Highlights of this issue

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PSYCHIATRIC PRACTICE AND ETHICS

Socrates suggested that 'the unexamined life is not worth living'; several papers in this issue of the *Journal* examine aspects of contemporary psychiatric life. For example, how does a psychiatrist assess a patient suffering from mental illness who is requesting euthanasia? Euthanasia was legalised in Belgium in 2002 and psychiatrists could be required to assess capacity in patients seeking euthanasia, not only for physical illness but also for mental suffering (Naudts *et al*, pp. 405–409). This raises complex questions about the different roles of a psychiatrist, highlighting the tension between being an advocate and a therapist, and this article examines practice in neighbouring Holland to clarify this complex area. This tension is also evident in working with different models of care for patients with serious mental illness. Lester & Gask (pp. 401–402) discuss the apparent conflict between the various national guidelines for providing optimal medical care in chronic disorders and those for promoting collaborative models of care to improve recovery in this group. They suggest that psychiatrists may need to listen to patients' wishes and that pursuing a genuine collaborative approach may necessitate acceptance that patients' preferences may lie outside the recognised treatment guidelines and protocols. Physical contact with patients is generally discouraged in psychiatric practice, usually with reference to the priority of maintaining boundaries over ordinary human empathic responses. Child psychiatrists are no different in their practice (Blower *et al*, pp. 486–487), but the authors suggest that the weakness of the evidence base and the importance of physical contact in normal interaction argue for a more detailed examination of this area. Stalking of mental health professionals is a common occupational hazard that is rarely examined, remaining underresearched and underreported yet causing considerable distress and morbidity. In their editorial, McIvor & Petch (pp. 403–404) propose that healthcare organisations have a duty to provide adequate education about stalking and have appropriate policies and support mechanisms in place.

DEPRESSION AND SUICIDE

It is not clear whether the optimal pharmacological treatment of unipolar psychotic depression should be with antidepressants, antipsychotics or both; recent international guidelines recommend treatment with both. However, Wijkstra *et al* (pp. 410–415) review the literature and conclude that combined treatment offers little advantage over treatment with antidepressants alone, and furthermore, that tricyclic antidepressants may be more effective than alternative antidepressants. C-reactive protein is a sensitive marker of inflammation and tissue damage, and levels are elevated in depressive illness (O'Brien *et al*, pp. 449–452). Interestingly, treatment with selective serotonin reuptake inhibitor antidepressants causes a significant reduction in C-reactive protein levels, but this reduction is not correlated with improvements in clinical state. Could these anti-inflammatory effects be utilised in inflammatory disorders? One would be forgiven for thinking that examining the time of birth and predicting the subsequent onset of disease would be the preserve of astrology rather than science, but there are robust epidemiological data demonstrating that more people with schizophrenia and Alzheimer's disease were born during the winter months, while affective disorders are associated with spring and summer births. Salib & Cortina-Borja (pp. 416–422) demonstrate that suicide is associated with having a birthday between April and June, and they discuss putative developmental mechanisms that may mediate this association.

PERSONALITY, PREDICTION AND PSYCHOSIS

Personality disorder is common in a community sample (Coid *et al*, pp. 423–431), even when people in hospital and in prison are excluded. Cluster C (obsessive/dependent) personality disorders were reported as more prevalent than cluster A (schizoid/schizotypal) or cluster B (antisocial/borderline). The authors suggest that public health initiatives targeted at the large percentage of those with personality disorder who have a childhood history of institutional care may be useful in reducing the number of criminal convictions, particularly in the cluster B personality disorder group. A wider issue relevant to all of healthcare is where finite resources should be applied for optimal benefit; Coid *et al* ask whether services should be devoted to the relatively small group of people with personality disorder who seek help within healthcare, or would be better employed in preventive work within the 'hidden' population that is leaving institutional care and those presenting to the criminal justice system. Predicting future criminal offending is difficult; age, gender and past offending are suggested as the critical indicators of risk. A follow-up study of special (high-security) hospital patients in the UK found that these factors were also the most useful in predicting offending in this rather specialised population, and that the addition of the legal class of their mental disorder did not enhance the predictive value (Buchanan & Leese, pp. 472–478). However, the legal class was useful in predicting serious offences alone. Patients with dual diagnosis are recognised to be difficult to treat. Baker *et al* (pp. 439–448) examined the effect of 10 sessions of cognitive–behavioural therapy for substance use disorders in patients with psychosis and reported short-term improvement in depression at 6 months and beneficial effects on general functioning at 12 months. However, there was no differential benefit on levels of substance misuse at 12 months. They conclude that stepped-care approaches may be useful in integrating different treatment approaches within one therapeutic framework.

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