IN THIS ISSUE

This issue contains two reviews, one on how well the Beck Hopelessness Scale can predict suicide and self-harm, and one on the validity of the distinction between bereavement-related and non-bereavement-related depression. Other sets of papers examine various aspects of suicide and depression.

Hopelessness as a predictor of suicide and self-harm

McMillan *et al.* (pp. 769–778) present findings from a meta-analysis of studies of hopelessness, measured using the Beck Hopelessness Scale (BHS), and suicide and non-fatal self-harm, addressing the question of how well the BHS predicts these two outcomes. With regard to both suicide (four studies) and self-harm (six studies), the authors found the BHS had high sensitivity (0·8 for both) but low specificity (0·4 for both). The authors conclude that, while the BHS identifies a high-risk group for suicide and self-harm, the low specificity (indicating a high number of false positives) means it is unlikely to be useful in targeting treatment to reduce these outcomes.

Bereavement-related depression

Zisook & Kendler (pp. 779–794) conducted a review of the extant literature to address the question, is bereavement-related depression (BRD) the same or different from standard major depression (SMD)? From their extensive review, the authors found that there were differences in the characteristics of the two disorders (e.g. the prevalence of BRD does not appear to differ by sex). However, the similarities were more marked than the differences. For example, both BRD and SMD were more common in the young and in those with poor health and in those with low social support. Both disorders were also associated with impaired immunological responses, altered sleep patterns and responsivity to antidepressants. The authors conclude that further research is needed to more directly assess the validity of the distinction between BRD and SMD.

Suicide

This issue contains five papers on various aspects of suicide. In the first, Dennis *et al.* (pp. 795–805) investigated suicidal ideation in a sample of 8580 subjects recruited to the National Survey of Psychiatric Morbidity in Britain, focusing specifically on age-related differences. They found that suicidal ideation was up to three times more common in younger adults compared with those aged 55–74 years. However, the association between depression and suicidal ideation was strongest in the older age group. Other positive associations with suicidal ideation were similar across the age groups (e.g. smaller social support group, being divorced or separated), with the exception of life events (that were associated with suicidal ideation only in younger people) and widowhood (associated with suicidal ideation only in older people).

Bromet *et al.* (pp. 807–819) report findings from the Ukranian arm of the World Mental Health Survey Initiative ($n = 4725$) on the lifetime prevalence and correlates of suicidal ideation, plans and attempts. In line with studies from Western Europe and the USA, the authors found a lifetime prevalence of suicidal ideation of 8·2%, with a mean age of onset of 31 years. The factors associated with suicidal ideation included female sex, younger age, trauma and parental depression. Among those with suicidal thoughts, those who had plans or had made attempts were generally younger, smoked more and more often had prior psychiatric disorders.

Gureje *et al.* (pp. 821–830) similarly present findings on the lifetime prevalence and correlates of suicidal ideation, plans and attempts in a sample of 6752 subjects aged over 18 years from the Nigerian Survey of Mental Health and Well-Being. The authors found lifetime prevalences for ideation, plans and attempts of 3·2%, 1% and 0·2% respectively. The transition from planning to attempting suicide occurred most often during the first year following onset of suicidal ideation. Similar risk factors for suicidal behaviour were found as in previous studies, e.g. mood disorder, childhood adversities and maternal mental disorder. However, no gender differences were found.

Hunt *et al.* (pp. 831–837) investigated risk factors for suicide in a sample of 222 in-patients who completed suicide, drawn from the UK National Confidential Inquiry into Suicide and Homicide, and 222 living controls. They found that 23 % of suicides were completed within the first week of admission, most of these being completed on the ward or after absconding. The variables independently associated with suicide were male sex, a primary diagnosis of affective disorder, and a history of self-harm. Being unemployed and being on long-term sick leave were associated with a reduced risk of suicide.

In the final paper on suicide, Dutta *et al.* (pp. 839–847) investigated rates of, and risk factors for, suicide and other causes of mortality in a cohort of 235 patients with bipolar I disorder followed over a 35-year period in south-east London. Deaths from causes other than suicide were not greater in the patients than in the general population. However, the standardized mortality ratio (SMR) for suicide was 9·8. While the rate of suicide was high compared with the general population, the percentage who died from suicide (7 % males, <1 % females) was lower than in other studies. The factors independently associated with suicide were alcohol abuse and a deterioration in functioning pre-onset.

Depression

Five further papers examine various aspects of depression and affective disorders. In the first, Conradi *et al.* (pp. 849–862) present findings from a randomized controlled trial comparing the effectiveness of four forms of GP intervention for depression: (1) usual care (UC) ($n=72$); (2) UC and a psycho-educational prevention (PEP) programme ($n=112$); (3) psychiatrist-enhanced PEP ($n=37$); and (4) cognitive-behavioural (CBT) enhanced PEP. Over a 3-year follow-up period, there was no evidence that UC plus PEP was more effective than UC alone in lowering depressive symptoms. However, both psychiatrist-enhanced PEP and CBT enhanced PEP outperformed UC plus PEP and UC alone.

Monroe *et al.* (pp. 863–871) investigated the question of whether cognitive biases are a cause or consequence of major depression. Drawing on cognitive theory, the authors reasoned that, if dysfunctional cognitive processes are activated by stressful life events in the aetiology of depression, then those who experience such events prior to a depressive episode should experience greater changes in cognitive biases over time. In a sample of 53 patients with major depression followed for 1 year, the authors found that cognitive biases (measured using the Dysfunctional Attitudes Scale) did change more markedly in those who experienced prior life events. The authors conclude that such findings support a causal role for cognitive biases in major depression.

Cooper *et al.* (pp. 873–882) investigated the point prevalence of affective disorders and the correlates of depression in a population-based sample of 1023 adults with intellectual disabilities in Scotland. They found higher prevalences of affective disorders than for the general population, e.g. 3·8 % for depression and 0·6 % for mania. Many of the factors associated with depression in this sample were the same as for the general population, including female sex and prior life events. However, there were also a number of differences. For example, hearing impairment was associated with a lower risk of depression.

Mattison *et al.* (pp. 883–891) examined the long-term course and outcome of depressive disorders in 344 subjects from the Lundby Study, a longitudinal cohort study of 3563 subjects, who developed a depressive disorder over the 40-year study period. Those followed for 30–49 years had a median age of onset of depression of 35 years. The recurrence rate was around 40 % overall and ranged from 17 % to 76 % depending on the length of follow-up. Twenty-three percent developed another disorder and 5 % committed suicide. The independent predictors of suicide were: male gender and severity of depression.

In the final paper, Vuorilehto *et al.* (pp. 893–904) compared the clinical and sociodemographic characteristics of patients with major depressive disorder being treated in primary care ($n=79$), in community mental health services ($n=223$) and in hospital ($n=46$). Subjects were drawn from the Finnish Vantaa Primary Care Depression and Vantaa Depression studies. In-patients were distinguished from the other groups by severity of disorder and prevalence of psychotic symptoms. Few other clinical differences were evident between the three groups. Suicide attempts, alcohol dependence, and cluster A personality disorder were more common among those in psychiatric care compared with those in primary care.

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