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From the Editor's desk

By Kamaldeep Bhui

Matters of the heart and mind

Stigma continues to challenge the lives of people with mental illness who fear disclosure and avoid seeking help: men, young people, military personnel, ethnic minorities and health professionals are the most affected.[1] Diagnostic labels are often blamed for adding to stigma. Ellison *et al*'s study (pp. 341–342) tested reactions to vignettes of people with mental illness. A less stigmatising label of 'integration disorder' rather than schizophrenia produced surprising findings: although there was less perceived dangerousness and more attributions of biopsychosocial causation, the respondents conveyed greater social distance. This contrasts with the findings for a label of bipolar disorder rather than manic depression, where social distance and fear were positively associated and both diminished. Contrary to public perceptions of dangerousness among the mentally ill, Khalifeh *et al* (pp. 275–282) show that people with mental illness are actually more likely to be victims of both non-violent and violent crime, and women with mental illness are especially likely to suffer community, sexual and domestic violence.

Stigma and negative attitudes towards mental illness may affect career choices in medicine,[2] yet there is uncertainty about which interventions are effective and can be scaled in diverse settings and countries.[3,4] The extent to which discrimination is experienced as a consequence of stigma remains controversial and less well researched. An important influence is the quality of medical care received by people with mental illness. There is evidence of variation in take-up of screening to provide early intervention and to improve recovery from illnesses.[5–9] These disparities may explain a higher mortality among those with mental illness.[10–12] The research of Krivoy *et al* (pp. 297–301) and Chen *et al* (pp. 302–307) suggest that the treatment and aetiology of vascular and psychiatric disorders are closely linked, and their new data show that vascular disease might lead to neuropsychiatric symptoms including depression,[13] movement disorders and dementia.[14] These findings are complemented by Li *et al* (pp. 316–323) and Pan *et al* (pp. 339–340) finding important structural and functional brain correlates of the psychiatric disorders including mood states and suicidal thinking. Continuing this theme, Allan *et al* (pp. 308–315) show that hypertension may lead to white matter hyperintensities, associated with global or hippocampal atrophy, further revealing a potential pathway linking vascular disease to neuropsychiatric disorders. Smoking and physical inactivity profiles are implicated as behavioural factors and can be modified.[15] However, the profile of causes of mortality may be quite different in lower-income countries where infectious diseases may still be relevant and offer important preventive targets (see Fekadu and colleagues, pp. 289–296). More data on mortality, treatment and prognosis are needed from all countries (see Ran *et al*'s study (pp. 283–288) of poor prognosis among men with severe mental illness in China). However, we also need ways of ensuring that the data are well managed and reflect phenotypic comorbidities and shared aetiologies, rather than convenient but simplistic analysis of single diagnostic groups.[12]

What makes a *BJPsych* paper? This is an important question. Papers in this month's issue highlight the essential elements. Cognitive–behavioural therapy may help secure employment (Fournier *et al*, pp. 332–338) and Yesufu-Udechuku *et al* (pp. 268–274) show the importance of psychoeducation to reduce carer burden and psychological distress. And negative studies are welcome, for example, Okereke *et al*'s paper (pp. 324–331) on folic acid, B_6 and B_{12}; these are not effective in the treatment of depression. All papers accepted by *BJPsych* show strong and innovative methodology, definitive findings (positive or negative), a sufficient advance in knowledge with potential or actual clinical impact; and the findings, even if located in a particular setting or country, should have international relevance for the practice of psychiatry and for the provision of mental healthcare. As outlined in previous comments on editorial policy, we welcome cross-disciplinary research that meets these essential criteria. Positive reviews are not always sufficient for acceptance in the *BJPsych* and many sound papers do not make it in the competition for limited space. In order to promote dissemination of research, public education and better-informed clinical care, we wish to publish all methodologically sound papers. Hence, our new open access journal *BJPsych Open* is now accepting submissions. *BJPsych Open* will consider a wider range of original papers. I welcome two deputy editors to *BJPsych Open*: Gin Malhi from Sydney and Kenneth Kaufman from New Brunswick, New Jersey. And Amanda Baxter, Peter Byrne and Anne-Lingford Hughes form the new members of the *BJPsych Open* editorial board, supported by the existing *BJPsych* board members. All papers will be peer-reviewed, and we hope to make speedier decisions using previous reviews of your papers where available. Fast track for *BJPsych* and *BJPsych Open* should only be requested where the findings of your paper might have an impact on immediate practice, or the findings should be placed in the public domain for reasons of patient safety or to mandate a change in practice where previous practice is no longer acceptable or ethical on the basis of the findings. I look forward to seeing your best research papers, full of heart and mind, and powerful enough to improve the quality and range of clinical care for people with mental illnesses.

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