standards when considering a new app. The potential of smartphone apps for mental health is as bright as the authors allude to, but the challenges are turning out to also be greater than many realised.

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doi: 10.1192/pb.40.2.106b

Authors' reply: We are grateful for Dr Touros' interest in our article and his considered response.

Our article is a brief overview of a complex subject area which has scope for further detailed discussion. There is an emerging division between professional and patient-centred apps similar to that between prescribed and over-the-counter medications. As medical professionals we can make regulatory demands in our sphere of influence but apps for the general market will emerge independently of our influence; we will need an awareness of such apps to manage the complex issues that arise when patients raise questions about diagnosis and management after interacting with them.

We requested an update from NHS Choices and have been informed that the Health Apps Library is being upgraded following work on the assessment process by the National Information Board. The first apps are expected to have completed the new evaluation process in April 2016.

Declaration of interest
S.F. has developed an app called QDoc to assist self-management in psychiatric disorders.

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doi: 10.1192/pb.40.2.107

You too, YouTube?

The study by Gordon *et al*[1] looking at the portrayal of psychiatry in YouTube videos was novel, although it was disheartening to note their finding that our field is being depicted in a predominantly negative light.

In this context, I am writing to provide some details of my YouTube channel called 'Psychiatry Lectures' (www.youtube.com/channel/UCVZhg8unEqo0XUm8cHAIwbA/videos). This is a free-to-access educational channel featuring videos on psychiatry topics targeted at health professionals who see psychiatric patients. So far, I have uploaded 19 videos covering most of the major psychiatry topics, for example, schizophrenia, mood disorders and anxiety disorders. The average duration of the videos is 50 min and most videos end with a set of five multiple choice questions. The videos are in the form of PowerPoint presentations with my narration.

YouTube has an analytics section that is accessible to the channel's creator and that provides detailed statistics about viewership. Until 31 December 2015 the 19 videos had garnered over 34 000 views in 160 countries, with the top 5 nations in terms of views being the USA, India, UK, Australia and Canada. Viewer demographic details show a male preponderance (65%). With respect to age, the 25–34 group had the maximum number of viewers, followed by the 18–24 group. This suggests – and is supported by feedback in the comments section – that medical students and postgraduate psychiatry trainees form the bulk of the audience. In total, the videos have received 210 'likes' and only 6 'dislikes', indicating a high degree of acceptability in a discerning, mainly professional audience.

My YouTube channel may be considered as part of free open access medical education (FOAM). The FOAM movement, pioneered by emergency medicine physicians in Australia,[2] aims to offer medical students and doctors free access to medical information online, delivered in a variety of formats such as videos, slideshows, podcasts, articles, blogs and Twitter (#FOAMed).

The paper by Gordon *et al*[1] is a timely reminder to the psychiatric profession that we have to battle widespread misinformation, whether deliberate or well-intentioned, about our specialty, not only in traditional, mainstream media such as print and TV, but also in cyberspace. Constructive criticism, both from within and outside the profession, is definitely valid and welcome. But biased and baseless distortions about psychiatry only reinforce the already entrenched stigma, with far-reaching consequences ranging from inadequate recruitment of psychiatrists[3] to discrimination against patients.[4] Gordon *et al*'s suggestions on how psychiatry can fight back against this misrepresentation are worthy of consideration.

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doi: 10.1192/pb.40.2.107a

No smoke without fire

In trying to explain why the portrayal of psychiatry on YouTube might be predominantly negative, Gordon *et al*[1] fail to consider the obvious – that the producers of negative videos may actually have a point.

It is hard to disagree with any of the accusations about overuse of drugs made by the lawyer featured in the first video on their list. Of the many speakers in the second clip, a couple make slightly exaggerated statements, but its main message,

that the *Diagnostic and Statistical Manual of Mental Disorders*[2] is an arbitrary and harmful construct, is entirely correct. The third and final negative video on the authors' list follows in this vein.

It is notable that some speakers in these videos doubt the existence of, say, schizophrenia, by virtue of the fact that it is listed in the same book as nonsensical diseases such as conduct disorder or compulsive buying disorder. Who can blame them? Similarly, others might doubt that bipolar affective disorder exists at all because the diagnostic criteria for one of its forms are so wide they have no face validity. When the public's intelligence is insulted by the psychiatric establishment in such a manner, how can it be expected to believe the basic facts about what we really do know?

Psychiatry has become the slave of its pharmaceutical masters, with diseases and pathophysiologies invented and widened to create a market for drugs.[3,4] Psychiatrists have been complicit in this. Yet Gordon *et al* refer to people like me, who endeavour to expose this truth and make positive changes to practice in the interests of our patients, as 'disgruntled psychiatrists'; they suggest waging a media war by posting more positive videos. But this will get us nowhere.

If we want the outside world to be kind to us, we need to get our own house in order first. We need to dispense with absurd disorders from our classifications, narrow our definitions of serious illness, focus on those endogenous diseases for which we have clear meta-analytic evidence of effective treatment and restrict provision of pharmacological treatment to patients who are actually ill.

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doi: 10.1192/pb.40.2.107b

Projection prevention and control

Although I was delighted to see him referred to in a recent cover of *BJPsych Bulletin*, Robert Burns was not at his most ambitious when he asked: 'O wad some Power the giftie gie us/ To see oursels as ithers see us!' To see ourselves as others see us is not really the fundamental problem. The difficulty is rather in seeing what of ourselves we see mirrored in others, yet cannot own.[1]

In the multidisciplinary ward round, I usually see an overwhelmed person. It feels slightly irritating when they are too overwhelmed to make the interview lead to decisions. That may be telling. Perhaps we are the overwhelmed ones. After all, it is often plain that our efforts will not be enough to make things go just the way we and they would prefer them to.

And so, we treat what is really a rich, stressful small group interaction as though it were an individual interview – a forum for demonstrating psychopathology then coming to decisions.

Perhaps Dr Black's suggestion[2] of a closed-circuit televising of the individual interview to the multidisciplinary team offers just the right level of projection prevention and control to make the interview work for patient and team.

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doi: 10.1192/pb.40.2.108