

Highlights of this issue

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SENSATION-SEEKING AND DEPRESSION

Farmer *et al* (pp. 549–552) investigate whether certain familial personality traits, such as risk-taking behaviour, could explain the familial clustering of both depression and adverse life events. Using a sib-pair design, sensation-seeking was modestly associated with life events carrying low threat but not with those highly threatening events commonly associated with depressive onsets. Sensation-seeking did have the characteristics of a familial trait, but could not explain the link between both depression and adverse life events clustering in families.

STILLBIRTH, PREGNANCY AND PTSD

Over half of women who suffer stillbirth become pregnant within 12 months. As pregnancy might serve as a reactivating stressor for post-traumatic stress disorder (PTSD), Turton *et al* (pp. 556–560) assessed the incidence, correlates and predictors of PTSD during and following the pregnancy after stillbirth. PTSD was associated with conception closer to loss, depression and state anxiety. Twenty six per cent of women who had seen their stillborn infant had PTSD symptoms compared with only 7% who had not seen the infant. Although not reaching statistical significance, this finding suggests that the current practice of encouraging women to see and hold the dead infant may actually increase the risk of PTSD. Study of a larger sample may help clarify this.

SUICIDE PREDICTION – AN INEXACT SCIENCE

We cannot predict or prevent suicide with any reasonable level of accuracy and must

accept that all our patients are at increased risk (Eagles *et al*, pp. 494–496). This view is supported by two studies identifying risk factors for suicide among in-patients (King *et al*, pp. 537–542) and those recently discharged from hospital (King *et al*, pp. 531–536). Along with previously identified factors, suicide risk was increased 16-fold among out-patients when a significant professional was on leave or about to go on leave. This suggests that a break in the continuity of the carer may be the final precipitating factor in predisposed individuals. King *et al* suggest the possibility of assigning numerical current risk scores based on identified risk factors. If this is adopted as part of the Care Programme Approach, mental health care services could to be delivered in a flexible fashion, with increased intervention at times of higher risk and lesser involvement during periods of low risk. The fact that so many more individuals will score highly on the scale than are at real risk of suicide could render this impractical.

PSYCHOSIS – OUTCOME

Harrison *et al* (pp. 506–517) report long-term outcome in schizophrenia from 18 geographically diverse treated cohorts. Global outcomes at 15 and 25 years were favourable for over half of those followed up, but there was marked heterogeneity between different geographical centres. Measures of early course were the strongest predictors of 15-year outcome. Late recovery in a significant minority underlines the importance of energetic long-term treatment.

... ONSET

Sipos *et al* (pp. 518–523) assess patterns and predictors of admission in a consecutive series of people with first-episode psychoses

during the first 3 years following initial contact. Over half were admitted within 1 week of presentation. Manic symptoms at presentation were associated with an increased overall risk of admission and earlier admission. Patients admitted late were more likely to have presented with negative symptoms and a longer duration of untreated illness.

AND ORIGINS

Minor physical anomalies (MPAs) are more frequent in patients with schizophrenia than in normal controls. Lawrie *et al* (pp. 524–530) examine whether these abnormalities are genetically mediated and whether they are central to the genesis of symptoms or epiphenomena. Comparing high-risk individuals with first-episode patients and normal controls, MPAs were found to be most common in those with least genetic liability. This suggests they may be trait markers that are not mediated by the gene(s) for schizophrenia and are not directly related to the development of positive symptoms.

WHITHER COMMUNITY MENTAL HEALTH TEAMS

The systematic review of community mental health team (CMHT) management in severe mental illness is bound to provoke debate (Simmonds *et al*, pp. 497–502). Based on five suitable studies, it suggests that CMHT management (compared with standard care) is associated with fewer deaths by suicide and in suspicious circumstances, fewer drop-outs and less dissatisfaction with care. Despite no improvements in clinical symptoms or social functioning, this form of treatment was associated with shorter in-patient psychiatric treatment and lower costs of care. Holloway (pp. 503–505) starts the debate by underlining the limitations of the included studies. Read on . . .

BIPOLAR DISORDERS SUPPLEMENT

The proceedings of the First European Stanley Foundation Bipolar Symposium are presented as a supplement to this issue.