From the Editor's desk

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MIND THE GAP

The mildly menacing instruction 'mind the gap' often puzzles the visitor as it echoes in London underground stations. It is replete with hidden meaning; what exactly constitutes the gap and how exactly should it be looked at, for or after? This issue explores the curious space between the moving train of enquiry and the solid platform of more secure knowledge. Marneros (pp. 1–2) kicks off by looking at what occupies the gradually shrinking space between schizophrenia and bipolar disorder (Craddock & Owen, 2005) and not only finds no clear dichotomy but argues that Emil Kraepelin did not believe in one either. The disorders in the gap can make a bridge and it would be interesting to know how much they share the anatomical and obstetric history features of bipolar disorder also described here (El-Badri *et al*, pp. 81–82; Scott *et al*, pp. 3–11), compared with those of schizophrenia. Another gap, identified by Coid *et al* (pp. 12–19), is between the services we offer to reduce violence in psychiatry and the knowledge base of intervention. Concentrating our resources on the most violent people may not yield as many dividends as a more even spread.

Narrowing the gap between intervention and knowledge at the earliest stages of mental illness has been a key area of enquiry for some time, and the data from Rabinowitz *et al* (pp. 31–35) show the importance of premorbid functioning in this condition; but is poor functioning truly premorbid, or is it early illness? And should we be concentrating exclusively on schizophrenia when Kisely and his colleagues (pp. 79–80) show that the longer the gap between the exhibition of symptoms and treatment in common mental disorders the worse the outcome? This is of particular concern because our reliance on the successful detection and treatment of these disorders by general practitioners in primary care, while good in principle (Thornicroft & Tansella, 2004), is not achieved in practice (Boardman *et al*, 2004). The linking of mental disorder to its appropriate treatment is also far too often prevented by the 'pervasive concern' of stigma (Dinos *et al*, 2004) and this is very prevalent in Chinese society (Lee *et al*, 2005). So it is very pleasing to report a successful way of overcoming this in the treatment of schizophrenia in Hong Kong (Chien *et al*, pp. 41–49). Mutual support, or group therapy by proxy without the patients, was the most effective of the three interventions, and the results contrast nicely with the Western alternative of individual cognitive–behavioural therapy reported by Turkington *et al* (pp. 36–40). But we still have puzzling gaps to be filled. We do not yet have the answer to that stubborn gap between enquiry and knowledge in that most common of disorders, depression in general practice. We know depression is common there, that it can be treated, and yet so often is not managed effectively. One obvious pathway, general referral to community health nurses, is not the answer (Kendrick *et al*, pp. 50–59), so we will have to continue to try and find an answer in primary care.

THE ORIGIN OF COGNITIVE BEHAVIOUR THERAPY

At the 159th meeting of the American Psychiatric Association in Toronto on 23 May an additional event took place, the annual dinner of the Association for Research on Personality Disorders (ARPD). I was persuaded to attend as we were promised fundamental insights into the origin of cognitive behaviour therapy by the after-dinner speaker, Tim Beck. He, and David Bernstein, the president at the meeting, have kindly agreed that my vote of thanks, delivered in the Lancashire accent of my youth as I was so overcome by emotion, can be reproduced:

> The folks said – polite-like – just for me
> 'You must go to the ARPD'
> I said 'I can't' but were held in check
> 'You've got no choice, 'cos we've got Tim Beck'
> 'Ee, ee', I said, 'perhaps I don't mind
> Entertainment of a different kind'
> Tim detailed to us in proper order
> All his personality disorder
> He said, 'listen well, 'cos there's more than one'
> And that really got me thinking on
> Severe PD means total paralysis
> Then he told us why – 'psychoanalysis,
> It doesn't worry when it gets stuck
> It just rumbles on and makes it up'
> We all felt sorry for disordered Tim
> He barely knew what had happened to him
> We could see his mind were wracked by torsion
> Then the answer came, 'cognitive distortion'
> And that, my friends, is the history
> Of what – till now's – been a mystery
> We've been exposed to the ultimate verity
> The real start of cognitive behaviour therapy

Boardman, J., Henshaw, C. & Willmott, S. (2004) Needs for mental health treatment among general practice attenders. *British Journal of Psychiatry*, **185**, 318–327.

Craddock, N. & Owen, M. (2005) The beginning of the end for the Kraepelinian dichotomy. *British Journal of Psychiatry*, **186**, 364–366.

Dinos, S., Stevens, S., Serfaty, M., *et al* (2004) Stigma: the feelings and experiences of 46 people with mental illness. Qualitative study. *British Journal of Psychiatry*, **184**, 176–181.

Lee, S., Lee, M.T.Y., Chiu, M.Y.L., *et al* (2005) Experience of social stigma by people with schizophrenia in Hong Kong. *British Journal of Psychiatry*, **186**, 153–157.

Thornicroft, G. & Tansella, M. (2004) Components of a modern mental health service: a pragmatic balance of community and hospital care. Overview of systematic evidence. *British Journal of Psychiatry*, **185**, 283–290.