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Highlights of this issue

Katherine Adlington

'In with the new'

As I return from a period of parental leave to write this column – perhaps a little rusty and certainly somewhat sleep-deprived – this issue presents a useful refresher and insight into some of psychiatry's incoming trends. Talking of incoming trends, one of the biggest changes afoot for our journal is the arrival of a new Editor in Chief, Prof. Gin Malhi. Although we can't say a big enough thank you and fond enough farewell to Prof. Kam Bhui for years of dedication to these pages, we welcome Prof. Gin Malhi. You will be able to read all about what Prof. Malhi has in store for the *BJPsych* during his tenure as Editor in Chief in the upcoming issues.

Although there is nothing new about prognostic risk prediction models in clinical medicine – they have been heralded since the Framingham Risk Score in the 1990s – as yet it's safe to say they remain underutilised in front-line clinical practice, and their potential impact on patient outcomes has not yet been fulfilled, particularly in mental health settings. One major problem in practically implementing such models is ensuring that they consist of data that are available at a clinician's fingertips in a busy clinical setting. The PMH CAREPLAN study by Vigod et al (pp. 422–429) describes attempts to develop and internally validate a clinical index to quantify the 1-year risk of common postpartum mental health disorders. The authors developed a model incorporating risk factors that could be routinely collected from healthcare notes at the time of delivery and found it to be nearly 70% reliable in its ability to discriminate between those who would and would not develop mental health difficulties during their first postpartum year. Perhaps, at some point, such developments might allow a more individualised approach for patients, like me, who are in their first postpartum year, as well as helping to convey the risks and benefits of potential postnatal illnesses more clearly and succinctly.

The explosion in telepsychiatry triggered by the pandemic seems to have been maintained as accepted post-pandemic practice in many settings – leaving researchers and services trying to catch up with the evidence of acceptability and outcomes for patients. A secondary research study by Hagi et al (pp. 407–414) this month using meta-analytic data explores the impact of telepsychiatry in all settings, with symptom improvement as a primary outcome. This is an important attempt to provide an evidence-based foundation for ongoing practice, but the results are mixed. The available evidence suggests that telepsychiatry has a more positive impact versus face-to-face care for depressive disorders, but that face-to-face care is preferable in terms of improving the symptoms of people with eating disorders – perhaps a useful finding for eating disorder services. However, when all studies were combined for all conditions, there was no difference between telepsychiatry or face-to-face care in symptom improvement or all-cause discontinuation.

I recently tentatively dipped my toe back into the Twittersphere, only to find ongoing controversy about what we do and don't know about the role of serotonin in the pathophysiology of depressive illness. Any new data that can shed light on this topic are surely welcome, and luckily Galfalvy et al (pp. 415–421) this month publish their work on the role of epigenetics in the serotonergic system, particularly after childhood or recent life stress in people with major depressive disorder. Their findings lend support to a theory that recent stress increases 5-HT1A receptor binding via DNA methylation of promoter sites that bind inhibitory transcription factors, with a consequent impact on the pathophysiology of major depressive disorder. Perhaps they can disseminate their findings in the less-hostile surroundings of Threads (if it's still around by the time this issue appears in September).

There were slightly less complex and more intuitive results from a Danish randomised controlled study by Kehler Curth et al (pp. 430–437) that, perhaps unsurprisingly, showed greater symptom reduction in people with both anxiety and depression who experienced a model of intensive multidisciplinary mental healthcare coordination in primary care compared with those that experienced a more hands-off consultation liaison model of care.

At the other end of the scale in terms of intensity of primary care mental health provision is the use of guided self-help therapies. Kellett et al (pp. 438–445) used a pragmatic, randomised, patient-preference trial to compare cognitive–behavioural therapy (CBT) guided self-help (GSH) with cognitive analytic therapy (CAT) GSH for the treatment of mild-to-moderate anxiety. The study found no statistically significant difference in clinical outcomes between the two types of therapy – yet an interesting finding was that very few people wanted the treatment to be randomised; they wanted to know and choose what they were getting, an important point to reflect on given the often limited options available to people for therapy in primary care. Interestingly, there was a strong preference among participants to choose the CAT GSH over the CBT; furthermore, CAT GSH participants were significantly more likely to start treatment and to complete full treatment, and attended significantly more sessions. This leaves me pondering what it was about CAT that attracted patients so much more in this particular study.

Finally, I suspect that I am not alone in struggling to think clinically and diagnostically about how people with complex post-traumatic stress disorder differ from those with borderline personality disorder – particularly as we get to grips with the new ICD-11 classifications. Karatzias et al (pp. 403–406) have produced a useful educational article to help with this particular conundrum, including helpful case studies. I suspect many clinicians will add this practical pointer to their essential reading and teaching materials – it will certainly be useful in my return to full-time clinical practice.

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