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IN THIS ISSUE

This issue contains two reviews, one on the findings from high-risk studies of schizophrenia, and one comparing two psychological interventions for post-traumatic stress disorder (PTSD). Other sets of papers examine various aspects of PTSD, psychosis, personality disorder, and common mental disorders, and four individual papers examine a variety of topics.

Schizophrenia

In the first review, Owens & Johnstone (pp. 1501–1514) review findings from familial high-risk studies specifically in the context of the Edinburgh High Risk Study (EHRS). The authors identify 15 high-risk studies, of which five followed subjects through to adulthood. They conclude that these studies have provided evidence for multiple biological markers for schizophrenia, particularly neuromotor development and cognition. The evidence for family and environmental factors is weaker.

Treatment of PTSD

In the second review, Seidler & Wagner (pp. 1515–1522) present findings from a meta-analysis of studies comparing the efficacy of eye movement desensitization and reprocessing (EMDR) and trauma-focused cognitive-behavioural therapy (CBT) in the treatment of PTSD. Their analysis of data from seven studies (with a combined total of 209 patients) showed no significant differences between the two interventions. The authors conclude that future research should focus on establishing which clients will most benefit from one or other of these treatments.

Epidemiology of PTSD

A paper by Zlotnick and colleagues (pp. 1523–1533) examines the prevalence and correlates of PTSD in Chile, using data from a large cross-sectional survey. The lifetime prevalence of PTSD was 4·4%. This was higher for women (6·2%) than men (2·5%). The lifetime prevalence of at least one traumatic event was 39·7%. The authors further found that rape was the event most strongly associated with PTSD and that PTSD predicted the subsequent development of a number of common mental disorders.

Psychosis

Three papers examine aspects of psychosis. In the first, Wu *et al*. (pp. 1535–1540) used administrative health insurance claims data to estimate the prevalence of schizophrenia in the USA. They found an annual prevalence of 5·1 per 1000 people (0·5%). The highest prevalence rate was for those covered by Medicaid (a government insurance scheme for those under 65, usually covering those on low incomes) (1·7%).

Fearon *et al*. (pp. 1541–1550) report findings from a three-centre study of the incidence of psychoses in different ethnic groups in the UK. They found that, across all three centres, the incidence of all psychoses was over six times greater for African-Caribbeans compared with White British, and over four times greater for Black Africans. The rates were most elevated in these groups for schizophrenia and manic psychosis. These high incidence rates held across all age groups and for men and women. The incidence rates were more modestly raised for other ethnic groups (e.g. Asian, Other Whites).

In the final paper in this group, Bebbington *et al*. (pp. 1551–1562) report on the reliability and validity of a new method for evaluating remission and relapse in psychosis using routine clinical notes. Using data from the Lambeth Early Onset study, the authors found that ratings could be made with moderate-to-good reliability. The authors conclude that this instrument is a timely addition to available methods as the expansion of community-based care means it is no longer valid to use hospital admission as a proxy for relapse.

Personality disorder

In the first of three papers focusing on personality disorder, Dolan & Fullam (pp. 1563–1569) investigated face affect recognition deficits in a sample of 49 male prisoners with a diagnosis of anti-social personality disorder (ASPD) and 49 matched controls. They found that the ASPD group had a specific deficit in sad facial affect recognition. Within the ASPD group, sad face recognition was poorer in those who scored most highly on the

Psychopathy Checklist. The authors conclude that this suggests that ASPD is associated with deficits in recognizing aversive cues in others.

Marcus *et al*. (pp. 1571–1581), using data from 1146 male offenders, performed taxonomic analyses to assess whether ASPD is underpinned by a categorical or dimensional construct. They used two sets of symptom indicators (from a structured interview and from a self-report measure) and a number of different taxonomic procedures to maximize confidence in the findings. All the results were consistent with the proposition that ASPD is best understood as representing one end of a continuum rather than a discrete category.

Kendler *et al*. (pp. 1583–1591) investigated the relationship between genetic and environmental risk factors for dimensional representations of Cluster A personality disorders (paranoid, schizoid, and schizotypal), using data on 1386 twin pairs drawn from the Norwegian Institute of Public Health Twin Panel. The authors found that the three personality disorders in Cluster A were modestly heritable (21–28%) and shared a portion of their genetic and environmental risk factors. The authors interpret this as providing support for the validity of the Cluster A construct.

Common mental disorder

Two papers focus on aspects of common mental disorders. Slade & Watson (pp. 1593–1600) used data on 10 641 subjects recruited as part of the Australian National Survey of Mental Health and Well-Being to test which of four models best fit the co-occurrence of 10 common DSM-IV and 11 common ICD-10 mental disorders. In line with some previous research, they found that a hierarchical three-factor model provided the best fit for both DSM-IV and ICD-10 disorders. The factors were: (1) distress (depression, dysthymia, PTSD, generalized anxiety disorder, neurasthenia); (2) fear (social phobia, panic disorder, agoraphobia, obsessive–compulsive disorder); and (3) externalizing (drug and alcohol dependencies).

Zimmerman & Chelminski (pp. 1601–1611) report data from a second large-scale validation of the Psychiatric Diagnostic Screening Questionnaire (PDSQ). The PDSQ is a screening instrument for common mental disorders designed for use in routine clinical practice. The authors report very similar results to the first validation. The optimal cut- off points were the same for nine of the 13 PSDQ items, and similarly high sensitivity and negative predictive values were found.

Other topics

The issue concludes with four papers examining a variety of topics. Kuntsi *et al*. (pp. 1613–1624) investigated the extent of genetic and environmental influences on performance in a series of cognitive-experimental tests in a sample ($n = 400$) of 7- to 9-year-old twins. They found a moderate degree of genetic influence on measures of reaction time, inhibition and working-memory performance. The authors conclude that the data support the usefulness of the studied variables for endophenotype studies that aim to link genes to cognitive and motivational processes.

Lindesay *et al*. (pp. 1625–1633) examined the prevalence of worry across different age groups using data on 8580 individuals drawn from the British National Survey of Psychiatric Morbidity. They found that 63% of the sample reported worry in the previous month. The prevalence of worry decreased with age, and was positively associated with the categories of mental disorder studied, independent of life events and a range of sociodemographic variables.

Oude Voshaar *et al*. (pp. 1635–1645) investigated the relative effects of pain, depression, fear of falling and cognitive functioning on functional outcome following surgery for hip fracture in a sample of 187 patients aged over 60. They found that only fear of falling and cognitive function were independently associated with functional outcome at 6 months post-surgery. The authors conclude that CBT designed to reduce fear of falling may be a useful component of rehabilitative care in this group.

Kelly *et al*. (pp. 1647–1656) conducted a review of papers published in four psychiatric journals between 1992 and 2002 with the aim of investigating the relationship between source of funding and outcomes of clinical psychiatric research. They found the percentage of studies funded by drug companies increased from 25% in 1992 to 57% in 2002. Favourable outcomes were significantly more common in studies sponsored by the drug manufacturer (78%) compared with those with no sponsor (48%) and those funded by a competitor (28%).

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