

Highlights of this issue

By Kimberlie Dean

Challenging clinical practice

Several papers in the *Journal* this month challenge clinicians to re-evaluate their approach to clinical practice. Priebe *et al* (pp. 459–462) focus on the apparently simple task of introducing oneself to a patient in the context of a first clinical consultation. A sample of 120 psychiatric in- and out-patients were shown video clips of psychiatrists introducing themselves in different styles. Patients indicated a preference for scenarios in which psychiatrists provided information on what would happen during the consultation, in addition to a basic introduction (stating name, profession and reason for consultation). The authors also report that expressed preference was consistent across different patient subgroups.

In the course of clinical care, quality of life assessments have been recommended for routine use to, among other purposes, inform the evaluation of treatment outcomes in disorders such as schizophrenia, but in reality such routine use has not been implemented. Boyer *et al* (pp. 447–453) conducted a randomised controlled trial of quality of life assessment and feedback to evaluate the impact on patient satisfaction and other health outcomes. Quality of life feedback had a positive impact on patient satisfaction when compared with both standard psychiatric assessment alone and standard assessment augmented with quality of life assessment. The authors also found positive trend effects on health outcomes. The authors argue that their findings support the relevance of routine quality of life assessment and feedback but that the finding of an inadequate impact on clinical outcomes suggests that clinicians may not adequately utilise the data derived from such assessments. Another challenge to current clinical practice is highlighted by Langan *et al* (pp. 391–393) in an editorial focused on the rising prevalence of multimorbidity, particularly in the form of the co-occurrence of chronic mental and physical health problems. The authors call for more integrated models of psychiatric and physical healthcare services and training programmes, and in the short-term recommend psychiatrists start by engaging more with the physical health needs of their patients.

A consistent recommendation arising from a range of recent dementia care guidelines, reports, strategy plans and other publications is the need for increased awareness of, and capacity to deal with, relevant ethical issues. In order to aid the realisation of such recommendations, Strech *et al* (pp. 400–406) have undertaken a systematic qualitative review of the full spectrum of ethical issues in dementia care. The authors identified 56 ethical issues described in the searched literature and were able to propose 7 major categories of such issues – diagnosis and indication, patient decision-making competence, disclosure and patient information, decision-making and informed consent,

social and context-related aspects, professional conduct and evaluation, and specific care situations.

Understanding, managing and evaluating the impact of depression

Noting the well-established links between sleep and affect, de Wild-Hartmann *et al* (pp. 407–412) used an experience sampling method to examine at a micro-level the within-person day-to-day relationships between sleep and affect in a population-based sample of women. Sleep was found to be associated with next-day affect, but negative affect was not associated with subsequent sleep, indicating a lack of bi-directionality in the association. The authors also confirmed a macro-level longitudinal association between baseline sleep and later development of depressive symptoms. Case management of established depression by primary healthcare assistants has been shown to be effective in terms of symptom improvement and treatment adherence. In the *Journal* this month, Gensichen *et al* (pp. 441–446) report that such case management, even when undertaken in small primary care practices, is also likely to be cost-effective. Analysing data from a pragmatic cluster-randomised controlled trial, they found that the intervention was associated with more depression-free days, but no significant difference in quality-adjusted life-years, and that while there were no differences found in direct healthcare costs, total costs were lower for the intervention group owing to a reduction in indirect costs. The authors highlight the importance of evaluating low-intensity interventions, particularly in small and low-resource healthcare settings. Considering the effect of established depression on grey matter volumes, Serra-Blasco *et al* (pp. 434–440) have taken illness stage and treatment responsiveness into account in a voxel-based morphometry study involving 66 patients with depression and 32 healthy controls. They found evidence of volume reductions in frontolimbic areas among those with chronic/treatment-resistant depression, even when medication load was taken into account.

Capitalising on the electronic era

Leff *et al* (pp. 428–433) describe findings from a proof-of-concept study of a novel computer-assisted therapy for medication-resistant auditory hallucinations. On the basis that those suffering such symptoms but who are able to sustain a dialogue with their ‘persecutor’ are more likely feel in control, the authors developed and tested a computerised system for allowing patients to create an avatar of their persecutor. The study yielded promising results with those in the therapy group showing improvements in reported symptoms and beliefs about voices; results which were confirmed in the crossover component of the study. In a linked editorial, Kingdon (pp. 394–395) comments on the importance of prioritising development and testing of such psychosocial interventions and laments the persisting bias in journals, universities and funders towards neurobiological approaches.