BJPsych The British Journal of Psychiatry (2012) 200, 88. doi: 10.1192/bjp.200.1.88

From the Editor's desk

By Peter Tyrer

An honest mirror

One of my most satisfying moments as Editor occurred 4 years ago at the annual meeting of the American Psychiatric Association in Washington, DC. I was at the Royal College of Psychiatrists' stand in the exhibitors' area and as there were many lectures taking place there were few people about. I saw a man looking at me a little furtively and darting glances at other stands. Suddenly he approached, came right up to me and half-whispered, 'I like your journal – because it's clean'. Safely delivered of this message, he silently slipped away, leaving me in a glow of unfamiliar pride. What I would like to think is that this comment was not an isolated opinion, and that our journal is regarded as both independent and impartial, and has tried to maintain these aims over our long history (Tyrer & Craddock, pp. 1–4). We have seldom been a campaigning journal, because campaigning, even in pursuit of a noble cause, indicates partiality, and we also like to think that we are independent of the many lobbying groups that surround our subject, even though we sometimes venture into territory occupied by factional fighting, as illustrated for example in the correspondence in this issue (Howard *et al*, p. 74, etc.) over a paper we published in September.[1] This task is never easy, but as much as possible we have to reflect everything of importance that concerns psychiatry, being aware of fashion but not seduced, taking part in controversy but acting more as referee than protagonist, and allowing the voice of the minority to speak if it is holding the megaphone of good science.

So this issue, I hope, shows all these features in addressing several matters that continue to trouble us, and indeed they troubled many of our predecessors over the years. Clozapine is a valuable drug in our pharmacopoeia for psychotic disorders, but when and if it should be prescribed is by no means clear,[2,3] and we need to be aware of its adverse effects, even if some of them are dismissed as relatively trivial. Barnes *et al* (pp. 7–9) and Harrison-Woolrych *et al*[4] show that nocturnal enuresis is clearly not one that is. Clozapine is commonly used for treatment resistance in schizophrenia, and in the treatment of resistant bipolar depression we are increasingly using antipsychotic rather than antidepressant drugs in management. But might resistance to antidepressants in unipolar depression indicate that the diagnosis could really be bipolar disorder? Li *et al* (pp. 45–51) make a very good case for this hypothesis and Goodwin (pp. 5–6), despite a degree of partiality to be expected from the bipolar capital of the world,[5] agrees that this strong possibility should be considered in management. I certainly had cause to recall it when someone I had been treating rather ineffectively for several years with 'neurotic depression' suddenly demonstrated his new diagnosis by accelerating down a one way street and colliding with ten cars in succession. But drugs are not the only treatment option here. Loo *et al* (pp. 52–59) have carried out an important study of transcranial magnetic stimulation in depression, a subject that has been hovering at the edges of clinical application for years since its discovery in Sheffield in 1985.[6] Allan *et al* (pp. 10–11) now have enough information to suggest bringing this treatment more closely into the clinical arena. How to make sense of the group of disorders now called 'functional somatic symptoms and syndromes'[7] remains a major problem in therapeutics, and Sattel *et al* (pp. 60–67) suggest a role for a form of psychotherapy similar to mentalisation-based treatment[8] in this disorder. It seems to be most successful in improving quality of life but has little effect on health worries, which suggests a continuing role for other approaches.[9] So here, and in several other of our papers, we allow important problems to be both reflected starkly and solutions glimpsed (Bechdolf *et al*, pp. 22–29; Ginsberg & Lindefors, pp. 68–73); we just have to keep our mirror well polished.

Confused and delirious

We point out in our review of the *Journal* (Tyrer & Craddock, pp. 1–4) that although much has evolved in psychiatric thought and practice we still have continuing concerns that do not appear to change. In our second issue Bosquet took the psychiatrist, M. Moreau of Tours, to task for suggesting that delirium and insanity were the same condition. He had good reason to do so. 'Why confound the two states, of which the one is most generally of short duration, whilst the other is ordinarily of long duration, and too often ends but with life; of which the one appears unexpectedly, whilst the other, prepared, elaborated in the economy, forms itself slowly, mysteriously, and appears on the most unlooked-for or insignificant occasions'.[10] In the cut and thrust of this session in the Imperial Academy of Medicine in Paris the manifestations, causes and implications of delirium are tossed back and forth like choice morsels at a feast of jackals; what surprises me when reading these arguments of 1855 is how little we still know about delirium a century and a half later. We should therefore be grateful to Meagher and his colleagues (pp. 37–44) for adding to their previous work[11] and giving us new data to get this subject well and truly into the 21st century.

1 Coleman PK. Abortion and mental health: quantitative synthesis and analysis of research published 1995–2009. *Br J Psychiatry* 2011; **199**: 180–6.

2 Girgis RR, Phillips MR, Li X, Li K, Jiang H, Wu C, *et al.* Clozapine v. chlorpromazine in treatment-naive, first- episode schizophrenia: 9-year outcomes of a randomised clinical trial. *Br J Psychiatry* 2011; **199**: 281–8.

3 Leucht S, Davis JM. Are all antipsychotic drugs the same? *Br J Psychiatry* 2011; **199**: 269–71.

4 Harrison-Woolrych M, Skegg K, Ashton J, Herbison P, Skegg DCG. Nocturnal enuresis in patients taking clozapine, risperidone, olanzapine and quetiapine: comparative cohort study. *Br J Psychiatry* 2011; **199**: 140–4.

5 Tyrer P. From the Editor's Desk. *Br J Psychiatry* 2007; **191**: 278.

6 Barker AT, Jalinous R, Freeston IL. Non-invasive magnetic stimulation of human motor cortex. *Lancet* 1985; **325**: 1106–7.

7 Mayou R, Kirmayer LJ, Simon G, Kroenke K, Sharpe M. Somatoform disorders: time for a new approach in DSM-V. *Am J Psychiatry* 2005; **162**: 847–55.

8 Bateman A, Fonagy P. Mentalization based treatment for borderline personality disorder. *World Psychiatry* 2010; **9**: 11–5.

9 Hedman E, Andersson G, Andersson E, Ljótsson B, Rück C, Asmundson GJG, et al. Internet-based cognitive–behavioural therapy for severe health anxiety: randomised controlled trial. *Br J Psychiatry* 2011; **198**: 230–6.

10 Bosquet M. The pathological and anatopathological view of delirium, &c: a report read to the imperial academy of medicine, of France, in the session of 8th May, 1855. *Asylum J* 1856; **2**; 204–13.

11 Meagher D, Leonard M. The active management of delirium: improving detection and treatment. *Adv Psychiatr Treat* 2008; **14**: 292–301.

https://doi.org/10.1192/bjp.200.1.88 Published online by Cambridge University Press