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From the Editor's desk

By Peter Tyrer

Penetrating the blindfold

Recently I had occasion to recall a man to hospital who had absconded while under a compulsory order. It was suspected that he was at home and might be persuaded to come back voluntarily so I visited him at home early in the morning. Unfortunately our predictions about his cooperation were unfounded and he escaped out of a side door shortly after I had arrived at the front one. I pursued him down the street and, while running alongside him, tried to persuade him of the merits of returning to hospital as the easiest option available to him. My breathless arguments failed to impress, but fortunately when he ran into the nearest police station to complain of my harassment I was able to persuade the staff there about the merits of detaining him and an ambulance escorted him back to hospital soon afterwards. I had lunch later that day with a well-known politician who politely asked me what I had been doing. He was quite flabbergasted to hear my account, but more importantly, expressed his complete ignorance that any events like this ever occur in the country, never mind in central London.

When I explained in a little more detail exactly what 'care in the community' means nowadays he was quite understanding and made the revealing comment, 'It's obvious that this is a natural consequence of closing the mental hospitals but I suppose we don't want to be reminded of it'. When we are reminded of it, as for example when such people become our neighbours, we are not very forgiving, and this may explain the findings of Mehta *et al*, pp. 278–284) that public attitudes, accentuated by the popular press, have deteriorated with regard to the mentally ill. This is worrying, as access to care is reduced by discrimination[1,2] and when too much care is transferred from professionals the burden is greater.[3]

Politicians and opinion formers are feeling less uncomfortable about mental disorders but still prefer the comfy certainty of attitudes towards physical illnesses when making policy pronouncements. Attention-deficit hyperactivity disorder is widening its age range, prevalence and influence (McCarthy *et al*, pp. 273–277; Simon *et al*, pp. 204–211)[4] and if it were an established disease, no doubt the word 'epidemic' would be mentioned. Similarly, the bald statistic in the editorial by Harvey *et al* (pp. 201–203) that 'mental disorders are now the leading cause (40%) of sickness absence in most high-income countries' would be pounced on by politicians if it referred to a physical illness, and a similar reaction would be shown if obstetric and neonatal complications were associated with diabetes or asthma rather than intellectual disability (Sussmann *et al*, pp. 224–228). Dementia is now at the cusp of being embraced as a neurological disease that some would like to divorce from psychiatry, but the data from Savva *et al* (pp. 212–219), reinforced by Burns (pp. 199–200), show that it is the psychiatric symptoms and behavioural problems of dementia that differentiate the care of this group, and that attention to these is likely to lead to better outcomes than drug-oriented cognition-based management alone.[5] So we cannot airbrush away core psychiatry from the consciousness of politicians and at some point the blindfold will have to be removed. Perhaps I will have to wait for one of my more flamboyant patients to make his escape to the House of Commons at the time a motion of no confidence is being debated, to drive the point home.

Humour and mental illness

One of my theories about the stigma of mental disorders is that it inhibits good humour. It certainly promotes bad humour as we 'men in white coats' know to our cost but it prevents much of the real amusement of our craft from ever being exposed. There is a journal devoted to this, the *International Journal of Humor Research* (Editor-in-Chief: Salvatore Attardo) (impact factor 0.233) which obtains its material from many academic disciplines including, to quote the journal's website, 'anthropology, biology, computer science, education, family science, film studies, history, linguistics, literature, mathematics, medicine, philosophy, physiology, psychology, and sociology', but there is no mention of psychiatry, which is a pity. My first encounter with psychiatry was as a medical student. I was gardener to that prince of humour, the iconic iconoclast, Spike Milligan, whose wit was intimately bound to his mental state, and which certainly inhibited my gardening. His first instruction to me was: 'When you come to my house to garden and you see the curtains in that window drawn (pointing to the second floor window) it means that I am depressed'. 'What do I do about it?', I suggested, thinking this might be my first patient. 'Do about it?', Spike expostulated, 'It means you turn straight round and go back home. I will not be disturbed'. But he was, and quite magnificently, disturbed, and the best joke I know about hypochondriasis is on his gravestone in East Sussex, 'Duirt mé leat go raibh mé breoite'. It's only the Irish who know how to do it.

1 Thornicroft G. Stigma and discrimination limit access to mental health care. *Epidemiol Psichiatr Soc* 2008; **17**: 14–9.

2 Marwaha S, Johnson S, Bebbington P, Stafford M, Angermeyer MC, Brugha T, et al. Rates and correlates of employment in people with schizophrenia in the UK, France and Germany. *Br J Psychiatry* 2007; **191**: 30–7.

3 Roick C, Heider D, Bebbington PE, Angermeyer MC, Azorin JM, Brugha TS, et al. Burden on caregivers of people with schizophrenia: comparison between Germany and Britain. *Br J Psychiatry* 2007; **190**: 333–8.

4 Ormel J, Petukhova M, Chatterji S, Aguilar-Gaxiola S, Alonso J, Angermeyer MC, et al. Disability and treatment of specific mental and physical disorders across the world. *Br J Psychiatry* 2008; **192**: 368–75.

5 Wolfs CAG, Kessels A, Dirksen CD, Severens JL, Verhey FRJ. Integrated multidisciplinary diagnostic approach for dementia care: randomised controlled trial. *Br J Psychiatry* 2008; **192**: 300–5.

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