Correspondence

Genetics of human behaviour

Sir: It is a pity that Dr Moncrieff (*Psychiatric Bulletin*, March 1998, **22**, 158–161) has misunderstood the scientific evidence underpinning the role of genetic factors in influencing human behaviour, and that she is moved to rehearse arguments regarding reductionism and positivism that owe more to gut feeling than logical analysis. Behaviour genetics may be materialist but it is not necessarily reductionist or deterministic. Most of its proponents are not seeking to replace the languages of psychology and sociology with those of genetics or even physics. What we are seeking to demonstrate is that propensity to certain mental states or behaviours is associated with particular genes or combinations of genes. By doing this we hope to be able to understand better the neurobiology of mental disorders to allow better therapies to be developed. Nor can we be accused of genetic determinism. Indeed behaviour genetics emphasises the complexity of gene–environment co-actions and interactions in normal and abnormal human behaviour (Rutter & Plomin, 1997), and we and our colleagues have stressed the need to develop research strategies combining the best of genetic, psychological and social approaches (Owen & McGuffin, 1997).

Dr Moncrieff's article is littered with errors and misconceptions. For example, she muddles heritability with the monozygotic twin concordance rate. She is surprised that high heritability can be compatible with a majority of people with schizophrenia having no family history of the disorder, and she fails to grasp the concept of allelic association in a polygenic disorder.

She has also misrepresented our article in the *British Journal of Psychiatry* (Farmer & Owen, 1996). She asserts that we have applauded "Huxlean visions of a technology of behavioural manipulation using drugs to correct for the consequence of having the wrong sort of genes". We have said nothing of the sort. Rather we have suggested that the aetiological clues provided by an increased understanding of the role of genetic factors in disorders such as schizophrenia and depression may lead to the development of safer more specific drug therapies; hardly an evil aim.

Not content with that, Dr Moncrieff goes further and states that we have advocated "the use of drugs to correct undesirable behaviours arising from putative genetic abnormalities" and that this is based "on the same rationale" as a proposal made in the 1970s to use psychosurgery to manage the disruptive behaviour of inner-city militants. Extraordinary stuff, but we suppose that it reflects an exercise of free will to stretch iconoclastic argument to the very boundaries of defamation rather than having anything to do with her genes.

FARMER, A. & OWEN, M. (1996) Genomics: the next psychiatric revolution? *British Journal of Psychiatry*, **169**, 135–138.

OWEN, M. J. & MCGUFFIN, P. (1997) Genetics and psychiatry. *British Journal of Psychiatry*, **171**, 201–202.

RUTTER, M. & PLOMIN, R. (1997) Opportunities for psychiatry from genetic findings. *British Journal of Psychiatry*, **171**, 209–219.

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Author's reply: I am sorry if any personal offence was caused by my article on behaviour genetics (*Psychiatric Bulletin*, March 1998, **22**, 158–161), as this was no part of my intention. Although I do not question the motives of those involved in research in this area, I do not share their confidence, and the tacit consensus of much of psychiatry, that this work will evidently produce beneficial results. I am merely trying to indicate how evidence is generally presented in a way which emphasises the significance of a genetic component to causation. Selective emphasis is not unique to genetics, but the point I wish to make is that the role of genetics in psychiatric disorders may be taken for granted in a way that is not entirely warranted. I am well aware that modern geneticists talk in terms of propensities, but this does not alter my basic argument. The question is, propensities for what? There is no objective or neutral way of defining voluntary human activity. The meaning given to an action depends on the understanding of the person describing it. Looking for genetic contributions to behavioural propensities is like looking for the explanation of good manners or good music. What is designated as such varies between different people with different points of view at different times.

Whether psychiatric disorders consist of voluntary patterns of behaviour is another area of debate which I have chosen to avoid. Most people would agree that the patterns of behaviour associated with Alzheimer's disease and

Huntington's chorea are not voluntary or intentional. However, I think that most people would also recognise that much of psychiatric practice is concerned with behaviour that is. Any procedures concerned with managing or influencing voluntary behaviour are surely legitimate subjects of vigorous debate.

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Continuing Professional Development

Sir: Gethin Morgan (*Psychiatric Bulletin*, May 1998, **22**, 330–331) provides an interesting insight into his role as Director of the Continuing Professional Development programme. Implicit in his article is a reluctance on the part of psychiatrists to engage in the process of CPD, and he explores issues of cost, time and perceived relevance as aetiological in this motivational disorder. He also touches on the issue of making CPD mandatory.

Psychiatry has always attracted iconoclasts to its profession, and it is perhaps a sign of psychological health that a curmudgeonly group of individualists resist the attempt of their professional organisation to control them. At a time when senior psychiatrists are taking early retirement in droves, and recruitment to the profession is falling, it would seem counter-intuitive to raise the standards required in order to practise. If this remains the College's aim, there are few carrots or sticks at its disposal. Inclusion on a White List of participants would seem an inadequate carrot. Exclusion from roles carrying little financial incentive, such as clinical tutor, would seem a brittle stick.

The most potent motivator would surely be to link CPD to the merit award system, and make the holding of such awards contingent upon an adequate engagement in the process of CPD. This would also bring the focus of the merit award system away from academic or managerial success, and back to clinical excellence, where it surely belongs.

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Sir: Professor Morgan wishes to spend his second year as Director of CPD, developing and evaluating the College's CPD scheme, and I think that if he did, there would be less need to persuade clinicians to join. I also think it should be possible to offer advice without being part of the scheme at the moment (my own position).

Let us distinguish between CPD, and the College scheme. All clinicians recognise the importance of the former, and would welcome anything which facilitated their own CPD. Most recognise the need to monitor their professional activities in an open and defensible way. However, most do not wish to pay a fee for a service which the College should provide as a core function (as do most others), nor to pay for something which (currently) delivers no perceived benefit. (The spectre of cost effectiveness is inescapable).

The College scheme should be easy to use, free at the point of delivery, actively evaluate and credit local as well as national events and activities, and be of relevance to all sub-specialities.

Were this the case, Professor Morgan would be inundated with applications to join the scheme, and until it is, he faces an uphill task.

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Administration of electroconvulsive therapy by general practice vocational trainees

Sir: The College officially frowns on general practitioner (GP) vocational trainee scheme trainees administering electroconvulsive therapy (ECT). This view is expressly stated in their training video and reiterated by Duffett & Lelliott (1998). In their recent audit, hospitals which include GP trainees in their ECT rotas were 'marked down'. It is far from clear, however, whether this attitude is justified.

It is expected that during their hospital posts, GP trainees participate in the activity of each speciality. They are fully involved in its day-to-day clinical work and the relevance or otherwise to general practice is usually a secondary consideration. ECT is not a technically demanding procedure which requires years to master; training and experience in its administration can be gained during a six-month placement. Moreover, such experience can be of great benefit to depressed patients seen later in primary care. A GP who has had 'hands-on' experience of any procedure is in a good position to answer questions or allay fears.

The continuing stigma surrounding ECT can be addressed by ensuring that GPs are conversant with its use. Otherwise how can we expect the general public to change its views?