BJPsych The British Journal of Psychiatry (2015) 206, A23. doi: 10.1192/bjp.206.6.A23

Highlights of this issue

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Aetiological understanding – socioeconomic gradients, fatherhood, and religiosity

Several papers in the *BJPsych* this month explore the role of a range of aetiological factors, some well known and others less so, relevant across the spectrum of mental health. Two of these papers consider whether aetiological factors known to be important for mental ill health mirror those relevant to mental well-being. Utilising data from the 2010 and 2011 Health Surveys for England, Stewart-Brown *et al* (pp. 461–465) found that low mental well-being was associated with those sociodemographic variables known to be important risk factors for mental illness, including unemployment, age and marital status. However, this pattern was not seen when factors associated with high mental well-being were considered. Similarly, Kinderman *et al* (pp. 456–460) found support for a 'two continua' model of the relationships underpinning well-being and mental health problems – specifically, that depression and anxiety were associated with negative life events mediated by rumination, while low well-being was associated with material deprivation and social isolation mediated by coping style.

Studies demonstrating a reduction in suicide risk associated with religiosity have a long and consistent history but the association has not been fully tested in a modern secular environment. O'Reilly & Rosato (pp. 466–470) found that risks were similar for those with and without religious affiliation in a 9-year data-linkage study, the Northern Ireland Mortality Study. The authors did identify an association between those self-reporting to be conservative Christians and a lower risk of suicide. They comment on the possibility that there may be an increasing disconnection between religious affiliation and religious salience in modern secular societies, particularly among young people, who are also at the highest risk of suicide in such environments.

Finally, whereas maternal perinatal mental health has been the subject of much research, the mental health of fathers during this period is less well understood. Taking a prospective longitudinal research approach, Leach *et al* (pp. 471–478) found no increase in depression and anxiety among expectant or new fathers when compared with levels of illness prior to fatherhood. Interestingly, 'never fathers' appeared to be the group most psychologically distressed.

Intervention studies aimed at people with severe mental illness

Although early intervention programmes for first-episode psychosis have been shown to improve outcomes, longer-term maintenance of benefit has not been demonstrated. Chang *et al* (pp. 492–500) conducted a randomised single-blind controlled trial to evaluate the effect of extending early intervention by 1 year (beyond the standard 2-year programme). The authors found a range of benefits in functioning, symptom levels and treatment default rates among those randomised to programme extension but they also commented on the need for future studies to examine whether or not such benefits are sustained beyond programme end. Developments in pharmacogenetics offering the potential for personalised treatment for severe mental illness have been limited by the complex genetics of disorders such as schizophrenia. In this context, Butcher *et al* (pp. 484–491) examined clinical response to clozapine among individuals with a well-established genetic subtype of schizophrenia, 22q11.2 deletion. They found that individuals with the genetic subtype responded as well to clozapine as those with idiopathic schizophrenia but the former did appear to be more likely to experience severe adverse effects, particularly seizures. The authors propose that the study constitutes a proof-of-principle for personalised medicine and should encourage future such research in schizophrenia.

The elevated risk of trauma for those with severe mental illnesses, resultant occurrence of post-traumatic stress disorder (PTSD) and the emerging evidence of benefit from modified cognitive– behavioural therapy (CBT) approaches in reducing the impact of trauma in this group prompted Mueser *et al* (pp. 501–508) to evaluate the specific benefit of cognitive restructuring when added to the breathing retraining and education components of a CBT programme. Cognitive restructuring was found to be of significant benefit in terms of reducing PTSD symptoms and improving functioning.

Managing violence and the closure of forensic hospitals

Staff training in de-escalation techniques is widely practised across mental health services on the basis that such training will improve the safe and effective management of violence and aggression. Price *et al* (pp. 447–455) undertook a systematic review of the outcomes of such training and identified 38 relevant studies. The strongest impact of training appeared to be on staff knowledge, confidence and performance in training scenarios, but it was not possible to draw any conclusions about the impact of training on actual outcomes in clinical practice. Barbui & Saraceno (pp. 445–446) comment on recent legislative developments in Italy, which will see the progressive downsizing and closure of forensic psychiatric hospitals, with clinical responsibilities and resources transferred to the National Health System; a development occurring in the context of criticisms levelled at the quality of care for individuals in the forensic hospitals concerned. The authors compare the anticipated changes in services to the process of deinstitutionalisation which began 35 years ago, and call for a national registry to be set up to monitor outcomes for those affected.