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From the Editor's desk

By Peter Tyrer

Humdrum conundrums

Talking to a group of general practitioners recently, after presenting what I thought were some pretty impressive data showing why we get so exercised about good diagnosis, I was asked, 'why do you bother with diagnosis at all in psychiatry when you don't know the answers?' My questioner would doubtless find this issue of the *Journal* boring and anodyne, as many papers are concerned with the complex interrelationship of four common disorders – between anxiety and depression and between psychopathy and antisocial behaviour. One of the reasons why these topics receive so much attention is that they account for a large part of the total psychopathology that exists in the community, probably as much as 20%,[1,2] maybe more when subthreshold conditions are taken into account.[3]

The purpose of diagnosis in psychiatry is to aid communication and understanding, promote correct treatment and predict outcome. I have not added 'identify pathology' because although this is also true we are still far from certain where normality ends and pathology begins with the common mental disorders.[4] The findings of Coryell *et al* (pp. 210–215) and others,[5–7] including Bogic *et al* (pp. 216–223), confirm, if indeed such confirmation were needed, that whatever differences there are between anxiety and depression as symptoms they are close brothers in psychopathology and, like close brothers, stay together to the end, and do not assist remission in any form. Our primary care colleagues regard the anxiety–depression conundrum as irritating and tedious; they cannot understand why we cannot sort it out rather better than we have done to date, and the acronym covering mixed anxiety and depressive disorder is an apposite index of their frustration. Biological explanations, as Andreescu & Lenze (pp. 179–181) acknowledge, always seem to be at the point of providing an answer but, as with Newton in his later years, never reach the point of converting these base diagnoses into gold. But we have to continue the quest as it is so important clinically. In this issue, for example, Huntley *et al* (pp. 184–190) suggest the potential value of group treatment for depression, but their review does not include anxiety factors at all, even though these are likely to be highly relevant when considering the merits of, and personal choices for, individual and group treatment.

Psychopathy and antisocial personality disorder are even closer brothers, often in crime. Our diagnostic systems have never got to grips with psychopathy as a diagnostic entity and so it does not appear in our classification systems except as antisocial personality disorder or, latterly, as dangerous and severe personality disorder (Sinclair *et al*, pp. 252–253). It is clear that personality disorder arises in childhood no matter when it is diagnosed and the work of Kumsta *et al* (pp. 197–201) points to a genuine distinction between conduct disorder and callous–unemotional disorder, or psychopathy, at a young age. This is reinforced by Dadds *et al* (pp. 191–196) and by Viding & McCrory (pp. 177–178) in their lively contributions, and there is some biological support for this diagnostic separation.[8] Rutter (pp. 175–176) makes a strong case for serious consideration of conduct disorder and psychopathy as separate conditions but recognises the need for caution in formal classification. The common outcome of such diagnostic debates is 'further testing needed' and the uncertainty over the place of conditions such as ADHD[9] and the limited number of longer-term outcome studies[10] reinforces this caution. In the ICD-11[11] and DSM-5[12] proposed revisions of the classification of personality disorder, psychopathy as an entity is unlikely to appear. My own feeling, possibly a prejudice, is that intelligent, charming and manipulative antisocial people, highly intriguing to the media,[13] are called psychopaths and that unintelligent, recidivist, charmless vagabonds are dismissed as antisocial. But enquiries will continue and I can reply to my GP friend cheerily: 'of course we don't know the answers, sir, but isn't the search for solutions more exciting than finding what is already known?'

Our typical reader

Those of you who are unfortunate enough to receive a rejection letter for an article submitted to the *Journal* will find it often includes a sentence suggesting the paper is not in the 'mainstream of interest for our readers, who are mainly clinical psychiatrists'. Here I am taking a leap into the unknown as I have no right to arrogate to myself the collective wisdom of our readership, but I thought it worthwhile to at least state what I think our readers would like from our *Journal*, and then wait for corrections, which I am sure will be many. First, there are many who read the *Journal* who are not psychiatrists, and we need to take account of their interests too. Indeed, we embrace all who are interested in mental health and our former title, *Journal of Mental Science*, indicated we cover a broad sweep. Next, I perceive that most of our readers are not primarily academic, but interested in getting on with understanding and treating those who are ill, not in faffing around at the edges. Finally, they want a bit of light relief from time to time, and I hope they can find it in the pages of the *Journal*. In short, our typical reader is someone who:

'Reads a little, but thinks a lot
Needs a modicum of cheer
Takes breakthroughs with a pinch of salt
Yearns a simple path to steer'

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7 Klein Hofmeijer-Sevink M, Batelaan NM, van Megen HJ, Penninx BW, Cath DC, van den Hout MA, et al. Clinical relevance of comorbidity in anxiety disorders: a report from the Netherlands Study of Depression and Anxiety (NESDA). *J Affect Disord* 2012; Jan 10, epub ahead of print, doi: 10.1016/j.jad.2011.12.008.

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10 Fergusson DM, Boden JM, Horwood LJ, Miller AL, Kennedy MA. *MAOA*, abuse exposure and antisocial behaviour: 30-year longitudinal study. *Br J Psychiatry* 2011; **198**: 457–63.

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13 Byrne P. And the winner is . . . the loser – psychiatry in the movies. *Br J Psychiatry* 2010; **197**: 304.