

Highlights of this issue

BY MARY CANNON

STIGMA, SOCIETY AND EVOLUTION

Susan Sontag has observed that every society seems to need one illness that attaches stigma and blame to its 'victims' – mental illness, particularly schizophrenia, appears to have taken this mantle over from AIDS. A review paper by Haghghat (pp. 207–215) proposes that stigmatisation is a fundamental human tendency – a vestige of our animal evolutionary heritage – and, consequently, anti-stigma campaigns must work on many different levels in order to be successful. The power of the mass media has greatly increased the impact of stigma. If every time we hear the word 'schizophrenic' on television there is news of another murder, a form of classical conditioning occurs. Cognitive, affective and cultural strategies are therefore needed to 'desensitise' the public's fear and anxiety. Crisp (pp. 197–199), in an accompanying editorial, favours legislative and political interventions and feels that people with mental illnesses, like those with physical disabilities, should be empowered to 'fight their corner' and test out the relevance of human rights and disability discrimination legislation for their own ends.

PSYCHOLOGICAL TREATMENTS FOR ANOREXIA NERVOSA

There have been very few randomised controlled trials (RCTs) of psychological treatments for anorexia nervosa. Dare *et al* (pp. 216–221) carried out an RCT with 84 patients with anorexia nervosa comparing three specialised forms of psychotherapy (family, focal psychodynamic and cognitive-analytic) with a control group who received 'routine' treatment. Patients in the treatment groups gained significantly more weight than those in the control group.

About one-third of the patients in the treatment groups, but only 5% of those in the control groups, had 'recovered' at 1-year follow-up. Unfortunately, the trial had insufficient power to distinguish between the three types of psychotherapies.

SUICIDAL BEHAVIOUR AND PSYCHOSIS

Yet another outcome in psychosis that intensive case management fails to influence is suicidal behaviour. An analysis of UK700 data by Walsh *et al* (pp. 255–260) finds that the established predictors are still the best: past history of suicide attempts and multiple hospital admissions.

VENLAFAXINE: BETTER THAN ALL THE REST?

It is widely believed that the different classes of antidepressant medication are equally effective. However, a meta-analysis of eight trials by Thase *et al* (pp. 234–241) shows that patients treated with venlafaxine have a 10% greater chance of remission than those treated with selective serotonin reuptake inhibitors, and onset of remission occurs 1 week earlier. Maximum doses of venlafaxine seem to be necessary to produce this effect. One major consideration is that all eight trials were conducted by Wyeth–Ayerst Laboratories. The authors carry out a brief qualitative review of 12 other studies examining this issue and conclude that their results would not have changed if these studies had been included.

KEEP TAKING THE PLACEBO!

Although treatment with antidepressant medication is more effective than placebo, the size of the placebo effect is still surprisingly large. An editorial by Andrews (pp.

192–194) urges clinicians to take advantage of this and to strive to potentiate "the placebo effect with simple psychological strategies".

HAPPINESS IS MONEY?

The richest people are not always the happiest. Weich *et al* (pp. 222–227) find a non-linear association between individual income and prevalence of common mental disorders that follows a reverse J-shaped distribution. Individuals whose net weekly income is between £400 and £500 per week have lower rates of mental disorders than those earning either less or more. Furthermore, high-earners who live in London have a 35% greater risk of mental disorder than their counterparts living elsewhere. This 'London effect' may relate to income inequality. The situation is more straightforward in Chile, where Araya *et al* (pp. 228–233) find an inverse linear 'dose-response' relationship between socioeconomic status and prevalence of common mental disorders.

A MIND FOR WAR

Recent controversy about depleted uranium and the Gulf War syndrome may force us to extend our definition of war casualty to include chronic fatigue and cancer. Jones & Wessely (pp. 242–247) examine the history of psychiatric battle casualties from the Boer to the Falklands War. Intensity of battle is the most important predictor of the incidence of psychiatric casualties but other mediating factors such as the morale and preparedness of the troops are also important.

PASSING ON THE EVIDENCE

Everyone agrees that evidence-based information is a good thing, but no-one has considered how to convey this evidence effectively to individual practitioners. At present there is no accessible source of information that synthesises all the available evidence on interventions into brief 'pros and cons' for particular clinical scenarios. Lawrie *et al* (pp. 195–196) would like to hear what you think. Answers on a postcard please . . .