

## Highlights of this issue

By Derek K. Tracy

### in time of daffodils (who know)<sup>1</sup>

Some complex and thought-provoking editorials and analysis in this month's *Journal*. In a timely piece, given the recent independent review of the Mental Health Act, Pugh *et al* (pp. 133–136) argue for change and greater safeguards to current legislation in the specific case of deep brain stimulation (DBS). Problematically, DBS is lawful without either an individual's consent or independent approval, not falling under the aegis of governance for neurosurgery for mental disorder provided by the Mental Health Act. The Care Quality Commission has argued that DBS should be moved to that section, but the authors of this editorial argue even that is inadequate, with such guidance too permissive and insensitive for specific autonomy-based concerns in DBS. At an extreme end of this they raise the spectre of DBS being used as a form of social control in individuals considered a risk to themselves or others. Their recommendations include keeping DBS and neurosurgery for mental disorder separate in the revised Mental Health Act, and mandating the requirement of capacious consent to the proposed intervention.

What does 'recovery' mean to you? Corrigan *et al* (pp. 130–132) counsel that it depends on the situation and upon the person using the word: in most mental health settings it can mean both an outcome (the aspirational state of being symptom free) and a process (managing those symptoms and doing well despite them), but in the world of substance use disorder it is typically only the former. Does this matter? The authors say yes, not least as it is a phrase often endorsed by peer supporters, and variation in language meaning may lead to differing expectations.

Former College President, Professor John Cox, provides a historic overview and thoughts for the future (pp. 127–129) on the Edinburgh Postnatal Depression Scale. We are reminded that it is only 50 years since the first questionnaire on postnatal depression – in the *BJPsych* – following Pitt's recognition of this 'atypical' depression in women in the East End of London.

### the goal of living is to grow)<sup>1</sup>

This month two papers explore longer-term outcomes following earlier life trauma. Bell *et al* (pp. 153–158) examined data from a cohort of 1265 individuals from New Zealand followed up from birth to age 35. They were interviewed at ages 18 and 21 about childhood physical and sexual abuse, and at 30 and 35 about psychotic experiences. Overall, during childhood, 6.3% had been exposed to severe sexual abuse and 6.4% to severe physical abuse. The authors note how childhood physical and sexual abuse can co-occur and that they can interplay in complex ways with other confounders including socioeconomic disadvantage and family dysfunction. After adjusting for these, those exposed to severe sexual abuse were shown to have 2.25 times greater rates of abnormal thoughts, and just over four times as many abnormal perceptions compared with those without such exposure; interestingly there was no relationship to severe physical abuse.

Wan and colleagues (pp. 146–152) evaluated a school-based health survey of almost 15 000 Chinese school children for individual and interaction effects of adverse childhood experiences (ACEs) and social support on subsequent non-suicidal self-injury, suicidal ideation and suicide attempts. The 12-month prevalences of these three tested outcomes were 26.1%, 17.5% and 4.4%, respectively. Almost 90% of children had reported at least one ACE, and

increasing ACEs and reduced social supports were significantly associated with such events. There was an interaction effect, meaning a combination of ACEs and reduced social support was especially detrimental. Interestingly, girls with more ACEs and fewer social supports had higher risks than boys of suicide attempts.

Langevin *et al* (pp. 137–145) look at male antisocial behaviour, testing the role of serotonergic genes in its development. Although perhaps often seen as a largely environmental creation, antisocial behaviour has an estimated heritability of 50%, albeit multiple genes have been implicated. Data came from the Quebec Longitudinal Study of Kindergarten Children, with 410 males followed from the age of 6 to 23 years. Antisocial behaviour was measured by self-report and semi-structured interviews in adolescence and adulthood, and a range of 11 candidate serotonergic genes with prior identified associations were chosen. A cumulative effect of multiple haplotypes was seen, accounting for between 8.5% and 15.2% of the variance risk and protection for antisocial behaviour.

### forgetting why, remember how)<sup>1</sup>

The inevitable primary push-back against electroconvulsive therapy (ECT) is the lack of good randomised controlled trial data containing comparative outcomes for individuals who are severely depressed and randomised to placebo (general anaesthesia). The ethical reasons this has not occurred are self-evident, but without this there will always be some who vehemently rebut the intervention's efficacy (though interestingly, such folk are often curiously happy with anecdote when it comes to harms). There are ways to circumnavigate the randomised controlled trial, and Gryglewski *et al* report (pp. 159–167) on structural brain changes after a course of right unilateral ECT in 14 individuals with treatment-resistant depression. Increases in brain volume were shown in the right-sided hippocampi and amygdalae (possibly lateralised as a result of ECT placement), and through greater cortical thickness: all areas with strong neuroscientific links to depression, and all areas with potential for adult neurogenesis. Increased volumes have been shown in other work, but these data had greater test-retest reliability, occurring to a similar extent in most patients, and were refinable to very specific hippocampal subfields and amygdalar nuclei. There were exploratory correlations with clinical change, and – the authors argue – the teasing inference of being able to predict response to the intervention.

Of course, it behoves us to continue to monitor for harms, and Rozing *et al* (pp. 168–170) evaluated data from a Danish national registry of almost 175 000 people diagnosed with an affective disorder, testing for any association between having ECT and a subsequent cardiovascular accident. A stroke in the immediate aftermath of ECT is a recognised but very rare event, although in theory the considerable alterations in cardiovascular functioning commonly seen during the procedure might increase longer-term risk. In those under the age of 50, there was no association with a cardiovascular accident; in those over 50 there was a lower risk in those who had ECT. However, this reduction was more likely the result of competing mortality risk as opposed to any direct benefit from ECT in preventing stroke. Overall, reassurance for those who receive and administer ECT. Nevertheless, the initial question returns: has the time finally come for the adequately powered randomised, placebo-controlled trial of ECT?

Finally, Kaleidoscope (pp. 177–178) educates us on loneliness in young people, why women's preference for intelligent men may have selected for human brain growth, and – very contemporaneously – describes how attitudes to ethnicity, sexuality, disability, body weight and age have changed in recent years.

<sup>1</sup> Cummings e e. *Selected Poems* (introduction RS Kennedy). Liveright, 1994.