

Highlights of this issue

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Antidepressants and treating bipolar disorder

This first issue of the *Journal* in 2009 brings in the New Year with an exciting raft of clinically related research. Recent meta-analytic studies have suggested that antidepressants are no better than placebo in the treatment of depression, questioning their place in psychiatric practice, although this may appear counterintuitive to the clinician treating patients with severe depression. An editorial in the current issue takes a critical look at the questions raised by these studies and, in a refreshingly clear fashion, lays out the difficulties inherent in these meta-analytic approaches. Parker (pp. 1–3) highlights the crucial differences between the patients treated in routine clinical practice and those treated in clinical trials and shows how these differences can have an effect on the data being input into the meta-analysis, leading to systematic biases in the results. The manic and depressive phases of bipolar illness have traditionally been difficult to treat effectively: two studies address this problem. A review of lamotrigine in the treatment of bipolar depression, by Geddes and colleagues (pp. 4–9) using a meta-analytic approach, concludes that lamotrigine has a consistent beneficial effect on depressive symptoms in the depressive phase of bipolar disorder. This also supports one of the arguments made in the earlier editorial, as it reported larger effects in the patients with more severe depression, compared with placebo. The use of second-generation antipsychotic medication for the treatment of bipolar mania has become more widespread over the past few years. Young *et al* (pp. 40–48) report that patients with bipolar mania treated with aripiprazole for 12 weeks showed a significant improvement compared with those treated with placebo. The response rate to the aripiprazole was equivalent to the degree of improvement seen in the patients treated with haloperidol. They suggest that the relatively benign side-effect profile of aripiprazole may offer advantages with respect to other comparable drugs used in the treatment of bipolar mania.

Suicidal behaviour and anorexia

There is an intuitively attractive theory that suicidal behaviour is reduced during times of national threat, perhaps mediated by the need for higher social cohesion. Salib & Cortina-Borja (pp. 80–85) demonstrated that there was a small but significant drop in the suicide rate following the terrorist attacks in 2005 in England. They suggest that this may reflect the emotional reaction to the incidents and the effects of extensive media coverage, offering some weak support for the original theory. The observation that there is a much higher suicide rate in Scotland than in England prompted a study of self-harm levels in adolescents in Scotland. O'Connor *et al* (pp. 68–72) found that 14% of 15- to 16-year-olds reported self-harm. This was higher in girls and was associated with bullying, anxiety and the presence of self-harm in the family in both genders. The authors conclude that there may be value in offering emotional literacy and mental health promotion packages to these adolescent groups, to try to reduce the levels of distress

associated with self-harming behaviour. On a similar theme, it is accepted that patients who harm themselves are at higher risk of repeating this behaviour in the future. Heyerdahl and colleagues (pp. 73–79) attempted to quantify the frequency of this repetitive behaviour, examining the frequency of episodes of acute self-poisoning in Oslo. They found that 30% of patients had poisoned themselves again within the space of 1 year; such individuals were more likely to be middle-aged, unemployed and with a previous history of self-harm or psychiatric treatment. Interestingly, they found no predictive value in the statement of intent behind the poisoning, and the highest frequency of the repetition occurred in the first month. One disorder which has a significant suicide risk is anorexia nervosa, with a high reported rate of associated morbidity and all-cause mortality. Papadopoulos *et al* (pp. 10–17) followed up a large cohort of patients with this diagnosis and compared their mortality ratios with the general population. They reported that the highest standardised mortality ratio (SMR=6.2) was for anorexia nervosa, followed by alcohol misuse and suicide as the most prominent causes of death. They suggest that assessment and treatment of psychiatric comorbidity, especially alcohol misuse, could offer some benefits in the long-term outcome.

Psychosis, prodrome and predicting Lewy body dementia

The progression of psychotic illness remains poorly understood; recent interventions have been targeted at the early phase of the illness, predicated on the critical period hypothesis, which suggests a critical neuroplastic phase early in the illness, with entry into a subsequent phase of relatively stable deficit. Crumlish *et al* (pp. 18–24) report some support for this idea, as they found that the duration of untreated psychosis predicted remission, positive symptoms and social functioning at 8-year follow-up; however, they also found evidence of improvement of negative and disorganised symptoms between 4 and 8 years from the onset of the illness. They conclude that a shorter duration of psychosis, with earlier intervention, perhaps in the prodromal stage, may offer some advantage for the later course of illness. A functional magnetic resonance imaging study by Broome and colleagues (pp. 25–33) found the prodromal or 'at-risk' stage of illness was characterised by functional changes in key frontal cortical regions, which were not present in healthy controls and were present in a more extreme form in patients with clear psychotic illness. The authors suggest that these changes may be indicative of impairments in executive functioning and working memory, possibly conferring an increased vulnerability to psychosis. Neuroimaging has also been used to examine functional changes in Lewy body dementia, which is easily diagnosed when prominent symptoms are present but this is usually relatively late in the disease process. O'Brien and colleagues (pp. 34–39) suggest that abnormalities in single-photon emission computed tomography scans may be useful in distinguishing Lewy body from non-Lewy body dementia where there is diagnostic uncertainty and that this could assist in the earlier implementation of the most appropriate management.

We take this opportunity to wish the readers of the *Journal* a very peaceful and harmonious New Year.