From the Editor's desk

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UNKIND SELVES

Psychiatric patients are unpopular. This is often perceived as discrimination and therefore unfair but it is also true that the troubles many patients create so often spread far beyond the bounds of their own pathology. Often they recognise this and it is a cause of personal distress, but recognition is not a solution and adds to the distress. Cressida in Shakespeare's *Troilus and Cressida* is one who recognises her destructive pathology only too well, the face she presents to the world is her unkind self, and she cannot shake off its maleficence. This issue exposes quite a few unkind selves. We are used to seeing evidence that family members of patients with severe mental illness are often put under immense strain and this is illustrated excellently by Roick *et al* (pp. 333–338), whose paper interestingly hints that the lower burden of care in Germany compared with Britain may be related to the greater number of beds available in German settings. But it is probably the unkind face of psychiatry that leads to a six-fold greater level of unmet needs for mental disorder compared with diabetes (Alonso *et al*, pp. 299–306).

The hauntingly sad face of an ill child taps the caring juices much more than the crumbling countenance of a homeless alcoholic and recalls Chesterton's comment that it is 'strange how people can see beauty in the ruins of an old building but none in the ruins of a man'. This lack of response is aggravated by the general notion that many of the people who seek mental health care are just 'putting it on', and it is not pleasant to see this reinforced by Alonso *et al*'s data showing that more than one in eight of all mental health consultations were for a non-existent need. Unsung sacrifices abound among the stalwarts in the care brigade and most are forever hidden. Nevertheless, their value can be judged by the relative failure of institutional care for disadvantaged children compared with care in a private household (Ford *et al*, pp. 319–325); the cost burden is greater for the family (Romeo *et al*, 2006) but the outcome is so much better. Despite the data not being strictly comparable, as those who become more disturbed are more likely to become placed elsewhere, the effects of changes in environment and disturbances in continuity are writ large in their account.

Patients with personality disorder often show the unkindest of faces to the world. Carrasco *et al* (pp. 357–358) suggest that there are biological reasons for this other than stress and Huband *et al* (pp. 307–313) provide one of the first large-scale successes of a relatively brief intervention – mixed social problem-solving linked to psychoeducation – for a range of personality disorders. This could well be suitable for general application, and such an intervention would make many in the population eligible (Coid *et al*, 2006) but as Crawford (pp. 283–284) points out, much more needs to be done to consolidate this and similar approaches. Finally, the thorny question of whether the terrorism of suicide bombers represents *folie à plusieurs* as Salib (2003) has suggested or some form of explicable behaviour pales beneath the influence of their mental effects (Rubin *et al*, pp. 350–356). The phrase 'a more negative world view' gloomily reflects the immense impact that a tiny few can create among the many.

BOUNDARIES OF CARE

One of the big differences I have noticed in my visits to less affluent parts of the world is a difference in the geographical boundaries of psychiatric responsibility, and I realise how much has changed in the wealthy countries in the past 50 years. I work in an assertive outreach team and often suggest to the patients under my care that they can run but not hide. This is usually perceived as a jest – but I will not correct it when challenged – and its acceptance shows the big difference between my practice of 40 years ago and today. When once I only had responsibilities in a tiny hospital base I now cover a large catchment area and, wherever problems arise, I seem to be responsible. This is not so in the developing world. Recently I visited a psychiatric hospital near Galle in Sri Lanka and was interested to note the standard patient record form had a single line to be completed for 'Date of discharge, escape or death'. When I asked why these options all appeared together I was told, 'that means we close the file'. In other words, the responsibility of the (limited and overworked) staff in the unit were confined only to living in-patients; those who were unwise enough to escape – the unit was an open one – had nowhere to go but also no professionals to be responsible for them, and the same applied to them after formal discharge. So when one sees discontinuity of care as the norm our well-intentioned attempts at continuity almost seem like molly-coddling (Chitsabesan *et al*, 2006).

Chitsabesan, P., Kroll, L., Bailey, S., *et al* (2006) Mental health needs of young offenders in custody and in the community. *British Journal of Psychiatry*, **188**, 534–540.

Coid, J., Yang, M., Tyrer, P., *et al* (2006) Prevalence and correlates of personality disorder in Great Britain. *British Journal of Psychiatry*, **188**, 423–431.

Romeo, R., Knapp, M. & Scott, S. (2006) Economic cost of severe antisocial behaviour in children – and who pays it. *British Journal of Psychiatry*, **188**, 547–553.

Salib, E. (2003) Suicide terrorism: a case of *folie à plusieurs*? *British Journal of Psychiatry*, **182**, 475–476.