Highlights of this issue

BY ELIZABETH WALSH

SMOKING, DEEP VENOUS THROMBOSIS AND PSYCHOSIS

There is an association between smoking and schizophrenia, and patients who smoke score higher on rating scales for psychotic symptoms than their non-smoking peers. By examining the smoking behaviour of 92 patients with bipolar affective disorder, Corvin *et al* (pp. 35–38) investigate whether this association exists with psychotic symptomatology in general, rather than with schizophrenia specifically. Smoking was found to be associated with a history of psychotic symptoms in bipolar affective disorder. Smoking was less prevalent in patients who were less symptomatic than in patients with more severe psychosis. This is the first study to report such an association and, although based on a small sample, suggests that the link between smoking and psychosis may be independent of categorical diagnosis. The mechanism for this remains unclear but a regulatory effect for nicotine on neurotransmitter systems has been suggested. The authors suggest that those with psychotic bipolar illnesses be targeted as a population at particular risk of smoking-related illness. Psychiatrists should also be aware of the health risk posed by deep venous thrombosis (DVT) when a patient uses antipsychotic drugs in the presence of risk factors for venous thrombo-embolism (Thomassen *et al*, pp. 63–66). This warning, based on a case series and case–control study, echoes recent mounting evidence identifying antipsychotic drugs as significant risk factors for DVT.

SOMATOFORM AND SEASONAL AFFECTIVE DISORDERS – NEEDY AND NEGLECTED

Bass *et al* (pp. 11–14) review the prevalence, disability and economic burden represented by somatoform disorders and suggest useful strategies to overcome the current neglect of these disorders in practice. Using strict diagnostic criteria, Michalak *et al* (pp. 31–34) estimate the prevalence of seasonal affective disorder (SAD) to be 2.4% in a general population sample in rural North Wales. The fact that only one of the 25 patients identified with the disorder had previously received this diagnosis from their general practitioner (GP) is concerning, although over half had been diagnosed with other forms of depression and received treatment. Despite moves such as the Defeat Depression Campaign, which have concentrated upon improving the identification and treatment of depression in primary care, it may be particularly difficult for GPs to recognise forms of depression characterised by somatic symptoms such as weight gain and hypersomnia, which characterise SAD.

PSYCHOSIS – SYMPTOM DIMENSIONS

Symptomatology in psychotic disorders can be divided into three main psychotic symptom dimensions, positive, negative and disorganised. In a twin study, Cardno *et al* (pp. 39–45) investigate whether genes make an important contribution to symptom dimensions. Individuals with high disorganised dimension scores were found to have relatively high genetic loading for psychosis. It is suggested that this dimension may be a useful phenotype for molecular genetic studies of psychotic disorders.

. . . PLACE OF BIRTH

Pederson & Mortensen (pp. 46–52), replicating their previous study using additional data, find the environmental factors underlying the effect of place of birth are major determinants of schizophrenia at a population level, with the effect of family history being strongest at an individual level. There was a dose–response relationship between degree of urbanisation at place of birth and subsequent risk for developing schizophrenia. The reason for this urban–rural difference remains obscure despite extensive study.

. . . AND FAMILY INTERVENTION

Lenior *et al* (pp. 53–58) performed a 5-year follow-up of social functioning in young Dutch patients with schizophrenia after randomisation to either a standard intervention or standard plus behavioural family intervention. Although no differential treatment effect with regard to course of illness or relapse rate was found, patients in the family intervention group spent less time in psychiatric institutions than those in the standard arm. It would appear that parents who received the family intervention (support, psychoeducation, communication skills and problem-solving techniques) were better equipped to support their child and, in certain cases, rehospitalisation was prevented or delayed.

READING ABOUT . . . PERSONALITY DISORDER

This month we are treated to an entertaining commentary – with personal reflections on personality disorder (Tyrer, pp. 81–84). The work of playwrights and novelists who have the "empathic ability to synthesise understanding of the internal and intimate elements of personality with the impact their behaviours have on others" is recommended. The expansion of treatments away from the therapeutic community are discussed. Tyrer reminds us, with reference to Henderson's creative psychopath, that even abnormalities of personalities can have positive attributes that may have short-term gains and that do not necessarily lead to major adversity, except in the long term.

https://doi.org/10.1192/bjp.179.1.0 Published online by Cambridge University Press