

From the Editor's desk

By Peter Tyrer

Loathsome psychiatric harlotry

I am as much a botanist as a psychiatrist, and the only time I have been able to combine these interests effectively is on an African expedition many years ago when we were involved in collecting both flowering plants and those used as herbal remedies by 'witch doctors'. Although most psychiatrists left their botanical studies early in their career, I am sure many continue to yearn diagnostically for the equivalent of Carl Linnaeus, the botanical magician who with a flourish of his arm converted the ragbag of nature into proper order with his binomial classification. Although we often think this new system was embraced by the world, it certainly was not at first. Linnaeus, like Freud and the early psychoanalysts, came under attack for a classification based on sexual organs, rather than others that were much more respectable, and came under attack from a fellow botanist, Johann Siegesbeck, who called it 'loathsome harlotry'. In this issue, there are many pickings at diagnostic harlotry in psychiatry

Neither diagnosis by therapeutic inference (psychoanalysis) nor structured atheoretical enquiry (DSM) has covered itself with glory, and the attempt to separate the major diagnoses, begun by Kraepelin, seems to have stalled.^{1,2} Even conditions that I felt confident of in my diagnostic practice when I was younger, such as the subgroups of eating disorders, now appear heterogeneous and temporally unstable.^{3,4} So perhaps it is not surprising to find evidence that a wider tranche of diagnoses can be linked, as Morgan *et al* (pp. 282–289) find in their study of patients with intellectual disability, and Roest *et al* (pp. 324–329) show in linking anxiety to myocardial adversity. Owen (pp. 268–269) sees virtue, not harlotry, in these connections, in postulating a continuum of genetically and environmentally induced causality. Some colleagues may disagree⁵ but nobody can deny that clustering of mental disorders is common, as McLaughlin *et al* (pp. 290–299) show clearly in their study across generations. In reading these papers one can see why mental illness became tainted by stigma, with the notion that once a person had been touched by mental disorder others would follow in train, but of course this pattern is really only seen in small closed communities.⁶ Even when placed in highly unpleasant environmental circumstances, most people are highly resilient and adaptable (Bonanno *et al*, pp. 317–323) and do not qualify for the attribution of any meaningful mental disorder. Personality disorder has attracted more than its fair share of mischief over the years, and there was a time when any form of deviance from the mean allowed the diagnosis to be made. 'Dangerous and severe personality disorder' came close to being incorporated into the diagnostic lexicon⁷ and the paper by Barrett & Byford (pp. 336–341) suggests that we have been lucky to escape with only a hint of whoredom but healthy concern over its very high costs. We naturally would like to leave the uncertainties of phenomenology and descriptive psychiatry behind us and get some solid biological data to sort us out. Bodnar *et al* (pp. 300–307) tantalisingly suggest we might be able to separate those who have a good outcome after their first episode of psychosis from those who have poor one with the help of functional magnetic resonance imaging, but we would need a comparison with careful clinical diagnostic evaluation to show genuine

superiority, and Hegeman *et al* (pp. 275–281) show that good old-fashioned phenomenology still has a powerful part to play, at least in the classification of depression.

And just in case you feel botany got it all right and psychiatry got it quite wrong just visit your nearest briar patch. The classification of brambles continues to be a very thorny issue – over 5000 have been identified so far after a riot of indiscriminate harlotry – and its problem is just the same as in mental health: nothing quite fits but we would be much worse off with no classification at all.

Sleep and salience

Another visitor to our confusing diagnostic scene is salience, the recognition of what is prominent and needs attention in our interpretation of the world. Jim van Os has made a powerful argument that it is salience dysregulation, the inability to recognise what is prominent against a background of unimportant inputs, that lies behind the core of schizophrenia and other psychotic experiences.^{8,9} We now have increasing evidence that circadian rhythms are grossly disturbed in schizophrenia and may influence cognition and sleep patterns.^{10,11} The paper by Wulff *et al* (pp. 308–316) adds to this evidence significantly. One of my patients was involved in this study. She had largely come to terms with her many auditory hallucinations but claimed they occurred throughout the night and often woke her up. I had always felt somewhat sceptical about her reported frequency of these symptoms but my doubts were completely removed on seeing her sleep actigraph – it represented that of a highly aroused person watching a violent film and she never seemed to have any evidence of normal sleep. This was strong support for her sleep disturbance being a salience disorder. Every perceived stimulus represented another crashing wave in a sea of troubles, and whether she was awake or asleep made little difference to these, and even antipsychotic drugs had virtually no impact on their continuous clamour for attention. I now view sleep disturbance in schizophrenia very differently and I think it will open new vistas in research.

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