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From the Editor's desk

By Peter Tyrer

Undue veneration of accepted wisdom

Richard Asher, originator of the term 'Munchhausen's syndrome' and one of the most original literary minds in medicine, was once involved in an exchange with a correspondent who complained that Asher's criticism of something he had written was unfair because 'it was well-known'. 'Ah', replied Richard, 'but you make the mistake of assuming that what is well known is necessarily true'. The veneration of accepted wisdom comes under attack frequently in this issue. Many years ago a senior social worker refused to take part in one of our research trials because one of the randomised groups received much more resources than another. 'Why are you wasting your money on this?', she argued. 'It's well known that our service is underfunded so it's obvious that with more resources that group is bound to do better'. It didn't, and David Goldberg, in his special article (pp. 88–91), gives part of the answer why. A 48% increase in consultant psychiatrists over a 5-year period has not led to a 48% improvement in services, not least because a large proportion of the consultants' time is devoted to 'meetings with numerous managers, carrying out audit activities, filling in survey forms and reporting how they spend their time'. This is not just David Goldberg having a rant; I can say from personal experience it is not only true but extremely dispiriting for all those who want to give priority to good practice rather than good husbandry. Good husbandry is obsessed with records, including diagnosis, and tells us we must record this at all times. What it is does not tell us anything about is its likely validity or, as Cole *et al* (pp. 83–85) put it, 'few of those who use the two classification systems routinely . . . stop to reflect on them, let alone question their scientific veracity'. It is only when you see the capriciousness of these diagnoses longitudinally that you appreciate their inadequacies,[1] and when big national differences are detected something must be wrong (Post *et al*, pp. 150–151).

We have been similarly persuaded to believe that dopamine is the key neurotransmitter involved in schizophrenia and other psychoses but the pieces of the jigsaw are not all in place[2] and it is not heretical to look at other neurotransmitters also. Harrison (pp. 86–87) shows us the exciting possibility of glutamate receptors having a role too, with new evidence that a group II metabotropic glutamate receptor antagonist (the marketing people have a job to do here) may not only be of therapeutic value but may avoid most of the adverse effects of dopamine-blocking drugs that are causing increasing concern. The results of the study by Fournier *et al* (pp. 124–129) also challenge orthodox thinking. The management of personality disorder is traditionally felt to be in the province of the psychotherapies so it is somewhat disturbing to find that those with depression and personality disorder fare much better with antidepressant therapy than cognitive–behavioural therapy and the opposite is true in those with no personality disorder. This is useful in adding to the debate about the place of psychological treatments in depression[3,4] and clearly has some way to run.

So ask yourselves questions as you read this issue, and you might begin to get a little excited by the answers you generate. Richard Asher also asked 50 years ago, 'why are medical journals so dull?'[5] and illustrated this by giving an alternative switch-off title: 'A study of the negativistic psychomotor reactions induced by perusal of verbalized clinical material'. I hope that you, as the readers of this *Journal*, can make your reactions positive in a tidal wave of enthusiasm having the form, if not the content, of Fig. DS1 in the online data supplement to Nock *et al* (pp. 98–105), that will keep you going until the next issue.

Top Crown

This month we say goodbye to Sidney Crown, our Book Review Editor since milk bottle tops were made of cardboard. Sidney has not just been reviewing books for us, but has been a dispassionate reviewer of life. Take for example his views on celebrities: 'Their desire to be the centre of attention often overrides more obvious traits such as not wanting to come over as a fool in public'. Or try him on politics: 'One of the biggest things about him [Tony Blair] is that he doesn't exist,' says Crown. 'I know this sounds an odd thing to say but I mean it seriously. Right from the beginning, he's always trying to establish some sort of existence which would make sense to him' (http://wotisitgood4.blogspot.com/2005/11/sidney-crown.html). Sidney is also the author of what began life as the Middlesex Hospital Questionnaire,[6] which has been cited over 360 times in the literature in view of its primacy. It was a good instrument but did upset some people. For example a positive answer to the question 'do you often spend a lot of money of clothes?' was regarded as a histrionic attribute, but made some people feel it should be called the Unisex Hospital Questionnaire. But we must remember this was formulated long before the swinging sixties really burst on the scene. In any case, Sidney, who for years has run the London marathon, has always taken the long view, and we celebrate this now.

1 Baca-Garcia E, Perez-Rodriguez MM, Basurte-Villamor I, Del Moral ALF, Jimenez-Arriero MA, De Rivera JLG, Saiz-Ruiz J, Oquendo MA. Diagnostic stability of psychiatric disorders in clinical practice. *Br J Psychiatry* 2007; **190**: 210–16.

2 Waddington JL. Neuroimaging and other neurobiological indices in schizophrenia: relationship to measurement of functional outcome. *Br J Psychiatry* 2007; **191** (suppl 50); s52–7.

3 Newton-Howes G, Tyrer P, Johnson T. Personality disorder and the outcome of depression: meta-analysis of published studies. *Br J Psychiatry* 2006; **188**: 13–20.

4 Joyce PR, McKenzie JM, Carter JD, Rae AM, Luty SE, Frampton CMA, Mulder RT. Temperament, character and personality disorders as predictors of response to interpersonal psychotherapy and cognitive–behavioural therapy for depression. *Br J Psychiatry* 2007; **190**: 503–8.

5 Asher R. Why are medical journals so dull? *BMJ* 1958; **2**: 502–3.

6 Crown S, Crisp AH. A short clinical diagnostic self-rating scale for psychoneurotic patients: The Middlesex Hospital Questionnaire (MHQ). *Br J Psychiatry* 1966; **112**: 917–23.