Highlights of this issue

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TREATMENT OF DEPRESSION, ANXIETY AND DEPERSONALISATION

Most clinicians consider both antidepressants and psychotherapy as useful treatments for depression. Is it true that their combined use is better than each used individually? de Jonghe and colleagues (pp. 37–45) address this important issue and find the evidence supporting combined treatment to be limited. They demonstrate that there is no difference in the outcome of out-patients with depression treated with psychotherapy or psychotherapy combined with pharmacotherapy, as assessed by independent raters and the clinicians themselves. However, the patients rated the combined treatment as being more effective. Interestingly, more patients in the psychotherapy group complained of side-effects such as headache, nausea and trembling. With psychotherapy still a relatively scarce resource, it seems appropriate to investigate the potential of computerised cognitive–behavioural therapy for treatment of depression and anxiety. Proudfoot *et al* (pp. 46–54) report that such computerised therapy was effective in treating uncomplicated patients in primary care. This therapy also succeeded in bringing about a change in the patient's attributional style. An accompanying paper (McCrone *et al*, pp. 55–62) makes the case that such an intervention appears to provide a cost-effective treatment. Depersonalisation is a debilitating illness and there have been reports of successful treatment with selective serotonin reuptake inhibitors (SSRIs). The results of a randomised double-blind placebo-controlled trial of fluoxetine in the treatment of depersonalisation disorder demonstrated that fluoxetine was not significantly more effective than placebo (Simeon *et al*, pp. 31–36). The authors make the point that the previous reports may have included a greater number of patients with SSRI-responsive symptoms, such as panic or obsessions.

PARENTS, PITUITARY AND PSYCHOSIS

It is generally accepted that the children of parents with a psychotic illness are at a higher risk of developing psychiatric illness themselves. A follow-up study of the children of mothers with a psychotic illness (Niemi *et al*, pp. 11–17) adds further support by demonstrating that the cumulative incidence of a psychotic disorder in the children was as high as 13.5%, and the risk of them developing any mental disorder was 23%. The risk was highest in children of mothers with a diagnosis of schizophrenia. However, these children also had much higher odds of their father also having had a psychiatric disorder. It is recognised that the acute phase of the psychotic illness is characterised by increased arousal and concomitant hyperactivity of the hypothalamic–pituitary–adrenal (HPA) axis. Pituitary size was increased in depressive illness in line with activity within the HPA axis. Pariante *et al* (pp. 5–10) demonstrate that patients with first-episode psychosis exhibit increased pituitary volumes compared with controls, whereas there is a decrease in patients with more established schizophrenia. This would be compatible with an acute stress response in first-onset psychotic illness, but with ongoing chronic stress response leading to decreased pituitary size, secondary to negative feedback mechanisms. As stress reactions are considered to have a toxic effect on the brain, the reduction of the duration of untreated psychosis may be a key prognostic variable. A shorter duration of untreated psychosis was associated with better clinical outcome in patients with a first episode of non-affective psychosis (Perkins *et al*, pp. 18–24). Independently, and with less scope for intervention, good premorbid functioning was also related to a more favourable outcome. The authors conclude that earlier institution of antipsychotic treatment may be useful in optimising treatment, and that patients with poor premorbid functioning may comprise a subgroup that is generally less responsive to antipsychotic treatment.

RAPID TRANQUILLISATION, SAFETY IN MEDICINE AND CONSUMER EDUCATION

It has been widely recognised that violent or aggressive behaviour is a significant problem in psychiatric services. There has been an attempt to rationalise rapid tranquillisation regimes to minimise risk and optimise efficacy, and the use of intramuscular haloperidol and lorazepam is one favoured combination in the UK. It is interesting to note the variation in rapid tranquillisation regimes in different countries; Alexander *et al* (pp. 63–69) present the results of a randomised trial of intramuscular lorazepam (4 mg) compared with a mixture of haloperidol (10 mg) and promethazine (25–50 mg), the latter combination being widely used in India and Brazil. The haloperidol/promethazine mixture produced a faster onset of sedation and more clinical improvement over the first few hours. They considered the important issue of cost-effectiveness, and noted that this combination of drugs is cheap, effective and safe and that poorer countries are, in the main, unable to meet the costs of newer products such as the intramuscular atypical antipsychotics or even the existing typical antipsychotics such as zuclopenthixol acetate. Two editorials address themes related to drug advertising and violence. The first (Gilbody *et al*, pp. 1–2) expresses concern about the boom in direct-to-consumer advertising of psychotropic medication by the pharmaceutical industry. Although this is not yet possible in the European Union, experience in the USA suggests that psychiatrists need to be aware of the risks and benefits of this approach. In the second editorial, Munro (pp. 3–4) explains the thinking behind the new system-centred approach that will replace the statutory inquiries after homicides by people with mental illness. It will seek to implement a 'root cause analysis' that will concentrate on systems and procedures rather than apportioning blame to a person. However, this is complicated by the fact that individuals within the organisation will still have legal responsibility for their professional actions and cannot be given immunity from legal action.

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