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From the Editor's desk

By Peter Tyrer

Refreshing contradictions

My school headmaster was an autocrat whose motto was 'I will not be contradicted'. This is not the wisest of philosophies and, although he ran his school with military precision, beneath its superficial calm many developed a seething primordial desire to foment dissent. This achieved its most magnificent expression one summer term when some enterprising boys splendidly coordinated the diversion of traffic from the main road alongside the school so that every vehicle came into the school drive. At the same time a fake goodwill visit had been organised with a US Army unit, who also rolled down the drive in their military vehicles, adding to the magnificent unreality of the situation as the top brass disembarked in their fruit salad regalia waiting to be lauded by the school. My abiding memory is of the headmaster's lonely figure in the drive, fuming in impotent rage and desperately trying to assert his authority when all about had abandoned theirs.

Such are the perils of life for those who abhor contradiction, and they suffer appropriately in this issue as the iconoclasm of good science topples a few idols. We are reminded by Lewis & Lieberman (pp. 161–163) that the Orwellian chant of 'atypical antipsychotics good, typical antipsychotics bad' is indeed the vacant refrain of sheep-like adherents to an outdated chimera of progress, and the similarly universal one of 'community services good, hospital services bad' is questioned by Capdevielle & Ritchie (pp. 164–165). The old notion that those with severe mental illness should be kept safely but delicately away from the rest of society in 'sheltered employment', knitting furiously and stuffing rabbits, has also been contradicted entirely by the work of Catty *et al* (pp. 224–231) and others.[1] The now widespread belief that the cause of self-harm can be laid firmly at the door of past childhood sexual abuse also comes under the microscope in Klonsky & Moyer's systematic review (pp. 166–170) and is found to be surprisingly lacking in evidence. My general attitude to all such hypotheses is that when they seem to constitute a neat package with no loose ends they are probably wrong. The accumulating evidence that cognitive–behavioural and other related approaches are effective in those with recurrent self-harm (Slee *et al*, pp. 202–211) also runs against the child abuse theory; nothing in the treatment has any connection to past abuse, which is irrelevant to the success of the intervention. The simple truth is rarely simple in discovery, although after discovery is often simple to understand. The art of judicious contradiction is a useful sword to cut through obfuscation and dogma, and Cooper and her colleagues (pp. 185–190) may have hit on something in their elegant dissection of perceived and actual ethnic disadvantage. Perceived disadvantage should provoke paranoid thoughts, but those who have paranoid thoughts show no association with this perception. Could it be that we non-psychotic folk, anxious to reassure and explain, infer too much and ask too little?

Lost in classification

The paper by Das-Munshi *et al* (pp. 171–177) is an invitation for me to indulge in one of my greatest gripes. The failure in formal psychiatric classifications to acknowledge the clinical fact that mixed anxiety and depression is by far the most common psychiatric disorder is obtuse and inexplicable. It is allowed a foot in the door as a 'sub-syndromal' disorder and even at this level is associated clearly with distress and dysfunction that often exceeds that of single disorders.[2] When time after time we find that depression and anxiety develop as a common pattern,[3] show no evidence of hierarchical relationships[4] and together contribute so much to pathology and outcome[5,6] it seems bizarre that this combination of symptoms is merely regarded as an incidental 'comorbidity'. Of course the pathophysiology of anxiety and depression are different but there is no more reason to keep them apart as there is to keep apart the symptoms of anaemia and those of subacute combined degeneration of the spinal cord in pernicious anaemia just because they are in different physiological systems. So wake up, DSM–V and ICD–11, and remember:

Anxiety and depression
Teach us one important lesson
Though in separation their study pleases
We must remember they are not diseases
And like wind and rain in stormy weather
These symptoms always appear together.[7]

1 Latimer, EA, Lecomte, T, Becker, DR, Drake RE, Duclos I, Piat M, Lahaie N, St-Pierre M-S, Therrien C, Xie H. Generalisability of the individual placement and support model of supported employment: results of a Canadian randomised controlled trial. *Br J Psychiatry* 2006; **189**: 65–73.

2 Piccinelli M, Rucci P, Ustün B, Simon G. Typologies of anxiety, depression and somatization symptoms among primary care attenders with no formal mental disorder. *Psychol Med* 1999; **29**: 677–88.

3 Fergusson DM, Horwood LJ, Boden JM. Structure of internalising symptoms in early adulthood. *Br J Psychiatry* 2006; **189**: 540–6.

4 Moffitt TE, Harrington H, Caspi A, Kim-Cohen J, Goldberg D, Gregory AM, Poulton R. Depression and generalized anxiety disorder: cumulative and sequential comorbidity in a birth cohort followed prospectively to age 32 years. *Arch Gen Psychiatry* 2007; **64**: 651–60.

5 Dickens CM, McGowan L, Percival C, Tomenson B, Cotter L, Heagerty A, Creed FH. Contribution of depression and anxiety to impaired health-related quality of life following first myocardial infarction. *Br J Psychiatry* 2007; **189**: 367–72.

6 Andreescu C, Lenze EJ, Dew MA, Begley AE, Mulsant BH, Dombrovski AY, Pollock BG, Stack J, Miller MD, Reynolds CF. Effect of comorbid anxiety on treatment response and relapse risk in late-life depression: controlled study. *Br J Psychiatry* 2007; **190**: 344–9.

7 Tyrer P. *Anxiety: A Multidisciplinary Review*: 198. Oxford University Press, 1999.

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