

## HIGHLIGHTS IN THIS ISSUE

This issue features groups of papers on deliberate self-harm, neuroimaging, cognitive impairment, treatment of depression in primary care, neuroticism and attachment as aetiological factors. In an additional editorial Tavares *et al.* (pp. 959–967) review recent studies of cognition in mania and depression.

**Deliberate self-harm.** Deliberate self-harm (attempted suicide, parasuicide) continues to be a difficult management problem, with a particular lack of effective measures to reduce repetition rates. In two linked papers Tyrer *et al.* (pp. 969–976) and Byford *et al.* (pp. 977–986) report a large controlled trial of a cognitive approach using provision of a manual to subjects. Repetition rates were not reduced, but costs were lower, due to some reduction in use of other resources. An accompanying editorial by Hawton & Sinclair discusses these findings. Rates of deliberate self-harm in general populations are not easy to document accurately. The best figures have come from Hawton and colleagues in Oxford. In a further paper (pp. 987–995) they report rates for 1990–2000. Confirming the intractability of the problem, even in this area with a model treatment service, there was a considerable overall increase over the 11 years, particularly in repetition rates, although with some decline in the final 3 years.

**Neuroimaging studies.** Three papers report use of neuroimaging. Loo *et al.* (pp. 997–1006) find differences in cerebral blood flow measured by SPECT in depressed patients receiving the usual therapeutic high frequency repetitive transcranial magnetic stimulation, a modified low frequency procedure and sham stimulation. Honey *et al.* (pp. 1007–1018) find differences in regional activation measured by functional MRI produced by a working memory task in schizophrenics, associated with different symptomatic subsyndromal dimensions. Bachmann *et al.* (pp. 1019–1027) using structural MRI, report a smaller corpus callosum in first-episode schizophrenics than in matched controls.

**Mild cognitive impairment and its measurement.** Busse *et al.* (pp. 1029–1038) examined elderly subjects from the community with mild cognitive impairment (MCI) and followed them for 3 years. Among three subgroups of MCI, the highest rate of development of dementia was in those in the amnesic group. De Jager *et al.* (pp. 1039–1050) applied a battery of neuropsychological tests to controls, subjects with MCI, Alzheimer's disease and cerebrovascular disease. They report on the discriminative capacity of a number of specific tests.

**Treatment and assessment of depression in primary care.** Bech *et al.* (pp. 1051–1059) report dropout rates from treatment of depression in a longitudinal study in primary care. Encouragingly, dropout rates were generally low and were lower in older subjects and subjects on antidepressants, but, of concern, they were higher in more severely depressed subjects. Ludman *et al.* (pp. 1061–1070), in a controlled trial to improve long-term antidepressant adherence and to lower relapse rates in primary care, report that a brief intervention targeting cognitive-behavioural factors was highly successful in changing behaviours, particularly those related to self-efficacy and self management, and thence in improving outcome. In another controlled trial, in the community, Jorm *et al.* (pp. 1071–1079) focused on providing evidence-based treatment information for depression. The intervention brochure was rated by subjects as more useful than a control brochure and improved attitudes, but not symptoms.

In a further paper related to depression, Scott & Pope (pp. 1081–1088) report on self-esteem, dysfunctional attitudes and personality style in unipolar depressives, and bipolar subjects when depressed, hypomanic and remitted. Such studies are important in view of recent extension of cognitive therapy and related treatments to bipolar disorder. They find similarities in cognitive style between unipolar and bipolar depressives. Hypomanic subjects were found to show cognitive styles intermediate between depression and remission.

**Neuroticism and attachment in aetiology.** Goodwin *et al.* (pp. 1089–1097) report data from a longitudinal birth cohort. Neuroticism at age 14 was found to predict psychotic symptoms at age 18 and 21, with the effect remaining after adjustment for confounding factors. In a study of a more proximal aetiological factor, Bifulco *et al.* (pp. 1099–1110) report a new self-report measure of attachment styles, and find it highly related to social support and to depression.