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Highlights of this issue

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Koyaanisqatsi

Peter Tyrer opens his editorial (pp. 65–66) noting that 'some highly personality disordered people are my best friends'. In a provocative but thoughtful commentary he fronts up that although the diagnosis of personality disorder is often 'reviled', it nevertheless cannot be ignored or rejected because of perceived undesirability. He rejects the proposal to give it a 'more fragrant' name to battle stigma, dismissing the wider calls – typically from outside of psychiatry – to 'drop the disorder', although he notes that the new ICD-11 diagnosis of complex post-traumatic stress disorder might be a better fit for many. Professor Tyrer argues that both DSM-5 and the new ICD-11 criteria (which divides personality status into five groups from 'normal', through 'personality difficulty', to mild/moderate/severe) help understanding and are better fits with the current science. A wonderful piece to stimulate discussion.

The global prevalence of personality disorders has a very large range across many studies, and Winsper *et al* (pp. 69–78) review 46 relevant papers from 21 countries to redress the lack of systematic reviews on the topic. The pooled prevalence rate of any personality disorder was determined to be 7.8%, with considerably higher rates in high-income countries (9.6%) than low- and middle-income countries (LMICs) (4.3%). Several hypotheses are put forward for the geographical differences: cultural factors and societal norms in LMICs might reduce variation in behaviours; presentations might manifest differently yet be assayed against Western diagnostic criteria; and there might be methodological variations across trials. Breaking the data down further, the global rates of clusters A, B and C were 3.8%, 2.8% and 5.0%, respectively, although the authors urge caution in light of the high levels of heterogeneity across the reviewed studies.

In the first study of its kind, Brannigan *et al* (pp. 85–89) utilised a longitudinal birth cohort to test if prenatal stress has an impact on subsequent development of a personality disorder. In their Finnish sample, self-reported moderate maternal stress was associated with a tripling of the odds of the child developing a personality disorder, and severe stress with a sevenfold increase. The findings held after adjusting for parental psychiatric history, comorbid psychiatric diagnoses, prenatal smoking and antenatal depression. Anna Sri from Cornwall Partnership NHS Foundation Trust writes more in this month's Mental Elf blog: https://elfi.sh/bjp-me21.

Smits *et al* (pp. 79–84) look at treatment, comparing mentalisation-based treatment delivered in a day hospital with that in an intensive out-patient setting in a randomised controlled trial of over 100 individuals with borderline personality disorder. Mentalisation-based treatment is a core evidenced intervention for borderline personality disorder, helping individuals develop better mentalising abilities for interpersonal interactions, but the impact of location has been less studied. In this work both interventions showed moderate to very large effect size gains. The more intensive day hospital iteration was not superior on the primary outcome of symptom severity, but there were some additional gains on secondary measures, especially relational functioning.

Powaqqatsi

It is estimated that over one and a half million individuals in the UK have an eating disorder. These have the highest mortality of any psychiatric illness, as well as coming at a societal cost of up to eight billion pounds per annum. Dasha Nicholls, the past chair of the Royal College's Eating Disorders Faculty, and Professor Anne Becker call out in their editorial (pp. 67–68) that eating disorders are prevalent, lethal, but treatable, yet underprioritised and marginalised across service provision, research and healthcare policy. This month's *BJPsych* helps redress this somewhat, with four papers on the topic. Demmler *et al* (pp. 105–112) start at the beginning, questioning the incidence of eating disorders, their most common comorbidities and their longer-term prognosis. They note that attaining such data is impeded by the facts that many might not wish to seek help or disclose their difficulties, obtaining an accurate diagnosis can actually be quite hard, and only a minority in need actually attain appropriate care. Utilising linked primary care and hospital admission electronic records from Wales they identified over 15 000 individuals diagnosed with an eating disorder between 1990 and 2017, determining a peak incidence of 24 per 100 000. Exploring the 2 years before, and 3 years after diagnosis, they found higher levels of other mental illnesses and prescriptions of psychotropic, gastrointestinal and dietetic medications. There was an excess mortality when compared with controls, although interestingly, for reasons that remain unclear, this was considerably less in this cohort (about 1.7 per 1000 person-years at follow-up) compared with that more commonly reported (in the region of about 5.0).

Herle *et al* (pp. 113–119) note how eating behaviours are a reflection of one's relationship with food and food cues. They examine how childhood eating patterns have an impact on the subsequent development of eating disorders, something that has more commonly been explored just with obesity. Taking data from almost 5000 participants in the Avon Longitudinal Study of Parent and Children (ALSPAC), they explored parent and child ratings of early behaviours such as binge eating, purging, fasting and excessive exercise, and compared this with repeat ratings and anthropometric data at aged 16. Childhood overeating had an increased risk of later adolescent binge eating; undereating and persistent fussy eating predicted greater likelihood of anorexia nervosa, although interestingly the former factor only has an impact in girls. The findings raise the prospect of targeting problematic eating behaviours at a much earlier stage than currently occurs.

Rydberg Dobrescu *et al* (pp. 97–104) look into the future, exploring 30-year outcomes in 51 Swedish individuals with adolescent-onset anorexia nervosa compared with matched controls. One in five still had an eating disorder at this end-point; although clearly that is problematic, the authors reflect that this equally demonstrates that the majority showed a favourable outcome in terms of full symptom recovery. Their findings are more positive than the 50% full-recovery rate often cited.

It has been estimated that between two-fifths and two-thirds of women with a history of eating disorders will experience postnatal depression, but there has been a dearth of information on such individuals beyond about a year post-partum. Using data from the aforementioned longitudinal ALSPAC cohort, Chua *et al* (pp. 90–96) tackle longer-term trajectories of depression in mothers with lifetime histories of eating disorders. This affective disorder was more common in those with anorexia or bulimia nervosa across their lifespan. Interestingly, they found a specific dose–response relationship between body image and eating concerns during pregnancy, including a generally more severe depressive trajectory.

Finally, Kaleidoscope (pp. 122–123) asks why research led by women scientists takes longer to go through the peer review process, why men scientists use so many superlatives praising their own work (I think these two issues are linked) and notes research on the disproportionately negative impact of unnecessarily scathing reviewer comments on scientists from minority backgrounds.