

Highlights of this issue

By Derek K. Tracy

Burnt Norton

One hundred billion neurons, 1000 trillion connections; the most sophisticated machine in the known universe. The hardest of hard-core neuroscience combined with the art, practice, and beauty of understanding what it means to be human. And yet we've difficulty recruiting our best medical students, and public perceptions of psychiatrists can vary from woollily ineffective to societal arch-manipulators. We need a makeover, TV-style. Crabb and colleagues (pp. 259–261) explore this, convincingly arguing that we should get more professional about our image and brand: it's not enough for us to whinge (though we still can); it's up to us all to do something about this – 'be unashamedly confident and proudly elitist' they rightly state. Claire Henderson and colleagues (pp. 316–322) take the public's perspective, evaluating the impact of the Time to Change anti-stigma campaign in England. Such work is growing, but its effectiveness on changing behaviour is less explored: would it lead to greater awareness and help-seeking for mental ill health? Yes, they find, with greater comfort in disclosing a mental health problem. It's reassuring to see this, and a spur to grow on such meaningful work. Aileen O'Brien explores more in this month's Mental Elf blog: <https://elfi.sh/bjp-me9>. Which segues to the issue of cognitive biases: we all have them (some more than others, or so I think), how modifiable are they in mental health management? A recent meta-analysis in the *BJPsych* tackled this, but an analysis by Grafton *et al* (pp. 266–271) claims that the work had problematic ambiguities and didn't adequately unpick key aspects. Their re-analysis finds that although the procedures utilised to modify such biases may not reliably create the intended cognitive change, when cognitive bias modification *is* elicited, it has a reliable impact on emotional vulnerability. Footfalls echo in the memory down the passage which we did not take.

East Coker

Kaleidoscope (pp. 329–330) reviews interventions to manage psychological well-being after environmental disasters, and a new algorithm with a relatively high predictive value for subsequent post-traumatic stress disorder (PTSD) development. McLaughlin *et al* (pp. 280–288) step this back further, to look at how different childhood adversities may sensitise individuals for the later development of PTSD. While an association with early life stress is recognised, it has been unclear whether this just represented a more generalised vulnerability. Taking epidemiological data from the WHO World Mental Health Surveys, only four types of childhood adversities were associated with (similarly) increased odds of later-life PTSD: physical and sexual abuse, neglect, and parent psychopathology. It's not clear why other trauma types lacked this association, but the authors evoke differential heightened salience of threat cues and magnification of emotional reactions to subsequent potential threats. In our beginning is our end. Early-life institutional deprivation can lead to disinhibited social engagement (DSE) that can include 'lack of stranger wariness' and 'excessive self-disclosure', but how this might persist and manifest into adulthood has not been well described. Kennedy *et al* (pp. 289–295) followed up 122 of 165 Romanian orphans adopted into the UK, finding that DSE was strongly associated with early deprivation – with a 6-fold increase in those who had spent over 6 months in such institutions. Interestingly, and

perhaps against prediction, DSE was not associated with wider mental ill health or deficits in social functioning, and appeared to be largely benign. The authors question whether DSE should be seen as an impairment in diagnostic manuals, and note how the 'natural' openness it produces can be positive for some.

The Dry Salvages

The *BJPsych* recently reported data¹ showing that although physical health outcomes in those with serious mental illness (SMI) had improved over the past decade or so, the gap had widened compared with the general population. Manderbacka *et al* (pp. 304–309) take one aspect for this group – survival in individuals with a first cancer episode. Fitting with other work on the topic, Finland's Cancer Registry data showed an excess mortality in the SMI (and substance use) group. Troublingly, cancer stage and comorbidities did not explain the differences, but cancer *treatment* did: there are clearly barriers to getting appropriate care. Further, fitting with the aforementioned paper by Hayes *et al*, the gap is widening with time . . . Looijmans *et al* (pp. 296–303) show that something can be done, randomising 29 care teams to tackle an obesogenic environment or provide treatment as usual (TAU). The intervention was targeted at nursing teams, with lifestyle coaches evaluating the environment, team routines, and patient and staff preferences and logistic possibilities for change: all tailoring increased exercise and availability of healthy food. This showed significant reductions in patient waist circumference and metabolic syndrome scores over TAU by 3 months, though the gains had dissipated by 1 year. What we call the beginning is often the end: change can be created – sustaining it will be the real challenge.

Little Gidding

Kaleidoscope looks at data on putative biomarkers for suicide prediction, but Jacob (pp. 264–265) offers a far broader and more meaningful editorial on suicide prevention in low- and middle-income countries. Suicide is a common cause of death in such environments but, he posits, is problematically medicalised, failing to account for social and public health perspectives, not least the role of poverty and social deprivation. The need for social and economic interventions is persuasively argued: it's hard to disagree. Behavioural activation has a growing evidence base for the treatment of depression, but its effectiveness in older people is less explored. Vasiliki Orgeta and colleagues (pp. 274–279) from University College London systematically reviewed the best current evidence, finding data to support it in this population comparable to that for cognitive-behavioural therapy. The evaluated trials were notable for their small sizes, and the risks of bias were considered high, but their results are enough to encourage clinical application, and better future trials. And to end our exploring and arrive where we started, Zhou *et al* (pp. 310–315) report on findings that will resonate with us all. They report on an occupational physician reporting scheme that shows not just high rates of work-related physical and mental ill health in doctors, but that the incidence is growing – especially in women.

Finally, with significant changes coming to the *BJPsych* as we move shortly to a new publisher, a time for gratitude to journal staff who have done so much for so long, often unseen and behind the scenes. On behalf of the readership, to Dave Jago, Adam Hamilton, Lynnette Maddock, and – with a particular nod from me – Andrew Morris: thank you.

¹ Hayes JF, Marston L, Walters K, King MB, Osborn DPJ. Mortality gap for people with bipolar disorder and schizophrenia: UK-based cohort study 2000–2014. *Br J Psychiatry* 2017; **211**: 175–81.