From the Editor's desk

PETER TYRER

THIS MONTH'S ISSUE: PRECOGS TO THE FORE

One of the common public notions about psychiatrists is that they have the ability to predict people's behaviour and mental pathology. This derived originally from psychoanalysis, when one consequence of the analyst's Delphic inscrutability was the investment of all-seeing (and all-predicting) wisdom, but has been added to in recent years by advances in science. The futuristic film *Minority Report*, with Tom Cruise aided by a group of unusual women, suggested crime could be prevented by pre-crime intervention. The film centres around the innate abilities of the women, who could detect criminal acts before they took place, hence the collective noun 'precogs', and has added further to the idea that we can predict human behaviour.

This issue adds a little more weight to predictability. Claassen & Larkin (pp. 352–353) show that a single computerised screen accessed by patients attending an emergency clinic is successful in predicting future self-harming behaviour undetected by other means; Evans and his colleagues (pp. 302–307) found that apparently euthymic women with negative self-schemas were more likely to become depressed 14 weeks later, and the findings of Baldwin and his colleagues (pp. 308–313) suggest that late-onset depression may be a predictor or index of neurovascular degeneration. Add to this the editorial by Hallahan & Garland (pp. 275–277) detailing the increasing evidence (soon to be supplemented further in the *Journal*) that the consumption of fish and essential fatty acids is predictive of good mental health and the amelioration of depression. But of course there are limits, and these are imposed largely by our inability to predict human behaviour. This comes out strongly in the two papers by Morgan *et al* (pp. 281–289, 290–296). Although schizophrenia is generally similar in its manifestations across cultures and countries, there have long been differences shown between the presentation of certain ethnic groups – Asian, Black African, African–Caribbean and White – in exhibiting their symptoms to services. Morgan and his colleagues suggest that the pathway whereby Black patients are more commonly admitted under compulsion is now clearer. General practitioners are less likely to be involved in their presentation and the police more likely, and this seems to be related to higher levels of stigmatisation of mental illness in the Black community. Perhaps this is a partial explanation of the findings of Angermeyer *et al* (pp. 331–334), which suggest that greater 'social distance' of the population in relationship to those with schizophrenia has accompanied greater biological awareness of the condition. 'I can understand it better but I still want to stay away' is an increasing tendency in our risk-conscious society, and so perhaps these findings are not that surprising.

ON-LINE REPORT

Our on-line submissions are going well, but perhaps a little too well. There has been a 20% increase in the number of submissions since our launch but we hope that we are processing them more quickly than under the old system. We have also increased the size of the *Journal* a little to accommodate extra articles, but we will still have to reject rather more articles than we used to in the past. I send anticipatory apologies to disappointed authors.

PATIENT POWER

Henderson's editorial on volition in psychiatry in this issue (pp. 273–274) is also timely in our continuing attempts to predict human behaviour. One of the major changes in psychiatric practice in the past 10 years has been the growth of patient power. Researchers, clinicians and organisers of psychiatric services all have to take account of what the consumers of our treatments really feel. This used to be a token acknowledgement; now it has become the major currency of exchange. This is not just political correctness; the logic is inescapable. When patients are properly informed about research, they are more likely to complete their involvement in studies; when they have real investment in their treatment, they are more likely to be enthusiastic adherents; and when the views of patients in planning services are taken into account, those services are more likely to be accessible. (Having pointed out the logic, the research is still needed to show that these consequences do, in fact, occur.) Part of the currency of patient involvement is an interchange of equipoise with the responsibilities of the clinician and patient defined more explicitly, as Henderson has suggested. This does not necessary imply formal contracts but would regularise areas of responsibility instead of maintaining the current, anachronistic 'all or none' position for many disorders; patients can escape completely the consequences of their actions through the attribution of the embracing concept of illness. But power with responsibility always carries some disadvantages, as the lament below indicates.

The empowerment lament

I object, no-one has listened to me
Allowed me to be what I want to be
Now I can choose, but it's a state I rue
Because now you blame me for what I do

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