Highlights of this issue

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THE BURDEN OF DEPRESSION

ICD–10 depression predicts long-term course and outcome in hospitalised patients. Using the Danish Psychiatric Case Register, the risk of relapse and suicide were significantly different for the three types of depression, increasing from mild to moderate to severe depressive episodes. Concluding that the classification appears to be clinically useful, Kessing (pp. 153–156) recommends the system be preserved in future revisions. In the first general population survey of DSM–IV psychiatric disorders in the over-65s in France, Ritchie *et al* (pp. 147–152) found 17% of the population studied to have a current psychiatric disorder, excluding dementia. Almost half had had a psychiatric disorder in their lifetime, and the lifetime prevalence of major depression was higher than in other Western countries. A dramatic increase in sales of antidepressants in Iceland has made little impact on suicide or admission rates for depression (Helgason *et al*, pp. 157–162). It is suggested that improved targeting and follow-up of patients likely to benefit from these drugs is required.

CANNABIS AND PSYCHOSIS

Cannabis is a well-recognised precipitant of psychotic episodes but whether it acts as a causal risk factor for psychosis remains controversial. Arseneault *et al* (pp. 110–117) review this issue, focusing on five population-based studies. They conclude that cannabis use does not appear to be sufficient or necessary for the development of psychosis (the majority of users do not develop psychosis and not all adults with psychosis use cannabis in adolescence, respectively) but is a component among a causal constellation leading to adult schizophrenia. They estimate that about 8% of schizophrenia could be prevented by elimination of cannabis use in the population.

CHRONIC FATIGUE SYNDROME

Evidence suggests mild hypocortisolism in some people with chronic fatigue syndrome (CFS), implicating disturbances in the hypothalamic–pituitary–adrenal axis. Difficulties in interpreting previous studies that used stress-inducing procedures is a problem largely overcome by Roberts *et al* (pp. 136–141). Using a naturalistic measure of stress – the salivary cortisol response to awakening – to compare the cortisol elevation in 56 patients with CFS *v.* 35 healthy volunteers, they showed an impaired cortisol response in the patients. The response was not affected by the presence of comorbid depression. Powell *et al* (pp. 142–146) demonstrate that an educational intervention designed to encourage graded activity in CFS produces long-term benefits in outcome. Evidence at 2-year follow-up suggests that delay in treatment was associated with reduced treatment efficacy, possibly indicating the adverse effect of being placed on a waiting list for treatment.

A GENETIC MARKER FOR SCHIZOPHRENIA?

Decreased language lateralisation, caused by increased language-related activation in the right hemisphere, has been reported in those with schizophrenia. To determine whether this is a result of or a genetic predisposition for schizophrenia, Sommer *et al* (pp. 128–135) measured language activation using functional magnetic resonance imaging in 12 right-handed monozygotic (MZ) twin pairs discordant for schizophrenia and 12 healthy right-handed MZ twin pairs. Since MZ twin pairs are genetically identical, traits that reflect increased genetic vulnerability for schizophrenia will be present in both twins, while characteristics secondary to the disease will be absent in the twins without schizophrenia. The twin pairs discordant for schizophrenia displayed less language lateralisation (caused by higher language-related activation in the right hemisphere) than did the healthy twin pairs. It is suggested that decreased language lateralisation could thus be used as an endophenotype for research on high-risk groups.

STIGMA AND TRAUMA

Dinos *et al* (pp. 176–181) trained two mental health service users to interview 46 patients about their experience of stigma in the community. Stigma was a pervasive and serious concern to most and varied by diagnosis. People with psychosis or drug dependence were the most affected. Stigma was found to prevent people from disclosing their difficulties and is likely to affect how a psychiatric diagnosis is accepted and whether treatment is adhered to. Seedat *et al* (pp. 169–175) compared trauma exposure and post-traumatic stress symptoms in adolescents in South Africa and Kenya. Although lifetime exposure to trauma was comparable, Kenyan adolescents had much lower rates of PTSD. This difference could be due to trauma-related variables but might also suggest cultural differences in response to trauma.

CHILDHOOD PREDICTORS OF ANTISOCIAL PERSONALITY DISORDER

Certain childhood risk factors for antisocial behaviour up to late adolescence and early adulthood have been firmly established but it is not known whether these factors increase risk into mid-adult life. Simonoff *et al* (pp. 118–127), in a follow-up twin study, show that childhood conduct disorder and hyperactivity predict adult antisocial personality disorder, even when intervening risk factors, such as delinquent peer group and criminality during youth, are accounted for. The number of hyperactive and conduct symptoms also predicted adult outcome. Intermediate, 'stepping stone' experiences were found partially to mediate between childhood disruptive behaviour and adult outcomes, suggesting potential areas for intervention.

SUPPLEMENT

The transcultural study of postnatal depression is the subject of a special supplement to this month's *Journal*.

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