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From the Editor's desk

By Peter Tyrer

The new phrenology

One of my international correspondents has taken me to task. While praising the modern look of the journal he complains that we have too many articles that embrace the 'new phrenology', the obsession with brain patterns that is only a minor change from the older 'science' of measuring external measurements of head circumference and shape. He has a point. Phrenologists believed that the mind had clearly delineated areas responsible for different mental faculties, and variations in each faculty had, in effect, a skull print which denoted the faculty that lay underneath. The extent to which highly intelligent people such as Francis Galton were fascinated with this subject to the point of delusion should not be lost on us when we attempt to interpret the data in Fig. 1 (p. 225) from Lemche *et al* (pp. 222–228) (is that Matt Lucas from Little Britain in the bottom left hand corner?), the anatomical significance of the brain areas that are different in trichotillomania (Chamberlain *et al*, pp. 216–221), and the probability maps of individuals at high risk of developing psychosis (Figs DS2 and DS3 in Walterfang *et al*, pp. 210–215). So it is perhaps not surprising that another of my correspondents wants us to go back to the psychiatry we used to know and love, and 'get rid of all those new fangled Rorschach ink blots and resurrect the good old-fashioned case reports that we can understand'.

But there is another argument to be heard. One of the core problems in current psychiatric practice is that the conditions we fondly regard as real are not. Most ICD–10 and DSM–IV diagnoses are fiction masquerading as fact, and this can become dangerous when we are fooled into false belief. However much we would like to give these 'disorders' the same respectability as other diagnoses in medicine we deceive ourselves if we think that all we need to do to get them accepted as valid is to agree among ourselves. We need independent yardsticks of disease, not fluffy correlations of reliability that tell us nothing other than that people can be trained to be consistent. As Kupfer *et al*[1] sadly conclude in trying to generate a new approach to DSM–V, 'despite many proposed candidates, not one laboratory marker has been found to be specific in identifying any of the DSM-defined syndromes'. So dimensions rather than diagnoses reign supreme[2] and to make progress we need to look for markers in every mode of enquiry; pharmacological (as Spence, pp. 179–180, is hinting), anatomical and physiological studies,[3] neurotransmission (Nash *et al*, pp. 229–234), genetics and neurochemistry. We may not understand all the implications of the results of investigations with these new technologies but this does not mean we should deny ourselves the data. But it would be nice if they could give some clear-cut answers. Until then, the new phrenology critics will have much material to mull and filter.

Mind doctors are swell

I attended a wedding recently. At occasions such as this to be introduced as a psychiatrist is usually sufficient to send a frisson of excitement through the audience. Indeed this happened, as although the bride, just newly qualified, is seriously thinking of joining the psychiatric profession, most of the guests were unfamiliar with the subject. What struck me most, however, was that the occasion of my introduction was accompanied by a distinct movement of the group in my direction, which raised my spirits rather more than the distance covered on the ground. I recalled that when I first became a psychiatrist to admit to having anything to do with the profession at occasions such as weddings was always accompanied by clear recoil in the opposite direction. When decorum prevented the recoil from becoming a rout with communication possible only with a loudspeaker, the conversations that then took place were embarrassing and asinine. For those who were bold enough to go further than giggling sotto voce and winking askance at friends the observations that raised the roof were along the lines of 'so you're a psychiatrist; go on, analyse me then', and 'how could you tell if I was normal?' Now, everything is different. I get involved in earnest conversations about the place of mental health services in the prevention of knife crime, the pace of advance in our understanding and treatment of Alzheimer's disease, the merits and demerits of antidepressant drugs in common mood disorders, and even the need to make teaching of mental health more prominent in the teaching of undergraduates as it is 'really becoming so important nowadays'.

We may sometimes wonder whether stigma and discrimination are going to be indissolubly admixed with psychiatry, but what is now absolutely clear in most high-income countries with well-devolved community services is that these blots on the mental health landscape are much fewer than they were 40 years ago, with greater acceptance, despite all their failings, of the need for psychiatric diagnoses,[4] and better awareness of the many other factors associated with perception of stigma.[5–7] One of the major tasks now is to bring these levels of awareness and understanding to those countries in Eastern Europe, Africa and Asia where the possession of any significant mental illness comes close to making you a pariah (a geographically appropriate Tamil word for outcast). Before long I expect to be invited to another wedding, in which almost all those attending will be mental health service users. And when I get approached with the question, 'does your psychiatrist know you're here today?' I will really feel I belong to that brave new framework of autonomy, beneficence, non-maleficence and justice described by Bloch & Green[8] where the goodwill flows in both directions and nobody will exactly know who is treating whom.

1 Kupfer DJ, First MB, Regier DA. Introduction. In *A Research Agenda for DSM–V* (eds Kupfer DJ, First MB, Regier DA): xviii. American Psychiatric Association, 2002.

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3 Schug RA, Raine A, Wilcox RR. Psychophysiological and behavioural characteristics of individuals comorbid for antisocial personality disorder and schizophrenia-spectrum personality disorder. *Br J Psychiatry* 2007; **191**: 408–14.

4 Dinos S, Stevens S, Serfaty M, Weich S, King M. Stigma: the feelings and experiences of 46 people with mental illness: qualitative study. *Br J Psychiatry* 2004; **184**: 176–81.

5 Byrne P. Psychiatric stigma. *Br J Psychiatry* 2001; **178**: 281–4.

6 Perlick DA, Miklowitz DJ, Link BG, Struening E, Kaczynski R, Gonzalez J, Manning LN, Wolff N, Rosenheck RA. Perceived stigma and depression among caregivers of patients with bipolar disorder. *Br J Psychiatry* 2007; **190**: 535–6.

7 Thornicroft G. *Shunned: Discrimination against People with Mental Illness*. Oxford University Press, 2006.

8 Bloch S, Green SA. An ethical framework for psychiatry. *Br J Psychiatry* 2006; **188**: 7–12.