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From the Editor's desk

By Kamaldeep Bhui

Sorrow, suffering and the varieties of depressive experience

> O my country, my home!
> May the Gods save me from becoming
> A stateless refugee
> Dragging out an intolerable life
> In desperate helplessness!
> That is the most pitiful of all griefs;
> Death is better. Should such a day come to me
> I pray for death first.
> Of all pains and hardships none is worse
> Than to be deprived of your native land.
>
> Medea, Euripides[1]

Euripides, an Athenian born c.484 BC, wrote a number of tragedies that set out the varieties of human sorrow, suffering and emotional pain. Although we often think of statelessness as a modern invention, *Medea*, written thousands of years ago makes clear the personal tragedy, depression and near suicidal thinking that can accompany the loss of one's native land. Llosa *et al* (pp. 208–213) and Vostanis (pp. 176–177) report that among refugees in the suburbs of Beirut, depression is common (19%) as are suicidal ideas (8%), and there is significant disability associated with depression, although few are offered treatment. Conflict in the world is a common cause of statelessness and asylum, but the plight of soldiers sent to conflict zones is rarely considered. Sundin *et al* (pp. 200–207) contrast the effect of deployment to Iraq for soldiers from the USA and the UK. Combat exposures explain the levels of post-traumatic stress disorder (PTSD) similarly in both populations, but not patterns of hazardous alcohol consumption and aggression – both greater in UK than in US troops.

Studies of sorrow and depressive experience can inform more precise diagnostic practice and provide us with evidence of aetiology and impact. These works aim to capture the depth and detail of common human dilemmas and to be unconstrained by existing diagnostic conventions that do not always approximate well to personal experiences of suffering – see Dudas (pp. 178–179) and Bilderbeck *et al* (pp. 234–239). So diagnoses may be seen as the mediators of stigma if '[perceived by patients] as preconceived and unfavourable opinions' (p. 178). And, to some extent, the research community, practitioners and patients are in agreement, as evidenced by the Herculean efforts to reform diagnostic practice and ground it in research evidence (see Doherty & Owen, pp. 171–173).

Studies of depression are still needed. The link between depressive affect and future cognitive impairment has been the subject of much deliberation. Richards *et al* (pp. 194–199) suggest that there is no long-term cognitive impairment on objective measures, but there are certainly reports of a subjective experience of poor memory. As deliberated by Doherty & Owen (pp. 171–173), the evidence increasingly shows common antecedents across psychiatric and behavioural syndromes and links between psychiatric and general medical outcomes should not be surprising. For example, on studying the plight of refugees, much attention is given to PTSD, and now depression, but less to their higher risk of death related to cardiovascular disease.[2] Chen *et al* (pp. 188–193), in a study from Taiwan, show intriguing effects of anaesthesia as a risk factor for cognitive impairment and dementia, even after adjustment for physical comorbidities, including cardiovascular disease. Reassuringly, they revealed no cognitive impairment among patients who had previously received electroconvulsive treatment, but intravenous, intramuscular, regional or general anaesthesia were all implicated.

Interventions continue to attract critical attention, especially the use of compulsory admission and treatment for mental disorders. The data from England suggest a growing number of detentions despite fewer admission beds.[3] The reasons for this are under investigation, however, Kelly's editorial (pp. 174–175) on the United Nations Convention on the Rights of Persons with Disabilities reveals an overlooked but potentially important flaw in assessments for detention, that is the requirement for the presence of a mental disorder rather than disability and the inclusion of risk criteria linked to mental disorder, something notoriously difficult to assess[4] (see Singh *et al* (pp. 180–187) on risk assessment). Studies of the subjective experience of detention and compulsory treatment are perhaps needed, and this is important for both the patient and the practitioner as both are changed by it.[5]

1 Euripedes. *Medea and Other Plays*. Penguin, 1963.

2 Hollander AC, Bruce D, Ekberg J, Burstrom B, Borrell C, Ekblad S. Longitudinal study of mortality among refugees in Sweden. *Int J Epidemiol* 2012; **41**: 1153–61.

3 Keown P, Weich S, Bhui KS, Scott J. Association between provision of mental illness beds and rate of involuntary admissions in the NHS in England 1988–2008: ecological study. *BMJ* 2011; **343**: d3736.

4 Yang M, Wong SC, Coid J. The efficacy of violence prediction: a meta-analytic comparison of nine risk assessment tools. *Psychol Bull* 2010; **136**: 740–67.

5 Beveridge A. Psychology of compulsory detention. *Psychiatr Bull* 1998; **22**: 115–7.

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