

Highlights of this issue

By Sukhwinder S. Shergill

Somatic symptoms, work and combining therapy for depression

Somatisation disorder has been predicated on the presence of 'medically unexplained' symptoms, which is inherently unreliable, given that the 'unexplained' will vary depending on the level of medical investigation and pattern of symptoms. Tomenson and colleagues (pp. 373–380) report that the total somatic symptom score was associated with health status and healthcare utilisation, even after accounting for confounders such as female gender, depression, anxiety and general medical illness. This relationship was stronger than that for the number of medically unexplained symptoms. The authors suggest that, given that their data support the proposition that medically unexplained symptoms are also associated with medical illness, patients with medically unexplained symptoms are unlikely to represent a distinct group. They propose that the change in terminology from 'medically unexplained' to 'any severely distressing somatic' symptom is a helpful step forwards in the treatment of these patients. An accompanying editorial by Sharpe (pp. 320–321) reviews the wider context around these changes, and their instantiation in DSM-5. He predicts that reducing the emphasis on 'medically unexplained' offers a broader role for psychiatrists in helping manage severely troublesome symptoms of any cause. He suggests that the utility of this approach can be seen in the successful application of cognitive-behavioural therapy – not only for fatigue in the context of chronic fatigue syndrome, but also for fatigue associated with multiple sclerosis. Major depressive disorder has a significant impact on occupational and social functioning, in addition to the personal distress related to the symptoms. Lam and colleagues (pp. 358–365) examined the effects of combined pharmacotherapy and psychotherapy in treating major depressive disorder. They found that there were no significant differences in symptom ratings after 12 weeks of treatment between the psychotherapy and control groups. However, self-rated work productivity ratings were significantly higher in the psychotherapy plus pharmacotherapy group. The authors optimised their design to address the work productivity question by only recruiting employed patients and using telephone-administered psychotherapy to reduce time away from work. A broader work-related issue for patients is whether to reveal their mental health status to employers, balancing the risk of stigmatisation against the potential for accessing additional support. Henderson and colleagues (pp. 350–357) demonstrated that the use of a standard decision aid helped patients reduce their decisional conflict, both at the time of the decision and at 3-month follow-up. They suggest that this could be a useful tool to assist vocational advisors and health professionals to advise patients in a collaborative manner.

Delusions, psychosis and self-management for families

There has been an increasing awareness of the limitations of our current treatments for psychotic illness, both pharmacological and psychological. Garety & Freeman (pp. 327–333) propose that one way out of the current impasse is to focus our attention on

individual symptoms rather than the syndrome. They reviewed the research literature focused on delusions: examining reasoning biases, theory of mind and affective processes, they found that there is good evidence supporting the presence of 'jumping to conclusions' reasoning biases, and a role for emotional processing biases in individuals with delusions. They did not find a similar association of delusional beliefs with deficits in theory of mind. The authors suggest that the individual factors associated with delusions, such as low self-esteem, worry and jumping to conclusions, are all valid targets for intervention. In the future, they anticipate a more positive outcome from clinical trials aimed at single psychotic experiences, such as auditory hallucinations or delusions. They also highlight the lack of self-management studies in patients with psychotic illness. While they did not examine this in patients with psychosis, Lobhan and colleagues (pp. 366–372) examined the impact of providing a self-management package for relatives of patients with recent-onset psychosis. The relatives that used the self-management package showed reduced distress, increased support and perceived ability to cope, and increased well-being. The authors highlight the low cost of this low-intensity intervention, and potential for development in longer-term studies.

Cost-effectiveness of injectable heroin, and predicting violence in offenders

Heroin addiction is most commonly treated with oral methadone maintenance, but those who fail to benefit can be helped with the use of injectable methadone or diamorphine. This latter approach has significantly higher costs associated with the treatment. Byford and colleagues (pp. 341–349) demonstrate that injectable treatments show superior cost-effectiveness relative to oral methadone treatment, but the cost-effectiveness is driven by savings in the criminal justice sector, not the health sector. The authors suggest that continuing oral methadone treatment in chronic refractory heroin addiction is not cost-effective, despite the low treatment costs, relative to the injectable treatment options. The choice of injectable drug is not clear, depending to a greater extent on the balance between the relatively higher costs and better outcomes with diamorphine, despite a clear cost-effectiveness benefit over injectable methadone. An accompanying editorial reviews the lack of widespread uptake of treatment with injectable heroin, despite its superior efficacy in this group. Hunter & Hasan (pp. 325–326) advocate for an examination of cost-effectiveness in a real-world service, rather than within the auspices of a standard clinical trial, with an explicit longer-term examination of costs, especially those within the criminal justice sector system. Prediction of violence in offenders is assessed using actuarial instruments and structured professional judgement instruments. Coid and colleagues (pp. 387–388) used three of these commonly used instruments – the Violence Risk Assessment Guide, the 20-item Historical, Clinical, Risk Management-20 and the Offenders Group Reconviction Scale-II – to assess their accuracy in predicting future violence in offenders imprisoned for a sexual or violent crime. They found that these instruments were most useful in predicting violence in the prisoners with no mental disorder, less useful in participants with schizophrenia and depression, especially those with comorbid substance misuse; but in prisoners with antisocial or other personality disorder, the instruments performed at chance levels. The authors highlight that risk assessment for violence in prisoners with psychopathic traits should not rely unduly on the results of these risk assessment instruments.