

Highlights of this issue

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Outcomes of positive childhood attributes and bipolar disorder

The New Year has traditionally been a time to reflect on the past and plan for the future; a process in some respects analogous to a psychiatric assessment. In both, there should be a cautious review of difficulties, but also of strengths. The benefits of assessing positive attributes is demonstrated in the paper by Vidal-Ribas and colleagues (pp. 17–25), where parental perceptions of their children's positive attributes served to predict psychiatric outcomes at 3 years, in a large epidemiological study of British children. The authors suggest that measuring positive attributes, alongside symptoms, during mental health assessments not only contributes to the prediction of psychiatric symptoms in the longer term, but also enhances family engagement, caregiver satisfaction and treatment adherence. Bipolar disorder exerts a heavy cost in respect of patient's social and occupational functioning, necessitating the use of combined pharmacological and psychological therapies. Traditional psychological treatment approaches have focused on symptom control, and there has been a movement to adapt these treatments towards a more personal, recovery-focused approach. These recovery-based treatments have a more explicit focus on patient-defined goals and encourage a personalised formulation-driven approach, characterised by greater flexibility in the formulation model driving the therapy. Jones and colleagues (pp. 58–66) report that this novel recovery-focused approach was not only feasible, but effective, with improved personal ratings of recovery at 6- and 12-month follow-up, and an increased time to relapse. Medication adherence continued to be high across the study. Bipolar disorder carries a threefold increased risk of developing type 2 diabetes; insulin resistance is associated with an unfavourable course and poor response to lithium. A study by Calkin and colleagues (pp. 52–57) found elevated rates of both insulin resistance and diabetes in their sample of patients with bipolar disorder; controlling for body mass index did not attenuate this association. The authors suggest this may reflect common pathophysiological features, including hypothalamic–pituitary–adrenal abnormalities, mitochondrial dysfunction and neuroinflammatory changes. This suggests that potential therapies for bipolar disorder could usefully be focused on modifying glucose metabolism.

Psychosis, words and global voices

A computerised text analysis of word use by patients with schizophrenia revealed that their language use differs from that of patients with mood disorders. Fineberg *et al* found that patients with schizophrenia used the word 'they' more often, supporting theories of increased external attribution in this disorder, perhaps reflecting a shift towards thinking of themselves as 'other'. There was also a negative correlation between the use of perceptual and causal language in patients with schizophrenia, with the correlation reversed in patients with mood disorder. The authors suggest that these differences in language use may index

psychopathology of symptoms. An accompanying commentary by Jones (pp. 39–40) highlights some limitations of this study, including the lack of common source material used to distinguish between the disorders, and offers a historical context to the perceived utility of examining the writing produced by patients with mental disorder over the years. Clearly, the link with underlying pathophysiology remains intriguing, but tentative. This study was carried out with English language material, and raises the question whether findings would be similar in different cultures and across different languages. A study of hearing voices from sites sampled across the USA, India and Ghana suggests that although the core experience of hearing voices in the absence of an external stimulus is similar, the quality of the subjective experience is culture-bound. Luhrmann *et al* (pp. 41–44) found that patients in the USA were more likely to experience their voices as intrusive and assaultative, and were upset that they could not be controlled. The patients in India and Ghana were less troubled by this inability to control the voices, and more likely to say they liked the voices. The authors suggest that this reflects a cultural aspect to the subjective experience; suggesting that the more individualistic Western perspective has a greater dissonance with other people interfering with oneself, while in India and Ghana people consider themselves as more interdependent, accepting themselves as connected through their external relationships. One consequence of this interdependent view is a greater acceptance of voices as being, like other people, largely out of our control.

Depression, bias, interferon-alpha and ECT

Human reasoning is not logical, being influenced by various cognitive biases, evidenced through our difficulty with solving logical puzzles, framing effects on financial decision-making, and behaviour demonstrating racism and sexism. These biases may also contribute to the development and maintenance of clinical disorders such as depression and anxiety. Cristea and colleagues (pp. 7–16) reviewed the data for cognitive bias modification interventions in anxiety and depression and found them to be inconclusive. They reported small, mostly non-significant, effects once publication bias was adjusted for, and advocated for larger studies with robust designs. Treatment with the antiviral drug interferon-alpha, used for the treatment of hepatitis C, is associated with an increased risk of depression in up to 70% of patients; this risk was significantly elevated in patients with baseline subclinical depressive symptoms or cognitive deficits on tests of cognitive flexibility. Sarkar *et al* (pp. 45–51) suggest that these tests could be used as screening tools to identify and prospectively treat patients at higher risk of depression. An interesting study has compared the speed of remission between two treatments, electroconvulsive therapy (ECT) and antidepressant medication, in elderly patients with severe depressive illness. Spaans and colleagues (pp. 67–71) found that ECT achieved remission after 3 weeks, significantly faster than medication alone, which took 4 weeks. The authors suggest that ECT should be considered as a treatment when speed of response is crucially important.

We take this opportunity to encourage our readers to appraise the research colour in the Kaleidoscope column (pp. 85–86); and wish the readers of the *BJPsych* a healthy, scientifically stimulating and peaceful New Year.