

## Highlights of this issue

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### Common mental disorders and psychological treatment centres

Depression and anxiety disorders are thought to occur in around 10% of patients attending their general practitioner; the PREDICT multicentre study compared rates of common mental disorders across general practice attendees in six European countries. King *et al* (pp. 362–367) report that the highest prevalence for all disorders was in the UK and Spain whereas the lowest rates were in The Netherlands and Slovenia. They consider alternative explanations for their data, including variations in cultural norms in attendance for consultations, and adequacy of available treatments. This leads nicely on to the debate in this issue of the *Journal* – on whether extensive expansion of psychological therapies via community-based psychological treatment centres, as advocated by Lord Layard, would be counterproductive across society. Summerfield (pp. 326–330) is concerned by the apparent willingness of mental health to label, and now treat, the normal process of suffering related to coping with daily adversities. He argues that this medicalisation of normal distress benefits no one, except the politicians who can distance themselves from the dysfunction arising out of their poor policy decisions; and, rather like building new roads, more treatment will only lead to increased demand. Veale (pp. 326–330) takes issue with the lack of substantial evidence behind these opinions, arguing that there is a significant problem with the high prevalence of depression and anxiety disorders, that there are currently inadequate resources to meet this need, and the key issue is not only providing access to well-validated psychological treatments but improving the quality of the service that is provided. He highlights the key criteria for providing an effective high-quality service, and it seems a useful question for current psychological treatment services to assess how well they measure up to these: any discrepancy may reflect the need for this new initiative. An invited commentary by King (pp. 331–332) views this argument as reflecting the balance between individualism on the one hand and citizenship on the other, in the context of individual happiness in the world. He suggests that only time will tell which is the optimal choice.

### Depression: classification, imaging and physical comorbidity

Distinguishing between depressive illness as part of a unipolar or a bipolar disorder is a relatively difficult task, especially in the first episode of illness. Forty and colleagues (pp. 388–389) examined a large cohort of patients with depressive illness, separated into unipolar and bipolar disorder, and found that several clinical features distinguished between them. Bipolar depression was more likely to be characterised by the presence of psychosis, diurnal mood variation and hypersomnia, whereas patients with unipolar depression exhibited greater self-reproach and loss of both energy

and libido. They suggest that this knowledge may raise awareness and improve pharmacological management in these patients. Depressive illness carries a significant genetic loading and Mannie *et al* (pp. 356–361) used functional magnetic resonance imaging to examine how this may be instantiated in the brain. They observed altered function within the anterior cingulate cortex in young people at increased familial risk of depression (via a parent with depressive illness). They suggest that the anterior cingulate cortex is important because it plays a privileged role in integrating and allocating attention between emotional and cognitive processes; thus, a deficit in activation may reflect less-efficient monitoring and merging of data from these two streams, which would confer an increased risk of depression. Physical ill health is a recognised risk factor for depressive disorder, but there is less awareness of the risk for comorbid physical ill health in patients with a depressive illness. Farmer *et al* (pp. 351–355) found that there was an increased risk of several physical disorders, including gastric ulcers, asthma, thyroid disease and rhinitis, in patients with depressive illness. They suggest that there may be a common aetiology through dysfunction of the hypothalamic–pituitary–adrenal axis; and that clinically, more attention needs to be paid to the physical health of people with depression.

### Prescribing in pregnancy: depression and psychosis

Three articles and an editorial examine the adverse effects of prescribing psychotropic medication during pregnancy. Ramos *et al* (pp. 344–350) report no association between duration of antidepressant use during the first trimester, accepted as the highest-risk developmental period, and major congenital malformations in the children of women with psychiatric disorder. Within their sample of over 2000 participants, they found a higher than predicted rate of malformations of 8%; but were confident that their robust case–control design was generalisable to other women. Oberlander *et al* (pp. 338–343) used a very large population data-set from administrative sources to show that longer maternal prenatal exposure to selective serotonin reuptake inhibitors was associated with lower birth weight, increased respiratory distress and reduced gestational age in children. They did not find any robust difference in adverse outcomes between early *v.* late gestational exposure to the selective serotonin reuptake inhibitors, once they had removed the confounding effects of the severity of maternal illness. They highlight the limitations of their approach; although their samples are large, they do not have data on other significant variables, including use of tobacco or alcohol during the pregnancy, and maternal weight and parity. Newham and colleagues (pp. 333–337) report that *in utero* exposure to atypical antipsychotic drugs may increase infant birth weight, analogous to the effect seen in treated patients; typical drugs were associated with shorter gestational age and lower birth weight. However, the authors point out the highly selective nature of their sample, ascertained from the National Teratology Information Service, and again the limitations include a lack of data on significant confounding variables. An accompanying editorial by Paton (pp. 321–322) places these findings in their wider context and illustrates the difficulties of assimilating data from these different approaches, each with their own strengths and weaknesses.