From the Editor's desk

PETER TYRER

THIS MONTH'S ISSUE: CONTROL

As I write, the death of Harold Shipman, the notorious GP and mass murderer, by hanging himself from the bars of his cell window in Wakefield Prison, has just been announced. This has led some observers to comment that he had not only controlled the time of death for his victims but also for himself and so he could at least be said to have been consistent. I was hoping that someone in our profession might at some point have elucidated from him a reason, or at least a clue, for the trail of quiet destruction he left from Todmorden to Hyde but speculation seems all that is likely to remain. It is a pity that the article by Shaw and her colleagues (pp. 263–267) had not been published a little earlier, as their observation that, as hanging is the most common form of prison suicide, 'removal of potential ligature points from cells should be a priority' was a prescient one.

Control is prominent elsewhere too. Cooper *et al* (pp. 210–215) point to the malign influence of 'maternal strong control and disharmony' in generating eating disorder, and Gudjonsson and her colleagues (pp. 258–262) show that the exhibition and control of violent behaviour in psychiatric in-patients is complicated, and that the quick conclusion that ethnic influences are high on the provoking list is likely to be mistaken. And with articles on the MRCPsych examination (pp. 197–199), now an agent of international control (of standards), and two others (Tarrier *et al*, pp. 231–239, and Huibers *et al*, pp. 240–246) showing that control therapies are competing favourably with the world leader in psychological therapies, cognitive–behavioural therapy, the subject has great scope to illustrate its versatility. But I must end with the control of speech and language, the great leap forward for a humankind that Tim Crow maintains left in its wake the Achilles heel of schizophrenia. Mitchell *et al* (pp. 223–230) show differences between those with schizophrenia, bipolar disorder and controls in brain activation following 'emotional prosody'. But they do not define prosody. My old Samuel Johnson dictionary does, quite lyrically – 'the part of grammar which teaches the sound and quantity of syllables and the measures of verse' – and this, to me, is control at its best.

WE ARE WHAT WE ARE – BUT FOR HOW LONG?

Recent evidence that personality and its attendant disorder is unstable in both the short and long-term (Seivewright *et al* (2002), *Lancet*, **359**, 2254–2255; Shea & Yen (2003), *Journal of Personality Disorders*, **17**, 373–386) suggests that one of the core features of the definition of personality disorder, a persistent template of behavioural characteristics beginning in adolescence and continuing throughout most of adult life, might be wrong. I was very conscious of this possibility when attending a reunion recently of classmates from school, last together in 1952. Would I recognise them as the same people I knew 50 years ago or would they all have changed fundamentally? What might have endured and why? Would they think that my twin brother and I were more like dizygotic twins now? These questions were answered by our reunion, but not in full. What I recognised were little islands of continuity in a sea of change – boyish enthusiasm at the latest in technology, a need for hierarchy in relationships, solid planning in all aspects of life, whimsy at the piquancies of others – but were these core personality features or just isolated pieces of a life jigsaw? I don't know, but one thing was clear: I wanted to retain the continuous features in my mind and discard the new ones. So this may be the reason for our belief in the persistence of personality; the consequence of selective memory. Nevertheless, it was good to note that I and my brother were still considered monozygotic, as Tienari *et al* (pp. 216–222) might have predicted.

USEFUL NEOLIGISMS – TROOPERSHIP

Neil was about to be discharged after 6 years as an in-patient, making him the most senior resident of the hospital even though he was not yet 30. 'We're very pleased that at last you can have a fresh start, Neil. How do you feel about it?', asked his consultant. 'Its all down to troopership', replied Neil, betraying what we thought were elements of his original diagnosis. 'When there was troopership, I got better. I hope troopership continues'. There seemed little more to say. One year later he remains out of hospital and still feels continuously invested with troopership, but neither we nor he can define exactly what it is. But we think we know its essentials, and are desperately trying to maintain them.

DOGGEREL OF THE MONTH: A NEW THERAPEUTIC APPROACH?

One of our more intractable patients moved away some years ago to a town 300 miles away. He has since kept in touch by letter and verse. His observations are usually pertinent and witty, but unprintable. However, he recently sent me a little note which set me thinking and to which he wanted a response with regard to his future treatment. It may not be original, but it led me to reflect that his recent treatment was much less contentious than in the past, and so I composed the following to him in response.

Follow, clever doctor,
On the road that I pursue
Its really quite a doddle
As you don't have much to do
You'll never hear of burn-out
Smiles will infect your staff
And when you treat your patients
You'll only make them laugh
And when delusions overwhelm us
First ranks doubling up as twins
Just tickle their inconsistencies
And watch them collapse in grins
So away with all your potions
Instead this path endorse
You just need to make us happy
While nature takes its course.

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