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Highlights of this issue

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Early psychosis interventions

Three papers in the *BJPsych* this month address aspects of treatment in the early stages of psychosis, including treatment for those at risk for or in the prodromal phase of psychosis. Utilising instrumental analysis to estimate the direct and indirect effect of treatment, Flach *et al* (pp. 123–129) examined the components of cognitive therapy for those at risk of psychosis as part of a multicentre randomised trial of psychotherapy to prevent psychosis. Although no direct effect of randomisation to treatment was found, the authors did find a significant decrease in symptom score for those receiving treatment if case formulation and homework were involved in the therapy. In a study by Valmaggia *et al* (pp. 130–134) comparing two clinical groups with first-episode psychosis – including a group presenting to mental health services during the prodromal phase and a group presenting with their first episode of psychosis – the former were found to have a shorter duration of untreated psychosis, were less likely to have been admitted to hospital once psychotic and less likely to have required compulsory treatment. The authors comment on the possibility that those who do not present to services until their first episode may be more likely to have a range of features associated with a poorer outcome. Finally, in a qualitative analysis of the impact of early intervention services on carers' experiences, Lavis *et al* (pp. 135–142) report that these services successfully aid carers to support their relatives, particularly in terms of providing psychoeducation, but that carers' own emotional needs tend to be unacknowledged by teams. The authors highlight the importance of focusing on how carers are best supported, particularly given the increasing reliance on care outside of the clinical environment.

Neurobiological mechanisms: autism, addiction and borderline personality

In a sample of individuals with autism spectrum disorder, Bölte *et al* (pp. 149–157) found that facial affect recognition (FAR) training improved results on behavioural FAR testing and also that such improvement was accompanied by evidence of social brain plasticity – increasing amygdala and fusiform gyrus activation. Cognitive inflexibility is postulated to contribute to persistence of harmful behaviours among those with cocaine and gambling addictions. In seeking to uncover the underlying neural substrates of such inflexibility, Verdejo-Garcia *et al* (pp. 158–164) found reduced ventrolateral prefrontal cortex signal during a probabilistic reversal learning task to be common across the two groups. A wider pattern of task-related dysregulation was also found for those with cocaine addiction only. In a study of self-injurious behaviour in borderline personality disorder, Reitz *et al* (pp. 165–172) compared functional magnetic resonance imaging responses after an intervention of stress induction followed by either a forearm incision or sham treatment. Compared with a control sample, those with personality disorder reported subjective benefits of the incision on stress levels and, on imaging, amygdala activity was found to reduce more and functional connectivity with superior frontal gyrus was normalised. The authors comment on the role that pain plays in normalising disturbed emotion regulation circuits in borderline personality disorder.

Patient involvement and duration of psychological therapy

Two reviews in the *BJPsych* this month focus on patient involvement. In a narrative synthesis, Bee *et al* (pp. 104–114) obtained data from 117 studies and found evidence that the involvement of service users in their own care typically fails because the frame of reference of patients differs from that of providers, with patients and carers emphasising the relational aspects of care planning. The authors highlight the linear and outcomes-based approach of providers, which can neglect context and quality. Bhui *et al* (pp. 95–103) have reviewed the evidence on interventions to improve therapeutic communications between Black and minority ethnic patients and mental health professionals. Including 21 studies, they found that intervention trials, involving a wide range of interventions, demonstrated benefits for depressive symptoms, experiences of care, knowledge, stigma, medication adherence, insight and alliance. The authors call for more research in settings outside the UK and USA, more studies with economic outcomes included and more studies of routine psychiatric care practices.

Duration of psychological therapy has been shown to be unimportant in terms of impact on recovery and improvement rates in studies based in primary care. Stiles *et al* (pp. 115–122) found evidence to support this finding in other treatment settings. The authors analysed data from over 25 000 adult patients recruited over a 12-year period at 50 services in the UK including primary care, secondary care, tertiary care, university counselling centres, voluntary sector services, workplace counselling centres and private practices. The authors postulate a 'responsive regulation' model to explain their findings – the notion that patients and providers regulate the dose of intervention against perceived improvement to achieve a 'good-enough' level. In a linked editorial, King (pp. 93–94) comments on the implications and limitations of such a large observational study and highlights the problem for any study design in answering the difficult question of what will work for an individual patient.