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Highlights of this issue

Edited by Derek Tracy

Music for the jilted generation

'NEET' – not in education, employment, or training. A grim acronym for too many young people, and clearly associated with a range of adverse outcomes. Ringbom et al (pp. 148–153) ask whether preceding adolescent psychiatric illnesses might have a role, utilising the 1987 Finnish Birth Cohort study. Out of over 55 000 individuals, 2.6% were 'long-term NEET' (defined as at least 5 years continuous duration), and they were significantly more likely to have had a prior mental health diagnosis. Psychoses and autism spectrum disorders were particularly notable, with up to 50% and 70%, respectively, falling into this long-term category if secondary education had not been completed. However, another way of framing it is that among those long-term NEET individuals, over one-fifth had a depressive disorder, and one-sixth an anxiety disorder. Interestingly, family background did not substantially alter the figures. The focus of healthcare systems is, well, health, but the authors point out that educational and employment support are particularly important in young people to prevent later-life marginalisation.

The PRODIGY study aimed to do this, with Berry et al (pp. 154–162) reporting on this randomised controlled trial of social recovery therapy (SRT) to prevent and treat long-term social disability in young people with emerging severe mental illness (SMI). Two hundred and seventy young people with an SMI and social impairment (manifesting with fewer than 30 h per typical week of structured activity – 64 h being the average in this age group) were randomised to receive either enhanced standard care or an additional 9 month psychotherapeutic SRT. Disappointingly, the active intervention provided no additional gains, though both groups showed a significant rise in structured activity, demonstrating that appropriate 'standard' care can also be effective. Zoë Hunter writes more in this month's Mental Elf blog at https://elfi.sh/bjp-me3. The pandemic has reinforced our awareness of the need for social bonds and of the adverse impact of loneliness. Cruwys et al (pp. 140–147) compared a loneliness intervention – 'Groups 4 Health' (G4H) – with standard cognitive–behavioural therapy in 174 young people experiencing loneliness and depressive symptomatology. The G4H intervention was non-inferior in terms of managing depression and showed superiority for loneliness that emerged after treatment completion. Loneliness is most studied among older individuals but is actually more common in the young.

Firestarter

Exposure to maternal depressive disorder (MDD) can affect children. In a novel piece of work, Zeev-Wolf et al (pp. 130–139) compared functional brain differences of those exposed to earlier- and later-childhood MDD experiences. Three groups of children were delineated: those whose mothers had depression from their birth to age 6 that had resolved by age 10; children of mothers without depression; and individuals whose mothers developed MDD in their later childhood. Magnetoencephalography was used to characterise brain functioning, focusing particularly on theta rhythms. Early MDD decreased default mode connectivity in children's brains in a manner similar to that seen with early trauma or chronic adversity. Conversely, where depression occurred later, the pattern seen in the child's brain was more similar to that of adult depression. Intrusive mothering in infancy and lower mother–child reciprocity in later childhood amplified the effects. Calderaro et al (pp. 121–129) tackle the challenging issue of the impact of parental suicide on the risk of the offspring similarly dying. Their systematic review found that such children were almost twice as likely to attempt suicide, and three times more likely to die by suicide, than those with two living parents or those where a parent had died by another cause. These two studies highlight two groups with greater vulnerabilities but, equally, interventional opportunities. Were it needed, we are reminded of the importance of supporting women with MDD, their children and those, including young people, who have suffered bereavement through suicide. This takes us to Andrea Danese and Stephanie Lewis' editorial (pp. 107–108), which notes that, fitting with the aforementioned pieces, although we have strong data on the impact of childhood adversity, this has not adequately translated into clinical gains. They show how there is inconsistency and a lack of adequate empirical data on measurement tools, understanding of the mechanisms through which trauma mediates ill health, and how we might optimise stratifying those who would most benefit from subsequent care.

No good (Start the Dance)

'Treatment resistance' can be a contentious term in contemporary mental health, potentially conferring blame on individuals for 'not getting better' despite our efforts. However, whatever the terminology used, we all recognise that enduring mental illness is associated with a raft of worse clinical and social outcomes. Siskind et al (pp. 115–120) ask how common it is in first-episode psychosis cohorts, systematically reviewing 12 studies that encompassed almost 12 000 individuals. Almost a quarter were found to meet international guideline criteria of: symptoms of at least moderate severity; moderate or worse functional impairment; and prior appropriate treatment regimens of at least two antipsychotics. The authors emphasise the need for more timely access to appropriate psychosocial supports and clozapine. The first of these can hardly be argued with; the latter is likely to raise a range of challenges, and I'm reminded of the incredible regional and clinician variation in its prescribing, and the disheartening lag to instigation more generally. I sometimes think it's clinicians who are 'treatment resistant' when it comes to clozapine.

I feel the final word in this month's *BJPsych Highlights* must go to Dr Tania Gergel (pp. 109–112), who combines both academic and lived experience of electroconvulsive therapy (ECT) to produce a very moving and provoking analysis piece. It is impossible to disagree with her comment that ECT 'remains arguably the most stigmatised, misunderstood, contested and feared psychiatric or perhaps even medical treatment'. She dismantles claims of inefficacy, conspiratorial arguments that clinicians minimise or deny side-effects, and that that it is inevitably a coercive experience. I cannot do justice to her abundantly evident thoughtfulness and reflections on her own mental health except, perhaps, to wholly commend it to you as essential reading.

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