From the Editor's desk

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THE YO-YO OF MENTAL ILLNESS

When I qualified as a doctor my first surgical registrar was a lugubrious South African who quickly put me in touch with reality: 'You may think you have just passed an examination, but in becoming a doctor you have really contracted a disease'. When I told him I wanted to be a psychiatrist he went even further: 'I am afraid the prognosis is bad, you clearly have a terminal disease'. Even allowing for the jesting element, this comment betrays one of the major misconceptions of those outside psychiatry – the notion that once touched by madness the sufferer will pursue a chronic and hopeless course that is beyond help, and which also sabotages therapy. This arrant nonsense is still peddled to medical students by teachers who seriously believe that those with talent should not go into our discipline. In fact, one of the most exciting aspects of our craft and of those we treat is the complete unpredictability of the course of so much mental illness, and the amazing powers of recovery and restitution shown by the patients who cause us most despair.

The yo-yo course is illustrated in many papers in this issue, nearly half of which are primarily concerned with young people, and which go far beyond the classical yo-yo disorder, bipolar affective disorder. Spauwen *et al* (pp. 527–533) provide a fascinating insight into the processes whereby psychotic symptoms may be generated by trauma in those who are prone to psychosis, while others remain unaffected. Chitsabesan *et al* (pp. 534–540) show that young offenders, far from being insulated from ill-health by a psychopathic lining, have a host of mental health needs that are often unmet, particularly in community settings, and the findings of Barrett *et al* (pp. 541–546) suggest that if only a small part of the resources currently devoted to institutional care were allocated to these needs, there could be marked improvement. Families, who currently come in for heavy criticism for allegedly not controlling their antisocial children, still carry the greatest financial burden for their offsprings' behaviour (Romeo *et al*, pp. 547–553). The evidence that this carries on into adult life in so many cases (Simonoff *et al*, 2004), and that the problems can be detected easily (Yates *et al*, pp. 583–584) shows the value of effective intervention at this stage. Greater problems in the young were also noted by Ryan *et al* (pp. 560–566) in their study of depression and poorly planned migration from Ireland. Being prepared is not just necessary for Scouts; it is clearly advantageous for all those coming into new settings where patronising attitudes can provoke feelings of discrimination and distress (Dinos *et al*, 2004). But a lot depends on specific circumstances too. One of the most stable and determined people I have ever met was a psychiatrist from a Jewish family brought up in Northern Ireland at a time when there was so much discrimination on show between Catholics and Protestants that there was none spare for anti-Semitism.

Whether the yo-yo is on the way up or going down depends a great deal on life events and other adversity. It is perhaps not surprising that those in deprived socioeconomic circumstances stay longer in hospital than those from more favoured environments (Abas *et al*, pp. 581–582). What is much more encouraging to report is the study from Uganda (Bass *et al*, pp. 567–573) in which lasting benefit is shown from group interpersonal psychotherapy for depression in a population for whom that other highly cost-effective intervention, computer-aided treatment (McCrone *et al*, 2004), is not likely to become available for a long time. So – if any medical students are reading this piece – don't be put off by stories of relapse and gloom in psychiatry; read a few of the articles in this issue to reignite your enthusiasm.

TITLE BITES

We live in an age of the sound bite, in which there is so little time for reflection and study that we have to get the message complete and ready wrapped. With the space pressures on journals we too are getting into this territory. Book publishers tell me that half the sales of popular books depend on a catchy title and cover so that the reader is enticed into opening and reading, and then buying, the book. Titles such as 'malignant alienation', surely one of the most economical and evocative of descriptions (Watts & Morgan, 1994), are the ones we are looking for, and the best of them stand alone and make the rest of the text almost redundant. At an international conference recently I saw two that came close to this status. One was in the symposium to close the congress, which had the title 'Conflicts of interest in the psychiatric profession'. Underneath was written: *Supported by Bristol-Myers Squibb and Otsuka Pharmaceuticals*. The second was a poster title, hidden among 218 others, from a psychiatrist from Honduras: 'Mental disorder: a solved problem'. I rushed desperately to the stand at the time stated on the programme. But, sad to report, no poster was displayed. On reflection I can understand why. Having solved the problem of mental disorder, our presenter no longer needed to be a psychiatrist, and was probably now a molecular geneticist creating disease-free people to make other doctors redundant too.

Dinos, S., Stevens, S., Serfaty, M., *et al* (2004) Stigma: the feelings and experiences of 46 people with mental illness. Qualitative study. *British Journal of Psychiatry*, **184**, 176–181.

McCrone, P., Knapp, M., Proudfoot, J., *et al* (2004) Cost-effectiveness of computerised cognitive–behavioural therapy for anxiety and depression in primary care: randomised controlled trial. *British Journal of Psychiatry*, **185**, 55–62.

Simonoff, E., Elander, J., Holmshaw, J., *et al* (2004) Predictors of antisocial personality: continuities from childhood to adult life. *British Journal of Psychiatry*, **184**, 118–127.

Watts, D. & Morgan, G. (1994) Malignant alienation. Dangers for patients who are hard to like. *British Journal of Psychiatry*, **164**, 11–15.

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