

Highlights of this issue

By Kimberlie Dean

Psychopharmacology under the microscope

A focus on psychopharmacological agents, antipsychotics in particular, is featured in the *Journal* this month. Kendall (pp. 266–268) argues that there is no clinical or scientific evidence to justify the notion that atypical antipsychotics represent a distinct antipsychotic class but rather that the drug industry has essentially fabricated new classes for marketing purposes. Supporting this argument, a study based in China provides further evidence of the lack of difference in outcome for those treated with first- v. second-generation antipsychotics (Girgis *et al*, pp. 281–288). In a randomised clinical trial, individuals presenting with first-episode psychosis were treated with either clozapine or chlorpromazine for up to 2 years and then followed up after a further 7 years of naturalistic treatment. No differences in measures of illness severity or secondary efficacy outcomes were found between the two groups. Leucht & Davis (pp. 269–271) also comment on the implications of this study and agree that the classification of atypical and typical antipsychotics has created confusion but they warn against regarding all antipsychotic drugs as equivalent. They argue that the differences between available drugs should be exploited in the shared decision-making process of prescribing for individual patients.

Frighi *et al* (pp. 289–295) note that antipsychotics are frequently prescribed for individuals with intellectual disability despite limited evidence of efficacy and little knowledge about safety. In an observational study, metabolic indices were found to be similar between those with intellectual disability treated with antipsychotics and those characterised as antipsychotic-naïve. Those treated with amisulpride/sulpiride and risperidone were found to have high rates of hyperprolactinaemia, however. Suzuki *et al* (pp. 275–280) identify individuals with treatment-resistant psychosis as another patient subgroup for whom little is known with regard to psychopharmacological treatment. Following a review of randomised double-blind trials of antipsychotic medication use in adults with treatment-resistant schizophrenia, the authors

found that response peaked early in the course of treatment, in line with other recent studies of antipsychotic response timing.

Finally, Harrison *et al* (pp. 263–265) contend that psychopharmacological expertise needs to be given greater prominence by psychiatrists, both for the benefit of patients, who should expect safe and effective treatment, and for supporting the future of the specialty, by helping to define psychiatrists among other mental health professionals.

The relationship between unipolar depression and bipolar disorder

Relatives of those with bipolar disorder are known to be at elevated risk of unipolar depression and it has long been assumed that the nature of depressive episodes experienced by these two groups is similar. Mitchell *et al* (pp. 303–309) examined the clinical characteristics of depressive episodes among those with bipolar disorder compared with those with major depression from bipolar pedigrees. In the former group, rates of psychomotor retardation, difficulty thinking, early morning waking, morning worsening and psychotic features were all higher. The authors also found evidence of two symptom clusters for the major depressive disorder group, possibly representing ‘genetic’ and ‘sporadic’ factors. In a related editorial, Smith & Craddock (pp. 272–274) argue that the distinction between unipolar depression and bipolar disorder may not be as easily delineated as previously thought.

Randomised trials – for self-harm and residual depression

Hatcher *et al* (pp. 310–316) report on findings from a randomised controlled trial of problem-solving therapy for individuals who present to hospital with self-harm. Compared with usual care, the authors found that therapy did not reduce rates of repeat self-harm presentation at 12 months except among those where the index episode was a repeat self-harm event. For those with medication-refractory residual depression, Watkins *et al* (pp. 317–322) found that rumination-focused cognitive-behavioural therapy was associated with improvements in residual symptoms and remission rates, with treatment effects being found to be mediated by change in rumination.