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Highlights from this issue

Edited by Derek K. Tracy

In the end, we will remember not the words of our enemies but the silence of our friends

Earlier (read: on-time) finishes at work; more time with my son Arun, including (responsible, socially distanced) sunny evenings playing with him in the park; and some homemade croissants that weren't as bad as you might imagine. Missing physically meeting family and friends; a (still) developing dental cavity needing ever more extensive treatment; and an ever-growing hairstyle that might generously be described as 'interesting'. Personal light and shade among the harsher challenges of the COVID-19 landscape; I'm sure you have your own. Strous & Gold talk (pp. 410–412) about the clinical, ethical and administrative complications psychiatry faces during this time, while Diamond and Willan discuss (pp. 408–409) achieving good mental health during social isolation, noting the additional challenges for those with existing mental health problems. Their recommendations are beautifully simple: learn, connect, take notice, give to others and be active. Sadly, they offer no guidance on the contemporary etiquette conundrum of whether one should wave to others at the end of work webcam meetings.

My Editor-in-Chief has to occasionally pull in the reins to make sure I don't become too (overtly) provocative in my writings, but with Kapilashrami he strikes us hard asking (pp. 405–407) 'is the virus racist'. The question is apposite: we have seen the disproportionality of the effects of COVID-19 in the UK and elsewhere. A key challenge has been determining if ethnicity is a marker for genetic or other health vulnerabilities, or primarily covers cultural, socioeconomic and structural differences or disadvantages. The answers are beginning to emerge and are complex and non-binary. However, as we think of the 'gains' of COVID-19, from greater digital working to more flexible work patterns, the exposure of, and need to remedy, deep societal inequities must be a primary one. As other recent social upheavals have reinforced, #BlackLivesMatter.

The ultimate measure of a man is not where he stands in moments of comfort and convenience, but where he stands at times of challenge and controversy

'Yeah, it's a lazy dog dangling afternoon' Homer Simpson once drolled. Within that, we can all intuitively relate to sedentary behaviour having different forms: some might be more active (for example writing the Highlights column), some more passive (for example reading the Highlights column). (In truth, both actually constitute 'active sedentary' as they require cognitive effort – at least if you're paying attention). Well, does it matter in terms of one's mental health? The question is important, as data show that those with depression spend far more time engaged in sedentary behaviour, so any positive tweaking could be potentially very useful. Hallgren et al (pp. 413–419) analysed over 24 000 survey responses from Swedish adults to model the impact of replacing half an hour of passive sedentary behaviour with either mentally active sedentary behaviour, light physical activity or moderate-to-vigorous physical activity. The result? More mentally active sedentary behaviour – and all exercise forms – were associated with reduced risks of depression. This infers that completing this column as my *BJPsych* copy deadline looms should really be doing wonders for my mental state: I must confess that my mini $n = 1$ trial is going against prediction. Susie Rudge writes more in this month's Mental Elf blog: https://elfi.sh/bjp-me24

There are long-standing debates on the factors that facilitate and hinder help-seeking. Britt et al (pp. 420–426) take this to the armed forces, surveying over 2000 US soldiers about their physical and mental health. A preference for handling the problem oneself was the main barrier in both domains – something the authors propose might be linked with the military's cultural emphasis on resilience – with more facilitators noted overall for physical ill health. There were few gender differences, but interestingly, officers noted both more barriers and facilitators than enlisted personnel.

Earlier presentation is clearly critical in cancer care; Stewart et al (pp. 427–433) looked at the histories of depression and anxiety in just over 400 individuals who received a first lifetime cancer diagnosis. Cancer 'beyond local extent of disease' at this initial assessment was more common in those with a history of depression, and less common than average in those with past anxiety (and, interestingly, those with *both* anxiety and depression did the same as the general population). The link between mental illness and cancer mortality are well established, and as strong as those for cardiovascular disease. These findings point to one causal mechanism being altered help-seeking behaviours and altered time to being initially seen.

There is nothing more tragic than to find an individual bogged down in the length of life, devoid of breath

Those with psychiatric disorders have higher rates of ischaemic heart disease and cerebrovascular accidents, but it has been less clear if this has been changing over time, and how any evolving risks might be stratified. Jackson et al (pp. 442–449) evaluated this by retrospectively reviewing Scottish population records from 1991 to 2015. The incidence of ischaemic heart disease has been falling with time for all groups, but compared with the general population, the relative risk has decreased only for those with depression. Overall, even in 2015 those with a psychiatric disorder still had a 2.5-fold higher risk than those without.

Directionality is inevitably questioned with ischaemic heart disease and cerebrovascular data: do those with a mental illness develop more such events, or is it the other way around. Most data show both aspects to be correct (bidirectionality), but the question is what drives this: shared risk factors, misclassification of disease measures or non-response to treatment? Wium-Andersen et al (pp. 434–441) test this for depression, using ten Danish population-based cohorts totalling about 100 000 individuals. Despite their large sample size, the authors were unable to disentangle causative factors, with the associations still there after adjustment for socioeconomic and clinical factors.

Osimo and colleagues go straight to the heart (pp. 450–457), using cardiac magnetic resonance imaging to explore the structure in 80 participants with schizophrenia. They found evidence of cardiac remodelling when compared with matched healthy controls, including smaller left and right ventricles and end-diastolic volumes, and increased concentricity and septal thicknesses. The findings persisted when adjusted for smoking and exercise levels, and were independent of antipsychotic medication dose or duration. Such remodelling occurs when myocytes are exposed to noxious stimuli, and the subsequent changes can be pathological. The authors note that these cardiac changes may be directly contributing to patient mortality.

Finally, Kaleidoscope (pp. 464–465) reviews if the popular press might at times be sensationalist in how they report upon antidepressants and psychological therapy. I know, you're thinking 'hard to imagine', but have a look, and see if there are differences between the *Daily Mail* and *The Guardian*.

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