BJPsych The British Journal of Psychiatry (2011)
199, 172. doi: 10.1192/bjp.199.2.172

From the Editor's desk

By Peter Tyrer

Abusing one's own

One of the most disturbing images I have ever seen is one of Francisco Goya's so-called black paintings, *Saturn devouring his son,* in the Prado museum in Madrid. This, the ultimate abuse of one's own, has often intruded into my consciousness when I receive papers on child abuse submitted to this *Journal*, and makes me shudder. It still surprises me that what is at the heart of self-preservation, the maintenance of the integrity of one's own family, can so often, and so fundamentally, be distorted in psychiatric pathology. I was reminded of this strongly again after reading Bass & Jones' article (pp. 113–118) about fabricated illness in children. We do not often publish case series in today's high-pressure publishing environment, but sometimes direct accounts are more powerful than standard tables and statistics and this is true here. I sometimes wonder whether the parents and alleged carers of children they abuse have any inkling of the harm they create, and promote in future generations long after they are gone, and, if they did, whether it would have any effect on their behaviour. When I first went into psychiatry I spoke to a respiratory physician whose main work was the treatment of infectious diseases such as tuberculosis. 'I'm not sure about psychiatry as a discipline', he observed in the usual prejudice of the time, 'but at least you're not going to run out of patients, which is looking increasingly likely for me'. I think he was right, but if we really could prevent childhood abuse and neglect across the world, which is likely to account for a third of all mental illness,[1] as well as suicidal behaviour[2] and psychosis,[3] we would make a serious dent in the relatively stable rates of mental illness found in epidemiological studies for decades. Why abuse should be so common when it goes against all evolutionary and biological imperatives continues to puzzle all those in the caring professions. Antenatal maternal depression is put forward as a powerful influence by Pawlby *et al* (pp. 106–112) and they suggest that maternal depression *in utero* may also play a part here, although this is a difficult hypothesis to test, as are the reasons for the possible difference in gender susceptibility.[3]

The parental role is one in which the exercise of control is fundamental to both good and poor caring, and this is one that all psychiatrists exercise in dealing with people with severe mental illness. Burns *et al* (pp. 145–150) have given a valuable insight into the extent to which patients are coerced into accepting treatment in community and assertive outreach teams and it will probably surprise few in these services that about a third of all patients are levered into positions where it is difficult for them to refuse treatment, and this is independent of statutory treatment orders and probably independent of ethnicity too.[4] Zigmond (pp. 90–91) questions both the ethics and clinical value of this increasing tendency to pressurise patients into doing what they do not want to do, now getting to be the norm in the USA,[5] particularly, as he rightly states, when in many instances the treatment is considered by the sufferer to be worse than the disease. Small wonder, therefore, that we are now finding that patients much prefer the less controlling settings of crisis homes to those of in-patients wards[6] and are attracted to more even-handed treatments such as music therapy (Maratos *et al*, pp. 92–93; Erkkilä *et al*, pp. 132–139). The distance between parental childhood abuse and professional patient abuse is perhaps not as far apart as many think.

Getting our definitions right

Mario Maj (pp. 85–86) poses a perennial question to psychiatrists in his editorial: When is a mental health problem a true disorder and when is it just normal variation? It is not a new question, but he is right to call our attention to it again, not least as there is abundant evidence that almost all diagnostic dividing lines are artificial, and that so-called 'sub-threshold' disorders are not qualitatively different from 'supra-threshold' ones.[7] The pragmatic approach he recommends seems a sensible one but it would be marvellous if it could have some independent markers that we could measure. In the meantime it would do no harm for psychiatrists to point out to other physicians that most diseases in medicine pose similar problems in setting diagnostic boundaries. At what level of blood pressure can we say someone is suffering from hypertension, and when does an obese person develop diabetes?

The question I always ask myself in such situations is also pragmatic but not based on entirely satisfactory evidence: 'Does this patient require specific treatment, even if none is available?' If I feel the answer is 'no', I will be reluctant to give a diagnosis that confers significant implications for intervention, so a term such as 'adjustment disorder' would not trouble me whereas one of depressive disorder would. This, I accept, is not the best way of proceeding as the diagnosis is in danger of being made after my treatment decision, not before. Perhaps I ought to input all the data I have into the hands of OPCRIT+ (Rucker *et al*, pp. 151–155) and then proceed smoothly towards the path of virtue.

1 Kessler RC, McLaughlin KA, Green JG, Gruber MJ, Sampson NA, Zaslavsky AM, et al. Childhood adversities and adult psychopathology in the WHO World Mental Health Surveys. *Br J Psychiatry* 2010; **197**: 378–85.

2 Bruffaerts R, Demyttenaere K, Borges G, Haro JM, Chiu WT, Hwang I, et al. Childhood adversities as risk factors for onset and persistence of suicidal behaviour. *Br J Psychiatry* 2010; **197**: 20–7.

3 Fisher H, Morgan C, Dazzan P, Craig TK, Morgan K, Hutchinson G, et al. Gender differences in the association between childhood abuse and psychosis. *Br J Psychiatry* 2009; **194**: 319–25.

4 Bennewith O, Amos T, Lewis G, Katsakou C, Wykes T, Morriss R, et al. Ethnicity and coercion among involuntarily detained psychiatric in-patients. *Br J Psychiatry* 2010; **196**: 75–6.

5 Busch A, Redlich A. Patients' perception of possible child custody or visitation loss if not adherent to psychiatric treatment. *Psychiatr Serv* 2007; **57**: 343–9.

6 Osborn DPJ, Lloyd-Evans B, Johnson S, Gilburt H, Byford S, Leese M, et al. Residential alternatives to acute in-patient care in England: satisfaction, ward atmosphere and service user experiences. *Br J Psychiatry* 2010; **197** (suppl 53): s41–5.

7 Ayuso-Mateos JL, Nuevo R, Verdes E, Naidoo N, Chatterji S. From depressive symptoms to depressive disorders: the relevance of thresholds. *Br J Psychiatry* 2010; **196**: 365–71.

https://doi.org/10.1192/bjp.199.2.172 Published online by Cambridge University Press