back-pedalled away from acknowledging that the discovery occurred in therapy. One mother of a complainant said she had always known, but had "put it on the back burner." Another, whose counsellors were recorded as pursuing the theory that she had experienced childhood abuse (initially with some difficulty because she was fond of her kindly father), developed her first ideas on a day in between therapy sessions. About 1000 hours of therapy later, she had an extensive belief system, including at least as many occasions of abuse as hours of treatment. A colleague in Quebec has observed the same outcome with rightful acquittals in six other trials. What juries and judges in Canada have just learned, Dr Brewin wishes us to unlearn.

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Genomics

SIR: Neuropsychiatry continues to leave me dumbfounded at its lack of connectedness with human experience. This 'cut-offness' was clearly demonstrated in Farmer & Owen's article (1996). First they sell the latest false dream. They conclude that "there is little doubt" that the genetic aetiology of "common familial disorders including the major psychiatric disorders" will be discovered, and that this knowledge "will radically alter clinical practice." A brief review of the history of psychiatry reveals how many previous false dawns there have been: hormone, pharmacotherapy, cognitive–behavioural therapy, neuroimaging, molecular biochemistry. Farmer & Owen point out the huge ethical dilemmas, not just about the potential misuse but the history of actual misuse of genetic notions of human history, culture and difference. This history and potential should not surprise us. The sense of omnipotence that accompanies such beliefs can never be far from the surface. Genetic science is saying, "I understand what the ideal gene pool should look like, I know therefore what the perfect human being should consist of." What parents, if told their baby had genes that put them at risk for a psychiatric disorder, would not want them changed? Farmer & Owen also suggest that knowledge of the genetics of psychiatric disorders could lead to pre-symptomatic testing. Some of their suggestions are simply laughable. "Advice can be given to individuals with high genetic loading for these disorders regarding exposure to environmental precipitants such as use of street drugs." Other suggestions terrified me. Pre-symptomatic identification of high-risk individuals is suggested. Imagine this: you are told that you have a high risk for schizophrenia. The warning signs have much to do with your thoughts. Suppose now that you get angry at someone, so angry that your thoughts are erratic, destructive and irrational. Will you question whether this is the first signs you were warned about? Worse still, will others now interpret this as a sign that you are developing the illness? (Oh dear, we were warned about this, we'd better get him down to the doctors, he has no insight.) Such a risk-factor culture is also an invitation for a spurious identification, a kind of self-fulfilling prophecy.

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SIR: Farmer & Owen (1996) gave a subtle description of the various reactions of psychiatrists with respect to the expansion of genetics in recent years. As do most articles addressing the developments in the combined field of psychiatry and genetics, those authors emphasise the detection, comprehension and prevention of the major entities in adult and geriatric psychiatry, and the ethical and psychological problems related to genetic counselling in the context of