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Highlights of this issue

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Bipolar disorder, childhood abuse and psychosis

There is an increasing awareness that bipolar disorder is often misdiagnosed as recurrent depressive disorder, with concomitant delays in appropriate management. Smith and colleagues (pp. 49–56) report that between 3% and 22% of patients seen in primary care with a current diagnosis of unipolar depression may fulfil criteria for bipolar disorder. These patients are usually treated with antidepressant medication which may potentially worsen their condition. They conclude that the subthreshold features of bipolar disorder are relatively common in these patients, and that these are associated with a higher burden of psychosocial impairments. An accompanying editorial by Young & MacPherson (pp. 3–4) places these findings in a wider context and cautions against the inappropriate use of antidepressant therapy in the depressive phase of a bipolar II illness; they advocate for improved screening instruments in both primary care and specialist services. They also discuss the pros and cons of putative screening instruments, such as the HCL-32, to assist practitioners with diagnosis. The main mood stabilisers used in the treatment of bipolar disorder are lithium and valproate; Kessing *et al* (pp. 57–63) describe a study examining the relative effectiveness of these two drugs in clinical practice. They found that treatment with lithium was superior to that with valproate, when assessing outcomes such as hospital admission and the need for switching or additional medication. They suggest that the advantage for lithium is robust and most likely to be evident after an initial treatment of a depressive episode. Childhood sexual abuse has been associated with increased rates of adult psychotic illness. Bebbington and colleagues (pp. 29–37) show that such abuse before the age of 16 years was associated with psychosis, particularly for non-consensual sexual intercourse. There was some mediation of this relationship through changes in affect, but not through heavy cannabis use. They conclude that people who have experienced sexual abuse in childhood could be targeted for intervention before psychiatric disorders become significant. The mechanism by which childhood adversity affects adult psychopathology remains unclear. However, recent interest in gene–environment interactions has sparked renewed interest in genes such as those encoding brain-derived neurotrophic factor (BDNF), which regulates neuronal growth and is affected by early stress. Alemany *et al* (pp. 38–42) show that childhood abuse is associated with the presence of psychotic-like symptoms in the general population, and that this association is moderated by polymorphisms within the BDNF genes. This gene–environment interaction may contribute to individual variation in the longer-term responses to stress.

Mental health services, home treatment teams and well-being

The value of the widespread implementation of crisis resolution and home treatment teams for community care in the UK, in the absence of any robust evidence for their effectiveness, has proved contentious. One aim of this change was to reduce hospital in-patient admission rates, and some individual services have shown benefits in this regard. However, Jacobs & Barrenho (pp. 71–76) found no evidence that the implementation of this policy significantly reduced hospital admissions in a nationwide study. In an accompanying editorial, Kingdon (pp. 1–2) suggests that, although the effectiveness of these teams is being questioned, there have been clear benefits in improving access, better engagement and the development of early intervention protocols which need to be supported and maintained in the future. He is also hopeful for the benefits of moving towards integrated care pathways and outcome measures, but is less convinced by the clustering approach for assessing patient needs for payment by results. Mental well-being is being proposed as a new metric for defining healthier populations; this can be separated into hedonic well-being, exemplified by happiness and life satisfaction, and eudaemonic well-being, related to positive relations with others and personal growth. Data from a national sample suggests that these two types of well-being can be reliably assessed, and are independent of symptoms of mental illness. Weich and colleagues (pp. 23–28) conclude that such positive aspects of mental well-being can remain stable despite the presence of mental suffering associated with mental illness.

Suicide around the world and psychodynamic psychotherapy

There is a marked difference, across different countries in the world, in the rates of treatment received by people with suicidal intentions, with most not receiving any treatment at all. Bruffaerts *et al* (pp. 64–70) report on data from the World Mental Health surveys across 21 countries on 6 continents, and conclude that regionally tailored strategies are likely to be more fruitful in preventing the serious sequelae of suicidal intentions, given that the main obstacles to seeking treatment were predominantly related to people's attitudes towards help-seeking, rather than any financial or stigma-related factors. Pitman & Osborn (pp 8–10), in their accompanying editorial, advocate for an increased awareness of and sensitivity to cultural values and differences as they influence acceptability of services to people who are suicidal. Leichsenring & Rabung (pp. 15–22) report that long-term psychodynamic psychotherapy, lasting more than 50 sessions, is superior to less intensive forms of psychotherapy in the treatment of complex mental disorders. Where mainstream psychological approaches are becoming more brief, they suggest that longer-term therapy should also be investigated for other psychological therapies.