwani P, Calabrese JR. Efficacy of typical and atypical antipsychotics for primary and comorbid anxiety symptoms or disorders: a review. *J Clin Psychiatry* 2006; **67**: 1327–40.

5 Tungaraza T, Poole R. Influence of drug company authorship and sponsorship on drug trial outcomes. *Br J Psychiatry* 2007; **191**: 82–3.

6 Linehan MM, McDavid JD, Brown MZ, Sayrs JH, Gallop RJ. Olanzapine plus dialectical behavior therapy for women with high irritability who meet criteria for borderline personality disorder: a double-blind, placebo-controlled pilot study. *J Clin Psychiatry* 2008; **69**: 999–1005.

7 Kirkpatrick T, Joyce E, Milton J, Duggan C, Tyrer P, Rogers RD. Altered memory and affective instability in prisoners assessed for dangerous and severe personality disorder. *Br J Psychiatry* 2007; **190** (suppl. 49): s20–6.

8 Prior MR. Biological and neuropsychological approaches to childhood autism. *Br J Psychiatry* 1987; **150**: 8–17.

9 Bradley E, Bolton P. Episodic psychiatric disorders in teenagers with learning disabilities with and without autism. *Br J Psychiatry* 2006; **189**: 361–6.

10 Jancar J. Increased life expectancy in people with untreated phenylketonuria. *J Intellect Dis Res* 1998; **42**: 97–9.

11 Powell J, Clarke A. Internet information-seeking in mental health: population survey. *Br J Psychiatry* 2006; **189**: 273–7.

12 Carlbring P, Gunnarsdóttir M, Hedensjö L, Andersson G, Ekselius L, Furmark T. Treatment of social phobia: randomised trial of internet-delivered cognitive–behavioural therapy with telephone support. *Br J Psychiatry* 2007; **190**: 123–8.