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Is the moon there when nobody looks?

The title of this letter is a comment made by Einstein to one of his assistants in relation to the hotly debated interpretation of quantum mechanics. At the heart of this debate is a seemingly simple statement: in the quantum world, objective states do not exist prior to an act of measurement. So, in a sense, the act of measurement is an integral part of phenomenology itself. The problem, though, is what does an act of measurement entail? Put differently, where does an act of measurement start and/or end? In the world of physics, it is still debated as to what an act of measurement is. The deterministic Schrödinger wave equation mysteriously collapses into specific probability numbers once subject to an act of measurement. For people who are puzzled by the relationship between quantum theory and psychiatric disorders, they should look no further than the fact that the identification of the phenomenology of psychiatric disorders is subject to almost the same conceptual difficulties. For example, any serious attempt to identify the aetiology of depression in a society will inevitably require knowledge of prevalence and incidence rates, which in turn requires the employment of certain diagnostic criteria that assume the existence of depression as an entity in the first place (*a priori*). So, in a way, the argument is partly circular. Put differently, depression as a 'disorder' cannot claim a separate existence to that of 'diagnostic processes' via the use of measuring tools. Therefore, in the process of trying to identify the phenomenology of mental disorders, the question is: 'What does an act of measurement entail?' In daily practice, a mental health professional's act of measurement revolves around the application of widely used international criteria: the ICD and DSM classification systems. But where do these classification systems come from? The answer is that both ICD and DSM systems have been produced by almost a century of amalgamation of clinical experience, consensus, philosophical schools, political influences and even World Wars. Therefore, current diagnostic systems represent historical processes with a particular narrative. The classification system's historical narrative assumes more relevance to the identification of mental health phenomenology than patients' personal narratives. Mental health phenomenology would not have existed without this historical narrative of our current diagnostic schemes. No wonder it has proved so difficult to reduce mental health phenomenology into basic blocks that can be reliably identified, considering the hundreds of variables embedded into the historical development of our classification systems.

Every time we measure the phenomenology of mental disorders we end up invoking the whole historical development of our classification systems. There is simply no line of demarcation that can separate phenomenology of mental disorders from that of the measurement process in the course of making a diagnosis. It is customary nowadays to describe the current classification systems as reliable, partly because they permit clinicians to communicate using the same language. I think this is a fallacy. Diagnostic systems are inherently operational, i.e. they are more about the 'processes' clinicians follow in order to reach a diagnosis. Therefore, it is inconceivable that two clinicians from two different cultures will end up going through exactly the same steps during the process of making a diagnosis, as this is likely to be influenced by personal experience, semantics, cultural issues and so forth. In my opinion, the diagnostic systems we currently have are inherently more valid than we are willing to accept. It is illogical to say that diagnostic systems are not valid enough because they do not accurately represent what is out there. In reality, they create what is out there. It does not even require a 'conscious' observer to do so. We only need to look!

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Suicide in Wales

The paper by Mok *et al*[1] makes for interesting reading but is something of a blunt instrument in the presentation of the figures.

By combining figures for England and Wales it overlooks the fact that the suicide rate for men in Wales is significantly higher than in England, with a peak between 20 and 39 years of age. For women in Wales the rate is a little higher than the English average. Within Wales the rate varies considerably, with higher rates in areas of high social deprivation.[2]

The figures for Wales are not as high as those for Scotland and Northern Ireland but have been of sufficient concern for the Welsh Government to launch its suicide prevention campaign 'Talk to Me'[3] in 2008, which is full of good intentions but lacks some detail as to real-life implementation. The impact of this is yet to be evaluated but it is not likely to have been helped by recent economic problems. The association between social adversity and suicide is easy to identify but harder to change.

Also of interest is the high incidence of drowning in Scotland. Of note is the fact that Scotland accounts for 90% of the standing freshwater of Great Britain and water makes up around 2% of the land area of Scotland compared with 0.5% in England.[4] Similarly in Ireland, drowning accounts for approximately a fifth of male suicides.[5] Although it may be simplistic to equate methods of suicide with geographical proximity, it is interesting to speculate on an individual's relationship with their culture, landscape and history which may have a bearing on attitudes to suicide and methods chosen. Drowning, for example, could be more easily explained away as accidental in cultures where everyday use of water for recreation or work is more commonplace, thereby avoiding a pronouncement of suicide and its associated stigma.

Although there are some common, well-replicated associations with completed suicide as discussed in Mok *et al*, broad statistics tend to hide subtle variations within regions and it is examination of these differences that can inform suicide prevention strategies that are relevant, practical, acceptable and beneficial for a given community.

1 Mok PLH, Kapur N, Windfuhr K, Leyland AH, Appleby L, Platt S, et al. Trends in national suicide rates for Scotland and for England & Wales, 1960–2008. *Br J Psychiatry* 2012; **200**: 245–51.

2 National Public Health Service for Wales. *Suicide in Wales: Data to Support Implementation of the National Action Plan to Reduce Suicide and Self Harm in Wales*. Welsh Assembly Government, 2008.