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Highlights of this issue

Edited by Derek K Tracy

The good, the bad and the ugly

Selective serotonin reuptake inhibitors (SSRIs) are good. On a benefit-to-harm basis, what's not to like, even if they don't work for everybody? Well, there has been considerable push-back against so naïve a perspective in recent times, led, importantly, by those who have taken these medications and been harmed by them. This has resulted in a College statement (https://www.rcpsych.ac.uk/mental-health/treatments-and-wellbeing/stopping-antidepressants) by Wendy Burn on the topic, acknowledging these difficulties. Massabki and Abi-Jaoude (pp. 168–171) take this up, arguing that 'discontinuation syndrome' is a term unsupported by the evidence, and that, instead, we need to recognise and have open discussions with patients about the risks of dependency and withdrawal from SSRIs. Erstwhile debates have – unintentionally, perhaps – highlighted limitations of language and criteria (for example, no one claims that SSRIs produce the drug-seeking or dose increases commonly seen in 'classical' drug dependency). I think we need to move beyond semantics and be more open to harms with these medications.

Benzodiazepines are bad. Use them when you must – for short timeframes only – and caution about addiction potential. We know the drill: to be dispensed only with one raised eyebrow, a stern look and an FP10 that needs two tugs to release it unwillingly from our paternalistic grasp. Silberman et al (pp. 125–127) tell us we need to recalibrate. They note that there has not been much recent relevant literature on the topic, but that the older material that does exist does not uphold contemporary concerns. Specifically, the authors – who are part of an international taskforce on benzodiazepines – argue that: benzodiazepines are *not* likely to be misused in those prescribed them for anxiety disorders; patients do *not* tend to escalate their doses over time; long-term use usually does not lead to dependence; and they are *not* especially dangerous in overdose. All of this is heretical to the Little Red Book I was given on commencing psychiatric training; I really recommend this stimulating piece for a journal club or continuing professional development group discussion.

And Omega 3 polyunsaturated fats are…popular? Two-for-one in your local health store, or is it one tub for a penny if you buy three? In any case, they seem as popular as wheatgrass smoothies – and just as tasty. Deane et al (pp. 135–142) systematically reviewed and meta-analysed the best current data with regards to preventing depression and anxiety. Their conclusion: they have no effect, though it seems to me they are good at helping you lose many pounds each month – at least pounds sterling.

For a few dollars more

More psychosocial interventions are always welcomed, but there has often been less evaluation as to which aspects of them are mediating outcomes. Determining these would help with optimisation and development of new treatments, and, in a precarious health economy, ensure that they are appropriately funded. It's thus triply pleasing to see the work of Singla et al (pp. 143–150), as they do just this, in an intervention for perinatal depression, and for a programme that is peer-delivered. The Thinking Healthy Programme is an individual, 16-session cognitive–behavioural approach; the study reaffirmed it to be effective in alleviating symptoms, in over 750 women across a site in India and one in Pakistan. Importantly, these data showed that 'patient activation' and 'support at 3 months' independently mediated the intervention; interestingly, mother-attachment scores did not. Such knowledge helps refine care and might also be transferable.

Educational attainment is poorer amongst children and adolescents with depression, but there has been less longitudinal work to see how that might vary over time and to examine mediating roles of sociodemographic factors. Wickersham et al (pp. 151–157) linked the health records of almost 1500 children referred to a single National Health Service trust across 6 years with data from the National Pupil Database. Compared with a local reference group, those who had been diagnosed with a depressive disorder had a drop in educational attainment only after UK school year 6, with a significant decline in year 11 (when pupils are typically 15–16 years old). Gender, ethnicity and socioeconomic status were important moderators. Money is needed; financing is warranted.

Every which way but loose

There's been lots of recent broad social debate about living through difficult times and the influence on all our mental health. Slee et al (pp. 158–164) look at the trends in generalised anxiety disorder (GAD), with data from 795 UK primary care practices and over 6.6 million patients. GAD rates increased from 2014 to 2018 (so, if you're punting on contemporary existentialism, pre-Covid, but sliced midway by a referendum and the Trump election). The growth occurred in both genders aged 18–24 but was particularly marked in younger women. There were increases, but lesser ones, for ages 25–44, with no change in anxiety above that. In these groups, rates of SSRIs have gone up, and those of benzodiazepines have gone down – in direct rejection of the opening paragraphs above. However, depending on how you want to slice that cake, with about 50% of previously drug-naïve patients being prescribed a medication within a year of diagnosis, one could equally argue that we're still not treating enough people. Alice Grishkov writes more in this month's Mental Elf blog at https://elfi.sh/bjp-me28.

Jacobson and O'Cleirigh (pp. 165–167) take on worry in a less explored area: that suffered by people living with HIV, and how it relates to pain severity and chronicity. The authors remind us that although both issues are disproportionately endured by individuals with HIV, and although they can profoundly affect quality of life, they are frequently under-identified and untreated. They report on the use of passive actigraphy data – continuously monitored via a low-cost wearable sensor – to better objectify these. Their results reaffirm the scale of the problems but also suggest a technological means to help capture and thus treat them.

Rachel Upthegrove et al (pp. 128–130) tackle the crucial issue of gender equality in academic publishing and, vitally, *action* from this journal. Following on from that – a little tenuously – this month's *BJPsych* also reports on other concerns about healthcare professionals, namely their being replaced by artificial intelligence. This has not worried me: I've seen what happens in the Terminator movies – we'll have nuclear Armageddon before the first robotically signed FP10 (and I bet they still get pharmacy calling to query the rate of quetiapine dose increase). Back to the existential angst, I also suspect it's more likely I'm a Boltzmann brain than will succumb to an AI one. In debating the issue, Brown et al (pp. 131–134) adopt a less absinthe-soaked approach than my musings.