

Highlights of this issue

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LIFETIME ABUSIVE EXPERIENCE AND MENTAL DISORDERS IN WOMEN

Coid *et al* (pp. 332–339) analysed the associations of lifetime abusive experiences and psychiatric morbidity in over 1000 consecutive female general practice attenders in east London. Abuse in childhood and adulthood had differential effects on adult mental health with these effects being increased by recency and severity. Domestic violence showed the strongest associations with most mental health measures, with sexual assault in adulthood also showing an association. It is suggested by Mullen (pp. 340–341) that the failure of this study to demonstrate a link between childhood sexual abuse and later psychiatric disorder (as nearly all others do) is most probably explained by methodological issues and that this result must therefore be viewed with extreme caution. Mullen points to the importance of the finding of a link between physical abuse in childhood and later mental health problems as helpful in reminding us of the detrimental impact of this less-reported aspect of childhood adversity.

EMBRACING TRADITIONAL HEALERS

In Tanzania, Ngoma *et al* (pp. 349–355) found the prevalence of common mental disorders to be twice as high among patients attending traditional healers than among those attending primary health clinics. Such patients usually presented with chronic symptoms and had previously consulted several doctors. The overwhelmingly somatic presentations may have militated against recognition by clinicians. It is suggested that the formal health system might usefully be aided by indigenous practitioners in improving the mental health of the community, by providing a better understanding of the prevailing indigenous

models and idioms of expression for common mental disorders.

PHASED TREATMENT IN SEVERE PERSONALITY DISORDER

Chiesa & Fonagy (pp. 356–362) demonstrate the benefit of a step-down psychosocial programme following a residential specialist programme for severe personality disorder. Those allocated to the step-down programme showed significantly better social adjustment and global mental health, displayed less self-destructive behaviour and were admitted less often than those not allocated to the programme. Findings support the use of a phased hospital-to-community programme for the treatment of severe personality disorder.

MENTAL DISORDER AND SUBJECTIVE PHYSICAL IMPAIRMENT

Surtees *et al* (pp. 299–303), in a population-based study, found the degree of subjective physical functional impairment associated with mental disorder to be considerable and of equal magnitude to that associated with a number of chronic medical conditions. Chronic anxiety was associated with subjective physical functional impairment in excess of that associated with either depression or a number of physical health conditions, including cancer and diabetes. Comorbidity of chronic medical conditions and prevalent mood disorder was associated with additional impairments in self-reported physical but not mental functional status beyond that associated with the presence of only one condition. With compelling evidence for the effective treatment of mood disorders having an associated benefit in terms of physical capabilities, more research is needed on preventing and managing mood disorders, including those comorbid with physical disease.

RECOGNITION OF COMORBIDITY

Psychiatric teams and substance misuse services fail to identify significant proportions of patients with such comorbidity on their case-loads. In a four-centre cross-sectional survey, Weaver *et al* (pp. 304–313) found that nearly half of patients treated within community mental health teams reported problem substance use in the past year, and up to three-quarters of substance misuse patients had had psychiatric disorders in the past year. Most patients with substance misuse problems on psychiatric case-loads received no substance misuse interventions, and a third of substance misuse patients with mental health problems did not receive any mental health intervention. The authors suggest that a new approach is needed to enable psychiatric and substance misuse services to offer evidence-based treatment of comorbid conditions.

ITT AND CACE

In a randomised trial, an intention-to-treat (ITT) estimate is valid only if there is 100% acceptance of the treatment among those offered it, and if none of those randomly allocated to the control condition gets access to the treatment. Dunn *et al* (pp. 323–331), using data from a large trial subject to non-compliance and loss to follow-up, illustrate the estimation of a CACE (complier average causal effect), an estimate of the effect of treatment in those patients who comply with the treatment offered. The authors suggest that such an analysis should be seen as complementary to a prior ITT analysis but not a replacement for it.

THE IMPACT OF MILITARY HAZARDS

While assessing the impact of military hazards after the event, in an ideal world we would have objective, independent, contemporary records of these hazards, but this is rarely the case. Wessely *et al* (pp. 314–322), studying UK armed forces, assess changes in the recall of military hazards following both fighting (in the Gulf War of 1991) and peacekeeping (in Bosnia). Reporting of hazards following conflict was not static and was associated with current self-rated perception of health. Reporting of hazards, particularly exposure to depleted uranium and various chemicals, increased with the passage of time following the Gulf War.