

Highlights of this issue

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Neuroimaging and depression

In the absence of robust biological markers of psychiatric disease, Phillips (pp. 1–3) reviews data from neuroimaging studies and concludes that this approach offers the opportunity to examine the neural networks subserving the cognitive and emotional processes that are dysfunctional in psychiatric disorders. In this editorial, she reviews recent advances in using neuroimaging technology to predict diagnosis, prognosis and therapeutic response to treatment. A practical application of these approaches is evident in three papers in the *Journal* reporting imaging findings in depressive illness. Cole and colleagues (pp. 33–39) found that there are white matter changes in depressive illness which correlate with increasing severity of depressive symptoms. The most prominent changes were evident in the corpus callosum and superior longitudinal fasciculi. Late-life depression is associated with changes in the connections between frontal and subcortical and limbic areas. Sexton *et al* (pp. 46–51) found widespread change in white matter tracts in their participants with late-life depression. Changes in frontal tracts were associated with older age at onset, supporting a vascular aetiology of illness, whereas younger age at onset correlated with hippocampal change and a longer duration of illness. The authors suggest that these changes support a glucocorticoid cascade hypothesis. Firbank and colleagues (pp. 40–45) performed a longitudinal study of white matter changes and late-life depression, reporting that progression in white matter changes, over a 3-year period, was associated with depressive illness in year 3. The authors suggest that their data support the vascular depression hypothesis and encourage measures to control vascular risk factors, such as antihypertensive treatment, that have been demonstrated to improve blood pressure control but also shown to reduce the progression of white matter changes.

Psychotic experiences in the population and reducing stigma

Increasingly, data suggest that rates of psychotic experiences in the general population are higher than previously thought. Kelleher *et al* (pp. 26–32) report that young adolescents experienced a higher prevalence of psychotic symptoms than older adolescents, with 21% of younger adolescents hearing voices, and that these psychotic symptoms were associated with a range of non-psychotic, as well as psychotic, psychopathology. The authors question the place of these psychotic symptoms in adolescence

within a traditional framework distinguishing neurosis from psychosis. In an accompanying editorial, Murray & Jones (pp. 4–6) review the prevalence of these psychotic symptoms in the young adult population and reiterate that their link to common mental disorders, such as depression and anxiety, outweighs their association with the development of psychotic illness in later life. They highlight the implications and risks in treating such early symptoms with antipsychotic medication, advocating a stepped care approach with early psychological intervention. Stigma is an everyday experience for people with mental disorders. Clement *et al* (pp. 57–64) describe an interventional study to reduce stigma against mental disorder during an educational initiative in student nurses. They found that the effects of watching an educational DVD of service users and carers was largely the same as listening to a live presentation, although both were better than listening to a didactic lecture. The authors suggest that the DVD is a more cost-effective intervention when working with this group of professionals. An accompanying editorial places these findings into context: Corrigan (pp. 7–8) reviews other data from studies on stigma, suggesting that having contact with service users and carers is more effective than educational input, but disagrees with one of the findings of this paper, in that live contact is more effective in changing attitudes than video-based approaches. He also points out that in order to be maximally effective, the contact with people with mental illness should be targeted at key groups, delivered by credible people who are as similar as possible to the target group, and must be sustained over time with quality of the contact and its efficacy monitored in an ongoing manner.

Grief and psychiatric disorder

Is grief a normal part of loss? In DSM-5, the latest guide to psychiatric classification, there has been controversy over the inclusion of a new category of an adjustment disorder related to bereavement. A reappraisal article by Bryant (pp. 9–10) reviews the pros and cons of this proposal. The suggestion is that severe and prolonged grief should be recognised as a form of psychiatric disorder, characterised by persistence of features such as yearning, pain or preoccupation following the loss of someone close, that persists for over 12 months. The objections to this proposal have referred to the ubiquitous nature of grief, and that death is a natural part of life so loss is understandable and should not be pathologised. Similarly, grief is associated with a myriad cultural and religious rituals, which make it very difficult to be prescriptive about the standard grieving process, which would be necessary in order to define deviations from this. The author makes a plea for data rather than ideology to guide the decision on the creation of novel diagnostic categories.