

Highlights of this issue

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Dementia and attention-deficit hyperactivity disorder

Dementia is most prominently characterised by memory deficits, but many of the significant difficulties of managing this disorder are related to behavioural and psychological symptoms. Savva and colleagues (pp.212–219) found these neuropsychiatric symptoms to be in almost all those with dementia. A factor analysis identified four clusters, relating to psychosis/apathy, depression/anxiety, persecution/irritability and wandering/sleep problems. In a related editorial, Burns (pp.199–200) takes a critical look at the implications raised by this apparent widening of the disorder and reminds us that these symptoms were present even in the original description of Alzheimer's disease. Burns concludes that these neuropsychiatric features of dementia are as central to the disorder as cognitive loss, and that they need to be identified as targets for change if one aims to improve the quality of life of people with dementia and their carers. Traditional boundaries are also extended at the other end of the age spectrum, where the diagnosis of attention-deficit hyperactivity disorder (ADHD), conventionally restricted to childhood, is increasingly being recognised as persisting into adulthood. Simon *et al* (pp.204–211) performed a meta-analysis of prevalence studies of adult ADHD and found a rate of 2.5%, which declined with age. They suggest that the validity of diagnostic criteria may lead to an underestimation of the true prevalence. A study examining the pattern of prescription of stimulant drugs by general practitioners for the treatment of ADHD demonstrated a significant decrease between the ages of 15 and 21 years. McCarthy *et al* (pp.273–277) conclude that this drop in prescribing for ADHD is in excess of age-related decreases in symptoms, raising the possibility that treatment may be prematurely terminated.

Treatment of affective disorders and imaging white matter in schizophrenia

Traditional wisdom suggests that all antidepressants are equally efficacious and differ predominantly in their side-effect profile. However, Uher *et al* (pp.252–259) report that this may be an artefact of insufficient attention to rating scales and inappropriate statistical methods. They found that the treatment effects of escitalopram and nortriptyline could be differentiated using dimensional measures of symptoms, with greater improvements on cognition and observed mood with escitalopram and improved neurovegetative symptoms, such as sleep and appetite, with nortriptyline. Although psychological treatments have been accepted as evidence-based treatments for depressive illness for some considerable time, similar data have only recently been available for the treatment of bipolar disorder, and there is little information on long-term follow-up. Colom and colleagues

(pp.260–265) report 5-year outcome data from a randomised controlled trial of individuals with bipolar disorder, initially treated with group psychoeducation over a 6-month period. This treatment group had fewer recurrences of their illness, with a longer time before recurrence, and spent less time acutely ill or in hospital. The authors suggest that the lack of favourable longer-term outcome data using psychological therapy in bipolar disorder may have limited its use, and make the argument for this treatment to be more widely available. The disconnection theory of schizophrenia posits a failure of integration between different regions of the brain, rather than one focal neuropathological lesion. Kanaan *et al* (pp.236–242) test this using diffusion tensor imaging, a relatively novel neuroimaging technique that permits better visualisation of white matter tracts implicated in cortico-cortical communication. They report a pattern of widespread changes in white matter tracts in patients with schizophrenia, which they suggest could arise either as a consequence of disordered neuronal integrity or alterations in myelination, both of which point to disconnectivity in schizophrenia.

Sickness, employment and public attitudes

The most common reasons for sickness absence in adulthood are psychiatric conditions and musculoskeletal disorders. The association of sickness with objective measures of the working environment are not clear, but the individual's perception of the environment may show a significant relationship to sickness absence. Henderson and colleagues (pp.220–223) used longitudinal data to show that children whose teachers described them as having frequent aches and pains, appearing miserable, and being off school for trivial reasons were more likely to be permanently off work sick or disabled. They suggest that understanding how early temperamental influences may interact with the individual perceptions of the workplace requires a life-course approach if one is to clarify the mechanisms by which these variables contribute to long-term sickness absence. Harvey *et al* (pp.201–203) emphasise the fact that mental illness is the leading cause of sickness and incapacity in most high-income countries. Recent work suggests that there are two main groups contributing to this: the majority group comprises people with common mental disorders and the smaller group those with severe mental illness. They discuss the impact of more recent changes proposed in the Black review such as the introduction of 'fit notes' and other initiatives such as the Improving Access to Psychological Therapies project. They conclude that a clearer focus is needed, along with the necessary resources, for employment and other rehabilitation services to work efficiently within mental health services. It is concerning to note that public attitudes towards people with mental illness may have become less sympathetic over the past decade. Mehta and colleagues (pp.278–284) analysed data from community samples between 1994 and 2003, acquired by the Department of Health, and speculate that this change in public opinion may have occurred as a consequence of negative media focus on psychiatric disorders and associations with violence, coupled with changes in mental health legislation.