

## Highlights of this issue

By Sukhwinder S. Shergill

### Antipsychotic medication in the elderly

Dementia commonly presents comorbid behavioural and psychological disturbance, which cause significant distress to the patient and carers alike, and are challenging to manage effectively. The most frequently reported symptoms are psychosis, aggression or agitation. There has been a widespread awareness of the increased risk of mortality related to treatment of these symptoms with antipsychotic medication. Gerhard *et al* (pp. 44–51) examined the mortality risk associated with new initiation of six different antipsychotic medications in community-based patients aged over 65 years, with and without a diagnosis of dementia. They found that many antipsychotics – including haloperidol, risperidone and olanzapine – demonstrated a positive dose–response effect. The authors advocate a cautious and targeted approach when using antipsychotic medication in this vulnerable population. They suggest that particular attention needs to be paid to using the lowest possible dose of antipsychotic, especially with haloperidol. An accompanying editorial by Ballard and colleagues (pp. 4–5) reviews the background literature in relation to dementia; they highlight the association of higher doses of antipsychotic medication with greater risk of mortality – independent of a diagnosis of dementia – and confirm the value of using the lowest possible effective doses of antipsychotics and using haloperidol with great caution.

### Psychosis, mindfulness, insight and resistance to treatment

Psychoeducation for patients with schizophrenia has been shown to improve their outcomes in some studies; similarly, the use of mindfulness-based stress reduction programmes has demonstrated a beneficial reappraisal of their illness. Chien & Thompson (pp. 52–59) report the result of a randomised controlled 6-month trial of mindfulness in schizophrenia, which resulted in improvements in symptom severity, function and insight. The authors, based in China, suggest that their mindfulness-based treatment programme offered an effective community-based intervention for schizophrenia. The role of attachment style in influencing the process of symptomatic recovery was examined in a prospective study of patients with first-episode psychosis in Scotland. Gumley *et al* (pp. 60–67) report that almost 70% of patients showed an insecure attachment; this did not predict change in positive symptoms but was a predictor of greater intensity of negative symptoms. They advocate an integration of interpersonal and metacognitive psychological therapies in order to facilitate better adaption to emotionally laden interpersonal events. Classification in psychiatry has been in the public eye with the recent publication

of DSM-5; Howes & Kapur (pp. 1–3) revisit the diagnosis of schizophrenia in an editorial that highlights the value of using treatment response as a neurobiological marker of different neurochemical mechanisms operating in schizophrenia. They suggest that treatment-refractory schizophrenia may be a different type of illness, related to abnormalities in other neurotransmitter systems, such as glutamate, as opposed to the more conventional type of illness that is modelled by dopaminergic hyper-responsivity and treated with current dopamine-modulating antipsychotic medication.

### Depression, cognitive deficits and brain-derived neurotrophic factor

While depression is common and recognised to be a multifactorial illness, the impact of early childhood conduct disorder on developing subsequent depressive illness remains uncertain. Stringaris and colleagues (pp. 17–23) use longitudinal data to demonstrate that early-life conduct difficulties were significantly associated with later development of depressive disorder. They suggest that this may offer an opportunity for early intervention, warranting both a careful assessment for depression during early-stage conduct disorder and interventions aimed at treating depression, in addition to the behavioural disorder, at this early stage. The impact of depressive episodes on the development of cognitive deficits in bipolar disorder is not clear; the report of Muralidharan *et al* (pp. 36–43) found that depressive episodes did not contribute any specific cognitive deficits, beyond the broad range of deficits associated with bipolar disorder generally. However, they noted that poorer verbal memory may serve as a marker for depressive recurrence in bipolar disorder. Brain-derived neurotrophic factor (BDNF) affects brain development and connectivity, and occurs at lower levels in bipolar disorder. Li and colleagues (pp. 29–35) examined a prospective cohort of patients with a first episode of depressive illness to assess the impact of BDNF levels on developing a bipolar illness. They found that the combination of BDNF gene expression and plasma BDNF offered the best predictor of those people at greater risk of developing subsequent bipolar disorder.

### Service user involvement in research

It's clear that involving service users in mental health-related research has several advantages, including the addition of a highly relevant perspective to the research process; however, systematic data on the people involved and their experience of the process have not been well explored. Patterson and colleagues (pp. 68–75) found that there is a diverse and highly skilled service user body contributing to mental health research. However, they did comment on concerns raised by service users that their involvement was sometimes treated as tokenism, with some of them reporting feelings of stigmatisation and discrimination. Overall, service users reported their involvement in research as a positive experience.