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Contents

Do we need to treat aggression?

'Once upon a time, plenty of children were unruly, some adults were shy, and bald men wore hats. Now all of these descriptions might be attributed to diseases – entities with names, diagnostic criteria, and an increasing array of therapeutic options.'[1]

Aggression in the absence of any disorder could just be that – aggression – or in other words, bad or criminal behaviour. Why are we so keen to medicalise bad behaviour or any other behaviour that is not within the 'defined' or accepted norms?

I think it is good thing that ICD has not yet included diagnoses such as 'intermittent explosive disorder'. Although we have come a long way from the time when modern medicine was accused of being a major threat to the world's health,[2] have we now gone too far in the opposite direction?

The problem of medicalisation is that it does not stop at that: it is only the beginning of a chaos that runs out of control. Once you make a diagnosis, you then have to treat the disorder. Often, behavioural problems are treated with medications that are not licensed for such indications, which in itself is bad practice in many cases. All treatments have their side-effects and many people are unnecessarily exposed to them. False hope is given to 'patients', their families and society. A culture is promoted in which people want medical solutions to all their problems, rather than taking responsibility for their actions. The cost of treatment adds up to a huge amount.

Also, costly research, including randomised controlled trials and meta-analysis, has to be carried out to establish the efficacy of these treatments. Often it reveals little or no evidence of efficacy. One simple reason could be that, for a treatment to be effective, there needs to be a real target illness.

In their meta-analysis, Jones *et al* conclude that the use of mood stabilisers resulted in an overall reduction in aggression.[3] However, given the high level of heterogeneity between studies and the risk of publication bias in half of them, the results suggest that there is actually not enough evidence to support this statement.

In the end, the authors recommend further randomised controlled trials. I would like to ask whether there is enough evidence to justify the cost of such trials, in terms of money and of the time and efforts of highly qualified professionals. What about schizophrenia and depression, which remain the leading causes of morbidity across the world, yet for which there are still relatively limited treatment options?

1 McLellan F. Medicalisation: a medical nemesis. *Lancet* 2007; **369**: 627–8.

2 Illich I. *Medical Nemesis*. Bantam, 1977.

3 Jones RM, Arlidge J, Gillham R, Reagu S, van den Bree M, Taylor PJ. Efficacy of mood stabilisers in the treatment of impulsive or repetitive aggression: systematic review and meta-analysis. *Br J Psychiatry* 2011; **198**: 93–8.

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Author's reply: Once upon a time the depressed were idle, the psychotic were possessed, and those suffering with any form of mental illness were punished, exorcised, ridiculed, confined, excluded or criminalised.

Thankfully, as a result of investment in research, there have been significant advances in the understanding of the brain and the biological underpinnings of mental disorders, emotions and behaviours, including aggression. To advocate the omission of the scientific study of aggression from that of the rest of the brain would be anomalous, to say the least.

Aggression can indeed lead to 'bad behaviour', as indicated by Dr Mushtaq, but to conclude that they are synonymous is inaccurate and is missing the point. Many individuals are extremely distressed by the impact of their own propensity to extreme anger or aggression. Many seek help, but often little is available. Without research into the efficacy and safety of potential interventions, be they medical, psychological or social, there would be no evidence to guide practice. Effective help is needed, not ostracism.

Dr Mushtaq makes a thoughtful point about medicalising conditions that do not fall within accepted norms. This is indeed a problem of the traditional medical model, in which there is a demand to dichotomise continuous symptoms or physio-biochemical measures (such as those of anxiety, mood, blood pressure, or haemoglobin concentration) into 'health' or 'disease'. Such a blunt approach is often arbitrary, and unsatisfactory, but the medical community seems to demand it. After all, how can you treat something unless it is an illness? Without clear boundaries between health and disease, fears of chaos and uncertainty abound, as Dr Mushtaq describes. Deciding on a threshold and giving it a label certainly has its place, but from an individual's perspective, it is the serious impact those symptoms have on their lives that is of most concern, and a desire to obtain relief. Health and illness of the human brain are more complex than dichotomies, and research is required to elucidate this subtlety and to identify and improve treatments. Without research, psychiatry would still be in the dark ages.

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Ward overcrowding and assaults on staff: cause and effect?

Virtanen *et al* draw our attention to the important problem of overcrowding in psychiatric wards and its association with increased risk of violence directed at staff.[1] There appears to be an error in the results section of the paper, in which it is reported that men are more likely than women to be working in high-occupancy wards. This is contrary to what is presented in Table 1, where women are more likely than men to be working in such wards.

Among the limitations of their study that the authors list is that data were drawn solely from the retrospective self-reports of staff, potentially resulting in errors arising from recall problems and under- or overreporting. In future prospective research, the use of structured instruments such as the Overt Aggression Scale[2] or the Staff Observation Aggression Scale[3] could minimise under- and overreporting.

The authors suggest a dose–response pattern after they found a strong linear trend between higher bed occupancy rates and a