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Highlights of this issue

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Five trials of treatment approaches in depression

Three papers in the *BJPsych* this month present findings from depression treatment trials and two papers address treatment of depressive episodes in bipolar disorder. Huijbers *et al* (pp. 366–373) trialled discontinuation of maintenance antidepressant medication following completion of mindfulness-based cognitive therapy in a sample of adults with recurrent depression in remission, and found an increased risk of relapse/recurrence in the discontinuation group. The authors comment that, while remitted patients under these circumstances should be advised to stay on medication, those who persist in their wish to discontinue should be supported to do so. A pilot randomised controlled trial of the Healthy Activity Program, a brief psychological treatment with behavioural activation at its core, was conducted in India and a positive impact of the intervention on the prevalence of depression was found. Chowdhary *et al* (pp. 381–388) comment on the potential of their systematic and context-specific approach to the development of the intervention to be applied to other mental disorders. In a UK-based trial of a practice nurse-led proactive care intervention for chronic depression in primary care, Buszewicz *et al* (pp. 374–380) found that the intervention improved levels of functional impairment but there was no improvement in either depression scores or quality of life, except in those engaging in the full intervention. The authors comment on the need to identify those patients, from this neglected clinical group, who are most likely to engage and benefit from such treatment.

Treatment of bipolar type II depression with antidepressant medication is controversial because of the potential problem with manic switch episodes. Amsterdam *et al* (pp. 359–365) compared antidepressant with mood stabiliser monotherapy in a sample of adult out-patients with bipolar II depression. They found that short-term use of venlafaxine produced better outcomes than lithium and did so without an increased risk of hypomania developing. Predictors of recovery from bipolar depression are not well established, nor is the role that such predictors might have in moderating response to treatment. Utilising data from the Systematic Treatment Enhancement Program for Bipolar Disorder (STEP-BD) randomised controlled trial of psychosocial treatment, Stange *et al* (pp. 352–358) examined the role of affective instability on the course of bipolar depression. The degree of instability of symptoms of both depressive and manic type was found to predict a lower likelihood of recovery and a longer time to recovery but did not moderate the effects of the various allocated psychosocial treatments tested. The authors call for further research to understand the role of personality comorbidities, the mechanisms underlying the associations found, and the extent to which treatments might impact directly on affective instability, as a means to improve recovery from depression.

Mortality and physical health comorbidity in those with mental illness

Using data from the English Longitudinal Study of Ageing (ELSA), White *et al* (pp. 337–342) were able to examine the impact of depressive symptom duration on mortality risk, an aspect of the established linked between depression and death which has not been well studied. They found evidence of a dose–response relationship between the duration of symptoms, measured over repeated assessments during follow-up, and mortality. The importance of physical activity, cognitive function, functional impairments and physical illness in explaining the association was considered. In a meta-review of interventions to reduce mortality risk in people with severe mental illness, Baxter *et al* (pp. 322–329) identified 16 systematic reviews, 8 with mortality as the primary outcome. On the basis of their review, the authors call for urgent action in two areas – improving adherence to psychiatric pharmacological guidelines and to guidelines for monitoring metabolic health. They also call for more research to understand the barriers to physical health monitoring and to understand the important ingredients of integrative community care programmes which have been shown to have a positive impact on physical health outcomes.

While those with bipolar disorder and depression are known to have poor physical health outcomes, the impact on cardiometabolic disease specifically is not well understood. Using cross-sectional data from the UK Biobank, Martin *et al* (pp. 343–351) found associations between both disorders and cardiovascular disease outcomes even after adjusting for a range of confounding factors, with risk broadly greater for those with features of bipolar disorder. An association was also found between psychotropic medication and cardiometabolic disease, even among those without a definite history of mood disorder.

Mental illness stigma

The development of stigma theory has occurred largely in a Western context. Angermeyer *et al* (pp. 389–397) sought to compare public beliefs and attitudes about schizophrenia in Germany and Tunisia in order to explore the impact of cultural differences on the social processes underlying stigma. The authors found differences in the form rather than the magnitude of stigma between the two settings – the difference seemed to manifest particularly in those social roles which 'matter most' to people in the different settings. In an editorial by Corrigan (pp. 314–315), two key approaches to resolving stigma are considered – promoting normalcy and promoting solidarity. In comparing the pros and cons of the two approaches, Corrigan proposes that future research and advocacy needs to identify which of the approaches should be employed in different circumstances.