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Psychiatry in the frame

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The contents of the very first issue of the ANZJP reflect the nature of academic psychiatry in Australia and New Zealand in 1967. It contains short editorial pieces on the assessment of dreams and on psychoanalysis, an article on 'mixed blood races' in Papua New Guinea, and of the few empirical articles, one by John Cade on inflammatory markers in melancholia.

There is also an article whose content is familiar to us. William Dibden, then president of the College, provides a cogent outline of the challenges facing psychiatry (Dibden, 1967). He worries that the scope of psychiatry has become too broad – extending its concerns into normal behaviour – and bemoans the divide between those who see mental illness as being predominantly socially determined versus those who see its origins as biological. He could see no need for such a dichotomy.

In taking on the editorship of the ANZJP, I am aware of how these arguments remain a preoccupation for many of us. We continue to debate the scope and role of psychiatry, and the essential nature of mental illnesses; and we do this because there are no definitive answers. We work at the seams where biology meets a world that is too human and where theoretical concepts are blurred by the messiness of human lives. When our critics tell us how little we still seem to know about the causes of mental illness, I am reminded of the comment ascribed to Emerson Pugh: *'If the human brain were so simple that we could understand it, we would be so simple that we couldn't'* (Pugh, 1977). The complexity of what we face as psychiatrists ensures the debates will go on.

But while we debate, we get on with our clinical work. The practice of psychiatry in Australia and New Zealand can be characterised by its pragmatism, being sceptical of both European theory making and North American exuberance – finding a middle path that emphasises finding treatments that work. This is best exemplified by John Cade, whose discovery of the therapeutic effects of lithium did not derive from any theory (and perhaps in spite of a theory that was erroneous), but from his being alert enough to recognise the possibility of lithium's therapeutic benefits when he saw its effects on his guinea pigs.

Pragmatism, and not dogmatism, is how we should practice medicine, and especially psychiatry. Psychiatry is a broad church. We bring to our practices different perspectives and interests, which is appropriate given the diversity of human problems we encounter. These differences can be enriching and can inform each other. They also lead too often to unnecessary dichotomies, like the biological versus social reductionism debates alluded to by Dibden, and which persist in earnest, as if focusing on one perspective negates the other. But we want neither a mindless psychiatry nor a brainless one (Eisenberg, 1986), and we can recognise that while all human experiences are mediated by our nervous systems, the experiences that are important for mental illness are driven by the social environment and occur in times and places that are consequential for understanding mental illness for a particular person.

It is unlikely that we will ever get a complete understanding of any of our major mental illnesses at a single level of explanation – not at the level of the synapse or at the level of the community. They arise from the interaction between multiple levels, and in different combinations with different emphases for different illnesses (Kendler, 2008). The biopsychosocial model, proposed by gastroenterologist George Engel, is criticised because what it proposes is self-evident and the conclusions that can be drawn from it banal (Ghaemi, 2011). Of course, mental illnesses, like all illnesses, manifest at the biological, psychological and social levels. But that tells us little about the aetiology for particular mental disorders, for which different levels of explanation can be more informative than others: compare, for example, Lewy body dementia to post-traumatic stress disorder. But for most of our disorders we don't know which levels of explanation are likely to be most pertinent and must continue to explore them with an open mind, and without any assumption that an explanation at one level forecloses another.

In taking on the editorship I am mindful of where psychiatry finds itself, with a rich history of clinical observation and research data to establish a base for progress, but with continued debate about many of the conceptual underpinnings of mental illnesses and the proper role of psychiatry. I will value a journal that shows an appreciation for these

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complexities, but which continues to follow lines of enquiry without being boxed in by dogma. While we should continue to debate the conceptual issues, we should avoid repetition of old arguments and instead encourage new perspectives that take the arguments forward. And we must be mindful always of the ultimate aim of our work: to help ease the suffering of the many people in the community who are experiencing mental illness. We work within mental health systems that are under strain and poorly adapted to confront the extent of community suffering, and must not only find new and better treatments, but must work to reform the systems so that more people get better care.

As editor of the ANZJP, I will be keen to continue the excellent work of Gin Malhi, who in his 10 years in charge of the journal has elevated it to the top tier of generalist psychiatry journals. He has been aided by a team of associate editors who have worked tirelessly to shepherd papers through the review process to publication. I am grateful for their work and look forward to working with the next generation of academic psychiatrists who will take the baton. Together we will endeavour to keep pushing psychiatry in Australia and New Zealand forwards, showcasing what we do as researchers and clinicians to the mental community here and around the world, with the hope that our work will help ease the suffering of the many people we care for.

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