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Highlights of this issue

By Derek K. Tracy

The psychosocial in psychosis

Longer-term outcomes in psychotic illnesses have scarcely improved in half a century. A primary reason is our general inability to ameliorate negative and cognitive symptoms that so heavily impact the factors by which we measure our lives: work, relationships and leisure activities. Mesolimbic hyperdopaminergia may be what Laruelle called the 'wind of the psychotic fire' in terms of positive symptomatology, but this is less predictive of quality of life, and antipsychotic medications have little useful effect elsewhere in the brain. Lutgens *et al* (pp. 324–332) update with a meta-analysis of 95 studies on psychological and psychosocial interventions for negative symptoms. The surveyed literature was of moderate quality overall, and with a high level of heterogeneity. Guidelines have typically advocated cognitive–behavioural therapy (CBT), and while this work supports that, skills-based interventions provided similar significant benefit over treatment as usual (TAU) in managing negative symptoms. The data that exist for exercise and music treatments were encouraging but limited, but there was no evidence to support neurocognitive, family-based or humour therapies. Interestingly, those with the greatest initial deficits showed the biggest gains: while such individuals clearly have the most room to improve, the finding goes (optimistically) against a clinical narrative that those with the more severe negative symptoms fare worst.

Lasalvia and colleagues advance this, reporting on the GET UP pragmatic cluster randomised controlled trial (pp. 342–349). This is a multi-element psychosocial intervention for individuals with a first psychotic episode, and had previously been reported to be feasible to implement and superior to TAU. Here, the authors tested whether particular sociodemographic or clinical factors predict or moderate response to such interventions. In their 'real world' setting, better education, reduced duration of untreated psychosis, and better premorbid adjustment and insight were predictors of positive outcomes more generally in the 444 completing patients. The only moderator of specific treatments was that the intervention provided additional improvements in psychopathology to those over the age of 35.

As part of the *BJPsych's* growing social media strategy (we'll be updating in more detail in a forthcoming editorial), we are now blogging with the Mental Elf each month: do check out Rachel Upthegrove's excellent piece on Lutgens *et al*'s paper at http://bit.ly/bjpme3. You can join the conversation by commenting on the blog, or via the new journal twitter handle @TheBJPsych.

North by Northfield

Therapeutic communities are, for many younger psychiatrists, a historical footnote of Bion and colleagues' Northfield experiments, covered for College Membership training and examinations. They still exist, though unicorns may be more common in some parts of the country. Rex Haigh's editorial (pp. 313–314) reorientates us, providing a timely overview of their evolution, taking us to contemporary practice, and a move to enhancing evidence-based practice. Initially based on Rapoport's proposed themes of democratisation, permissiveness, reality confrontation, and communalism, those that have survived into the contemporary NHS now exist as day units with a focus on empowerment, openness and 'ordinariness'. Their scientific underpinnings have historically faced the challenge of being primarily qualitative and sociological, but Haigh notes the recent randomised controlled trial on their effectiveness in personality disorder. In a constrained healthcare budget, such research will need to continue, even if some practitioners may balk at 'selling' these complex interventions as 'commodities'.

Jumping to a very 21st-century intervention, and computerised CBT (cCBT) continues to attract interest as a potentially cost-effective and easily upscaled treatment in resource-scarce times. However, data from primary care trials show that engagement can be poor. The REEACT trial, the largest primary care trial of cCBT, failed to show any benefit over ordinary GP care, but it was argued that uptake in the study's real-world conditions was poor, and needed augmentation or support. Gilbody *et al* (pp. 362–367) tested the benefits of adding structured facilitation whereby a support worker provided weekly telephone calls alongside the computerised programme. The first of these calls lasted about half an hour, introducing participants to the programme, explaining the process, and helping identify participants' goals and potential difficulties; subsequent calls were briefer, aimed at motivating and problem-solving. They found that this increased use of the therapy by a factor of 1.5 to 2 over just telephone technical support; at 4 months PHQ-9 scores were lower in those receiving the additional support, though these gains had dissipated by 12 months. The authors propose that the lack of benefit by the 1-year mark may be explained by the fact that most depressive episodes last less than this amount of time.

Mind and body, body in mind

Individuals with depression have greater rates of myocardial infarction (MI), but although they also commonly have poorer adherence to necessary post-MI lifestyle changes, any prognostic impact of depression upon survival has been poorly understood. The issue is important: while the incidence of MIs has significantly decreased in recent decades, the prevalence of survivors has increased. Sundbøll and colleagues (pp. 356–361) explored a Danish population-based cohort of over 170 000 patients with first-time MIs, of whom 6015 had a prior diagnosis of depression; the median age was just over 70, and follow-up was about 3 years. All comorbidities were more common in those with a history of depression, and they had a moderately increased all-cause mortality that was independent of depression severity and MI type.

Being teased by peers about one's weight is very common in young people, estimated to problematically occur for one in four. As well as other negative psychological sequelae, it has been considered to be a potentially powerful risk factor for subsequently developing an eating disorder. However, clearly not all who are so teased develop such problems, suggesting an interplay of these environmental factors with genetic susceptibility. Fairweather-Schmidt & Wade (pp. 350–355) modelled this in almost 700 adolescent female twins, with self-report questionnaires to parents, and telephone interviews with participating individuals. This was followed up with two further interview cycles, each about 1 year apart. Disordered eating was associated with teasing, and while both environment and genetics were important moderators of this, vulnerability varied primarily with the individual's genotype. Finally, more longitudinal outcomes are considered in this month's Kaleidoscope (pp. 375–376), with important and moving work describing the long-term outcomes of adults who faced enormous early-life deprivation in Ceaușescu's Romanian orphanages of the 1980s.

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