

Highlights of this issue

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Childhood adversity and interventions for self-harm

Adversity during childhood has been associated with a range of psychiatric sequelae in later life. Bruffaerts and colleagues (pp. 20–27) carried out a very comprehensive international study and report that childhood adversity was associated with increased risk of suicidal behaviour in adulthood. The data are interesting, in providing not only the baseline levels of childhood adversity – death of a parent in 12%, physical abuse in 8% and parental divorce in 6% – but also suicidal behaviour and thoughts in approximately 3% and 9% of responders respectively. The relationship with subsequent suicide attempts was strongest in those who had suffered physical or sexual abuse in childhood. The authors suggest that prevention of individual adversities may not be practicable, but identifying and supporting families at greater risk may be one way forward. The optimal intervention in preventing recurrence in people presenting with a suicide attempt is not clear. However, both following them up and offering psychological therapy have been shown to be effective in reducing recurrence rates. The relatively cost-effective solution of sending regular postcards to people in the year following the suicide attempt was examined by Beautrais *et al* (pp. 55–60). They found that this intervention did not reduce further self-harm, and discuss possible reasons for their non-replication of an earlier study. In a related editorial, Kapur *et al* (pp. 5–7) review other similar ‘contact-related’ interventions and suggest that, in this complex area, qualitative research may be useful in identifying key elements relevant to initiating change.

Tourette syndrome, psychosis and frontotemporal dementia

Patients with Tourette syndrome have high rates of comorbidity and psychosocial impairment, in addition to the classical features of motor and vocal tics. However, although the tics have been reported to improve in late adolescence, the impact on individuals’ wider functioning has not been clear. Gorman *et al* (pp. 36–44) carried out a controlled study assessing patients with Tourette syndrome aged 18 years and found that they had elevated rates of attention-deficit hyperactivity disorder (ADHD), major depression and conduct disorder. In these patients, increased ADHD, obsessive-compulsive disorder and tic severity were associated with poorer psychosocial outcomes. They conclude that although tics may resolve in late adolescence, these comorbid features appear to persist and lead to continued impairment in

psychosocial functioning. There are several commonalities in the diagnoses of schizophrenia and frontotemporal dementia, including symptoms related to emotional blunting, disorganised behaviour and language disturbance. Schoder and colleagues (pp. 28–35) found that the risk of schizophrenia in relatives of probands with frontotemporal dementia was higher than in a comparison group of relatives of those with Alzheimer’s dementia. They genotyped ten families with both schizophrenia and frontotemporal dementia and describe three of these with causal frontotemporal dementia mutations. They suggest that early subtle changes in the pathways responsible for frontotemporal dementia may be associated with schizophrenia.

Depression: prevention in older adults and CBT in somatic disease

Depression is more common in older age and in patients with somatic disease, three reports examine the assessment and treatment of these. Various non-medical approaches have been shown to reduce depressive symptoms in the community; Walker and colleagues (pp. 45–54) examined the effects of three strategies in preventing depression: mental health literacy; physical activity; and folic acid and B₁₂ supplementation. They report that none of these was effective in reducing depressive symptoms in a community sample over a 24-month follow-up period. They found a small short-term effect of the literacy intervention over the first 6 weeks – but no sustained benefit – and conclude that this relatively inexpensive intervention may warrant further investigation. Beltman *et al* (pp. 11–19) show that cognitive-behavioural therapy (CBT) is effective in treating depressive symptoms in a variety of somatic diseases, and has a greater effect in those with more prominent symptoms fulfilling a diagnosis of a depressive disorder. Their meta-analysis also found that other psychological approaches including problem solving, or supportive therapy, were as effective as CBT, and that individual therapy may be better than group approaches. A methodological issue related to the assessment of depression in somatic illness was probed by Thombs *et al* (pp. 61–66). They observed that it was commonly believed that the presence of somatic complaints, in themselves, may serve to inflate the scores of patients on depression questionnaires, and hence contribute to an elevated prevalence rate. However, they found that there was no significant difference in the somatic symptoms scores of somatically ill patients compared with psychiatry out-patients or even college students, as assessed by self-report using the Beck Depression Inventory–II. They conclude that self-report measures of depression can be used in these groups and that they will not systematically overestimate depression on the basis of elevated somatic symptoms.