

Highlights of this issue

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Aetiology and management of depression

It is well accepted that depressive illness has a multifactorial aetiology and there has been much recent interest in the interactions between various of the contributory factors. A recent driver has been data showing specific gene–environment relationships with regard to the serotonin transporter gene promoter interacting with adverse life events. Goodyer and colleagues (pp.365–371) provide evidence that the onset of depressive illness in adolescents could be predicted by the effects of two gene variants on cortisol levels. They suggest that these gene variants provide valuable additional information which could contribute to salivary cortisol becoming a useful biomarker for depression in adolescence. An accompanying editorial by Duffy (pp.341–342) places these findings in a wider context and examines the journey from predisposition to developing the illness. She concludes that the single most useful predictive factor for developing mood disorder is a positive family history, but that studies of genetic and epigenetic factors will offer the opportunity to identify those at greatest risk of developing illness, and thus contribute to understanding intermediate causal mechanisms. Pasco *et al* (pp.372–377) identify serum levels of C-reactive protein as an independent risk marker for major depressive illness in women, supporting the role of inflammatory activity in the pathophysiology of depression. They also suggest that this could provide a link with commonly comorbid medical disorders, explaining the increased risk of depression in physical illness, and question whether this could offer scope for prevention. There are new NICE guidelines updating the advice on management of depression in adults. An editorial by Kendrick & Peveler (pp.345–347) covers the key changes in advice, including identification or screening for depression, treating chronic subthreshold depressive symptoms, and a widening of the recommended psychological approaches, beyond individual cognitive–behavioural therapy (CBT), to include mindfulness and group CBT. The editorial is cautious about the extent of change that is possible with guidelines alone, without an examination of how they can best be implemented in the current National Health Service infrastructure.

Early intervention and quality of life in psychosis

There has been considerable investment in early intervention services for psychosis, and Bird *et al* (pp.350–356) review the effectiveness of trials of early intervention, CBT and family intervention in early psychosis. They conclude that early intervention services offer advantages over standard care and that the inclusion

of CBT and family intervention may contribute to improved outcomes. They did not find evidence for any reduction in relapse rates and readmission with CBT. They are also cautious about the longer-term effects of early intervention and advocate more longer-term follow-up studies. They would like to see these evidence-based approaches, including psychological interventions, being more routinely available to people with established psychosis. Quality of life measures are increasingly important in evaluating the outcomes of healthcare, especially in times of financial stringency. Positive psychotic symptoms are not a strong predictor of ability to function or quality of life, and other questionnaires have been introduced to better assess these outcomes. Saarni and colleagues (pp.386–394) report that depressive symptoms may contribute a disproportionate amount to the assessment of quality of life in patients with psychosis, and that psychotic illness may lead to a relatively smaller subjective loss of quality of life than the objective loss of functioning may suggest. They question the utility of the EQ-5D questionnaire in a population with psychotic illness, with a disproportionate emphasis on depressive symptoms.

Childhood adversity, physical activity and mental health

There are significant associations between reports of childhood adversity and adult mental illness. Kessler and colleagues (pp.378–385) carried out an international series of epidemiological surveys, examining these in a systematic fashion within 21 countries, under the auspices of the World Health Organization. They report childhood adversities to be highly prevalent, and that maladaptive family functioning was the strongest predictor of adult disorders, although this had little specificity across disorders. They also found that there was a sub-additive effect of multiple childhood adversities, suggesting that interventions geared at attending to any individual adversity were unlikely to be successful. They made a case for approaches that modify exposure to a host of these adversities. Physical activity has a considerable role to play in maintaining a healthy lifestyle, and this is also important for mental health. Harvey *et al* (pp.357–364) show that individuals who engage in regular leisure-time physical activity are less likely to have symptoms of depression. They found that higher levels of social support and engagement, indexed by number of friends and social activities, were important mediators of this association, whereas the intensity of activity, or physiological measures such as resting pulse or metabolic markers, were less important. Intriguingly, their results were much more mixed for the association of exercise with anxiety disorders, which showed a less robust inverse relationship, and positive findings only for light, rather than intense activity. They also suggest that the context of the physical activity is vital, with workplace activity not having an association with lower levels of depression.