

Highlights of this issue

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VIOLENCE AND SUICIDE

Violence and suicide have become linked with the month of September and it is appropriate that this issue of the *Journal* contains papers of interest not only to clinical and academic psychiatrists, but also to sociologists and anthropologists. Salib (pp. 207–212) demonstrates a decrease in the rates of suicide in the UK in the month following the tragedy of 11 September 2001. There was no corresponding decrease in homicide rates. The paper supports Durkheim's theory that periods of external threat improve social cohesion through group integration within society. Reflecting the importance of developmental factors, the propensity towards violence is suggested to be present from early childhood, perhaps from toddlerhood, and the continued presence of this behaviour later in life is suggestive of a failure within normal inhibitory developmental processes. Fonagy (pp. 190–192) discusses the importance, in early childhood, of secure attachment, modelling maternal behaviour without power assertion and the development of mentalising ability, and their associations with violent behaviour in later life. The prefrontal cortex may be the biological mediator, implicated in both anti-social behaviour and mentalising ability. However, it is important that all is not lost at this early stage, and the establishment of a strong attachment relationship in later life can still provide an environmental influence that can divert the child from a path of violence and behavioural disturbance. The proposition is that encouraging the exploration and enriching the representation of other people's mental states may be a more effective way of preventing violence, for example as an approach to combating bullying, than asserting power through exclusion. In the clinical population, the oft-quoted assertion that patients with psychosis are more likely to end up as victims rather than perpetrators of violent crime is supported by data from a study by Walsh *et al* (pp. 233–238);

they report that the past-year prevalence of having been a victim of violence in a community sample of 691 subjects with psychosis was double that of the general population. They suggest that victimisation needs to be enquired for when acquiring background information from the patient.

DEMENTIA; STIMULATION THERAPY AND LATE-ONSET SCHIZOPHRENIA

There has been considerable interest in pharmacological treatments for dementia and less attention has been focused on cognitive therapies. Following on from the findings of a Cochrane review that reality orientation may have a beneficial effect in both cognition and behaviour in patients with dementia, Spector *et al* (pp. 248–254) report a randomised trial of cognitive stimulation therapy in dementia, which demonstrated improvement in assessments of cognitive function and quality of life in the treated group. The treatment consisted of 14 45-minute sessions spread over 7 weeks and comprised reality orientation, multisensory stimulation and information-processing activities. The number needed to treat compared favourably with anti-dementia drug effects. Cognitive decline in schizophrenia has been a subject of much debate. A 5-year follow-up of patients with late-onset schizophrenia (Brodaty *et al*, pp. 213–219) supports the proposition that this condition may be a precursor to Alzheimer-type dementia. Nine of 19 patients met DSM-IV criteria for dementia after 5 years, while none of 24 comparison subjects developed dementia. Older patients, with more limited cognitive performance at first assessment were those most likely to develop dementia.

VALUE FOR MONEY

There is a four-fold variation in the costs associated with the running of 58 child and

adolescent psychiatric in-patient units assessed within the UK. Costs were increased in units managed within the NHS, specialist units and those in London, with children with psychosis and learning disabilities associated with higher unit costs (Beecham *et al*, pp. 220–225). The accompanying commentary (Harrington & Gowers, pp. 226–227) cautions against simplistic notions that this variation in costs necessarily reflects inefficiency, and notes that costs are predictable in that more spacious units, with fewer beds, based within London and treating patients with greater clinical need were going to be more expensive. The real question is whether patients do better in these units and what are the crucial variables determining outcome, particularly with respect to staff/patient ratios as staff costs comprise two-thirds of the total costs. Although economic analyses are useful in considering the effectiveness of services, optimal care must also consider the humanitarian and clinical issues.

PERSONALITY DISORDERS

Schedules for assessment of personality disorders are lengthy instruments often requiring specific training, leaving the clinician to rely on clinical judgement. Moran *et al* (pp. 228–232) have identified the need for a brief screening instrument for routine clinical use and describe the performance of one such scale – the Standardised Assessment of Personality – Abbreviated Scale (SAPAS). The SAPAS performed well against the gold-standard DSM-IV assessment of personality disorder (identifying 90%). The advantages of the SAPAS lie in time taken for assessment (2 minutes), absence of training requirements and acceptability to patients and staff. They caution against its use as a diagnostic instrument, suggesting more detailed assessment for subjects scoring above threshold. The SAPAS is appended to the article.

PSYCHIATRY AROUND THE WORLD

A series of invited articles opens a window onto psychiatric practice and research in different countries; the current contribution is from the University of Gent in Belgium and its Unit for suicide research.