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Highlights of this issue

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Diagnosis and patient experience

Diagnosis forms the core of psychiatric practice and research. However, there is an increasing awareness that there is a lack of a clear scientific rationale underpinning the current syndrome-based diagnostic system. An alternative is to adopt a transdiagnostic approach which has as its focus the different domains of illness. In their editorial, Doherty & Owen (pp. 171–173) review the advantages and disadvantages of taking this domain-level view to research across the different diagnostic categories, and use the research domain framework as an exemplar. They suggest that this should serve to improve the neuroscientific base of mental illness and thus to optimise the opportunity for developing more targeted therapies. One application of this symptom domain approach is to assess the experience of patients referred primarily for mood instability, with a range of potentially different diagnoses (Bilderbeck and colleagues, pp. 234–239). These patients placed a greater value in understanding their presenting difficulties, regardless of their eventual diagnosis. The authors concluded that clinicians should pay greater attention to patients' expectations and address these explicitly, rather than assume that the patients are seeking a diagnosis as the primary outcome. They also highlight the value of involving family and friends in assessments, serving to increase the patients' confidence in being heard. A related editorial by Dudas (pp. 178–179) encourages a more thoughtful and empathic approach to patients with mood instability, improving relationships through a greater focus on patients' expectations and increased awareness of the importance of managing the communication of their diagnosis.

Refugee and military mental health

The relationship between refugee status and mental health is increasingly important given the rise in numbers of refugees over recent years. Llosa and colleagues (pp. 208–213) found relatively elevated rates of significant mental illness in approximately 20% of the population of a long-term refugee camp in Lebanon. Interestingly, although they demonstrated increased rates of depressive illness, there were relatively lower rates of post-traumatic stress disorder (PTSD) in this population. The authors clarify the distinction between refugees in short-term post-conflict camps, characterised by higher rates of depressive and PTSD illness, and people settled in more established longer-term refugee camps, as in their study, experiencing lower levels of acute adversity but high rates of daily stressors as a consequence of poverty and marginalisation. A related editorial reviews the complexity of the mental health needs of refugees, presenting most commonly with elevated rates of PTSD, depression and anxiety disorders. Vostanis (pp. 176–177) suggests that, since refugee status includes a multitude of different aetiologies, treatment needs to be tailored to individual contexts. These contexts differ markedly between low-income countries, where service capacity building is a major issue, and higher-income countries, where there are fewer service capacity and delivery issues, but greater difficulty in adapting their treatment models to a very culturally diverse group of patients. Military personnel are exposed to traumatic events through the intrinsic nature of their work and, unsurprisingly, exhibit increased rates of PTSD, aggressive behaviour and hazardous alcohol use. However, Sundin and colleagues (pp. 200–207) found interesting differences between these mental health outcomes of US and UK military personnel returning from Iraq, with elevated rates of PTSD correlated with greater combat exposure in the US sample, but higher rates of alcohol misuse and aggression in the UK personnel. The authors suggest that a lack of tolerance of alcohol in the US army may have an effect on lower levels of relative alcohol misuse, and advocate the utility of having post-deployment mental health training in reducing negative outcomes in this vulnerable population.

Violence, and fostering

There is an active debate on the utility of structured instruments for assessing propensity for future violence in patients with mental illness. Singh and colleagues (pp. 180–187) report that there is an unexpectedly wide variation in the prediction of violence using these different instruments, evident in patients assessed as being at high risk of violence. Most of the models predicting future violence are predicated on a reliable knowledge of the baseline rates of violence in the population. Their study found reduced rates of actual violence in those predicted as high risk using actuarial measures, compared with those predicted as posing a high risk using structured professional judgement. The authors suggest that suitable caution needs to be incorporated in making sense of these probabilistic risk estimates, especially as they have a considerable impact on individual liberty and public safety. There has been increased concern about the difficulties experienced by children who are raised in care. Multidimensional treatment foster care is an intervention offered to foster carers based on the intensive social learning approach pioneered in Oregon, USA. This was examined in the UK, with no significant benefit of the intervention on global functioning, educational placement or offending behaviours when compared with care as usual. Green and colleagues (pp. 214–221) suggest that there is treatment heterogeneity in relation to baseline antisocial behaviour, which may explain the non-replication of earlier favourable studies with a focus on samples with prominent antisocial and offending behaviour.