

Highlights of this issue

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DEPRESSION, ADOLESCENCE AND SUICIDE

The Committee on the Safety of Medicines has issued a warning regarding the difference between adults and children in the risk-to-benefit ratio when treating depressive illness using most selective serotonin reuptake inhibitors. Dubicka *et al* (pp. 393–398) review this contentious literature and report the results of their meta-analysis, which suggests that there is a small increase in suicidal ideation in children and adolescents treated with these antidepressants, but that the significance of this needs to be considered within the broader context of this life-threatening disorder. This is an important issue as the prevalence of depression increases between the ages of 13 and 15 years. Lau & Eley (pp. 422–427) use data from twins and sibling pairs to tease out genetic and environmental contributions over this adolescent period, demonstrating that there is a moderate genetic influence on depressive illness throughout this time. However, there is a substantial non-shared environmental influence during this period, whereas shared environmental factors are significant only at the earlier time. They suggest that new genetic effects emerge, in association with individual environmental experiences, commensurate with significant biological changes taking place during this developmentally sensitive period. Although there has been considerable interest in the individual predictors of self-harm, there has been less research on wider area-level factors. Johnston *et al* (pp. 416–421) report that ethnicity, and specifically the proportion of White individuals, was significantly associated with repeated self-harm. This was in addition to the more standard individual

factors, such as a history of previous self-harm. They suggest that the degree to which an individual fits within their social environment may mediate their risk of self-harm.

SCHIZOPHRENIA THERAPY

There has been considerable investment in the development of antipsychotic medication since the advent of chlorpromazine in 1953. Modern antipsychotic medication is not affordable for the majority of the patients in poorer countries. Intuitively, one considers this an injustice; however, all that glitters may not be gold. In their editorial Adams *et al* (pp. 391–392) provide a wide-ranging review of the many factors relevant to drug development and evaluation. They conclude that people in more affluent countries may need to be protected from being unofficial participants in post-licensing studies, and that there may be benefits in not being the first to have the opportunity to try the most novel antipsychotic. There has also been more contemporary interest in having independent assessments of the comparative efficacy of the second-generation antipsychotic medications available on the market. McCue *et al* (pp. 433–440) report the results from a pragmatic randomised treatment study and demonstrate that certain antipsychotic medications – olanzapine, risperidone and haloperidol – are more effective than others, adding further support to recent findings from large-scale studies from the USA. Examining the non-pharmacological options, Talwar *et al* (pp. 405–409) demonstrate that a trial of music therapy for psychotic illness is not only feasible but that there may be

additional benefit to the patients randomised into the music treatment group.

PREDICTION AND PROGNOSIS

It is accepted that patients with schizophrenia and dementia experience specific cognitive difficulties; it is not clear when these develop and whether there are early predictors of these disorders. Cannon *et al* (pp. 463–464) use data from a birth cohort study in Dunedin, New Zealand, to demonstrate that attentional, executive and motor impairments at 13 years of age were more prominent in individuals who subsequently had a diagnosis of schizophreniform psychosis at age 26 years. They suggest that the observed memory and learning deficits must therefore occur later in the development of the illness and also that these early attentional, motor and executive impairments may be more specific for schizophrenia rather than an affective psychotic illness. Mild cognitive impairment is thought to be a transitional phase between healthy ageing and dementia, but the speed and nature of this transition remains unclear. Busse *et al* (pp. 399–404) followed up elderly individuals in the community and demonstrated that 60% of people with mild cognitive impairment go on to develop dementia and that this progression is most likely to occur in the first 18 months rather than at a constant rate over time. The longer-term prognosis in anorexia nervosa is reported to be poor, with an elevated mortality rate, around 5–10% over a 10-year follow-up period, and significant levels of longer-term impairment. Hjern *et al* (pp. 428–432) describe a Swedish register-based study which suggests a much more benign prognosis than previous studies. They found that the mortality rate was 1.2% when followed up 9–14 years after an index in-patient admission, but that 8% of patients had persisting mental health problems requiring hospital care. In line with earlier studies, they found that a longer duration of hospital care, more severe illness and significant comorbidity were associated with worse longer-term outcome.