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# From the Editor's desk

By Peter Tyrer

## Guarding the sacred professional ark

I recently took part in a psychoanalysis conference and it was an exciting experience. Interpret that as you will. Not surprisingly, in this evidence-preoccupied cost-conscious world, many of the participants felt as an embattled army under siege. One of the possible solutions, of retrenchment behind the certainties of the past, was beautifully summarised as 'guarding the sacred ark'. Any complacency I may have felt after this experience – reassuring myself that at least general psychiatry is not under such threat – was rudely shattered the following week at a European meeting on global mental health development, where one of the delegates claimed that in most parts of the world psychiatrists were not needed; in most places values and skills were important but the specialist knowledge of the psychiatrist was largely redundant. There were nods of approval from delegates who came from countries in which there is less than one working psychiatrist per million population, and where mental healthcare bears no resemblance to that in the affluent West. There are further jolts to professional complacency in this issue of the *Journal*. We have prided ourselves for more than a century that we are neo-Kraepelinians and now rely on science more than observation and dogma. But Lawrie *et al* (pp. 423–425) pick again at another festering wound that damages our professional status and practice[1] – the merits of separating or combining the diagnoses of the major psychoses[2–5] – in proposing a hybrid of continuous and categorical classifications that might have substance but I worry may merely paper over the cracks in our confidence as diagnosticians.

Mendel *et al* (pp. 441–447) add to our self-flagellation by elegantly pointing out that in our professional work we behave more like Madame Bovary than Candide, pretending we are being honest and independent when all the time acting differently when it comes to our personal lives. As Crawford & Dunlea (pp. 429–430) point out, patient-centred opinions differ from disease-focused ones, and we keep the patient-centred ones out of the consulting room too often, in making both short- and long-term decisions about care.[6,7] I have always felt that one of the reasons why cognitive–behavioural therapy is so successful in psychiatry is that it listens to patients and incorporates them in decision-making. One population in which it may not be so effective is the adolescent one, shown clearly in the meta-analysis by Dubicka *et al* (pp. 433–440). In my shallow way I interpret this as a consequence of homework being incorporated into standard therapeutic practice. An abhorrence of homework was incorporated into my adolescent thinking and possibly explains why a different, more patient-centred approach, may be better in this group.[8] But, as Davidson *et al* (pp. 456–462) might suggest, we need a longer period of follow-up before we can reach a considered verdict, and these studies are the ones that count in the long run. So do not despair at the lack of certainty and direction in your reading of this month's *Journal*. Perhaps the answer is not to guard the sacred ark but to open all its doors and come to joint agreements of mutual respect.

## Opinion and fact

I referred in my first contribution as Editor to C. P. Scott's famous dictum that guarded his ark of good journalism, 'Comment is free but the facts are sacred',[9] but also suggested that 'increasingly, it is informed and judicious comment that is getting closer to being sacred than the mere accumulation of facts'. I did not always follow this plan in my early editorial years but readers will have noticed that we are now adding much more judicious comment to our original articles, mainly in the form of editorials. My colleague who shattered my psyche at the European meeting by his low opinion of psychiatrists also told me frankly that virtually none of the scientific articles in the *British Journal of Psychiatry* was worth reading as they had no relevance to him in his daily work. I still think that the advice I gave a short time ago, to look at each article more than once before coming to a verdict,[10] is apposite here, but a good editorial does the job more effectively. So after reading the article by Staring *et al* (pp. 448–455), and wondering why treatment adherence therapy has not been used before, read the editorial by David (pp. 431–432) and get the study into good and proper perspective. And even my sceptical colleague representing the Rest of the World versus Albion, would be interested in the evidence from Pickett & Wilkinson (pp. 426–428) that inequality and deprivation are not just the lot of low- and middle-income countries. They surround us in the West and any feelings of personal superiority those in the UK may have in our universal National Health Service should be tempered by looking at Figure 1 of their paper. And look who is top of the inequality mental health league: the USA. Perhaps Emma Lazarus's words at the foot of the Statue of Liberty need a reminder in larger lettering:

> Give me your tired, your poor,
> Your huddled masses yearning to breathe free,
> The wretched refuse of your teeming shore.
> Send these, the homeless, tempest-tost to me.


1 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.

2 Bora E, Yucel M, Pantelis C. Cognitive functioning in schizophrenia, schizoaffective disorder and affective psychoses: meta-analytic study. *Br J Psychiatry* 2009; **195**: 475–82.

3 Lencz T, Lipsky RH, DeRosse P, Burdick KE, Kane JM, Malhotra AK. Molecular differentiation of schizoaffective disorder from schizophrenia using *BDNF* haplotypes. *Br J Psychiatry* 2009; **194**: 313–8.

4 Hamshere ML, Green EK, Jones IR, Jones L, Moskvina V, Kirov G, et al. Genetic utility of broadly defined bipolar schizoaffective disorder as a diagnostic concept. *Br J Psychiatry* 2009; **195**: 23–9.

5 Craddock N, Owen MJ. The Kraepelinian dichotomy – going, going . . . but still not gone. *Br J Psychiatry* 2010; **196**: 92–5.

6 Crawford MJ, Price K, Rutter D, Moran P, Tyrer P, Bateman A, et al. Dedicated community-based services for adults with personality disorder: Delphi study. *Br J Psychiatry* 2008; **193**: 342–3.

7 Bisson JI, Hampton V, Rosser A, Holm S. Developing a care pathway for advance decisions and powers of attorney: qualitative study. *Br J Psychiatry* 2009; **194**: 55–61.

8 Chanen AM, Jackson HJ, McCutcheon LK, Jovev M, Dudgeon P, Yuen HP, et al. Early intervention for adolescents with borderline personality disorder using cognitive analytic therapy: randomised controlled trial. *Br J Psychiatry* 2008; **193**: 477–84.

9 Tyrer P. Entertaining eminence in the *British Journal of Psychiatry*. *Br J Psychiatry* 2003; **183**: 1–2.

10 Tyrer P. Read once – and repeat. *Br J Psychiatry* 2008; **192**: 82.