Highlights of this issue

BY MARY CANNON

CORTISOL, STRESS AND DEPRESSION

The classification of depression into mutually exclusive 'reactive' and 'endogenous' types was common until very recently. O'Keane (pp. 482–483) discusses why we should shed these outmoded concepts and think of depression as a multifactorial illness caused by multiple, and possibly interacting, environmental, genetic and developmental risk factors. She presents evidence from animal studies showing that stress during critical periods of brain development (foetal life or early childhood) can lead to abnormal functioning of the hypothalamic–pituitary–adrenal (HPA) axis, and thereby increase vulnerability to later depression. O'Keane states that "studies spanning the disciplines of neuroendocrinology, epidemiology and psychology are required if we wish to advance our understanding of depression". Two such studies (Goodyer *et al* (pp. 499–504) Harris *et al* (pp. 505–510)) show that morning cortisol levels and adverse life events are independently associated with subsequent onset of depression in high-risk individuals. Unfortunately, there is no information on early-life risk factors such as childhood neglect or abuse, which could influence both cortisol levels and experience of adverse life events in adulthood.

SO MANY SAD CHILDREN . . .

Around 10% of 5- to 15-year-olds in Britain have psychiatric disorders that result in substantial distress or social impairment, but only 20% of these are in contact with mental health services. There would seem to be great scope, therefore, for the development of screening instruments. Goodman *et al* (pp. 534–539) present the Strengths and Difficulties Questionnaire (SDQ) – a brief, multi-informant questionnaire that can identify about two-thirds of children with psychiatric disorder in the community. Copies of the SDQ can be obtained free from www.sdqinfo.com. But the authors point out that increased detection rates can be a mixed blessing. Aside from the problems of false positives and unnecessary 'labelling', community-wide screening would need to be linked with more effective treatments and increased resources in order to improve outcomes.

OCCURRENCE AND ORIGINS OF POST-PSYCHOTIC DEPRESSION

Two related papers deal with the important topic of post-psychotic depression (PPD). Birchwood *et al* (pp. 516–521) report that PPD occurred in 36% of 105 patients with schizophrenia who were followed-up for 12 months after a psychotic episode. Iqbal *et al* (pp. 522–528) find that, prior to developing PPD, these patients had suffered greater feelings of loss, humiliation, and entrapment by their illness than those who did not become depressed.

DETECTION OF PSYCHOSIS AND CAREGIVER BURDEN

Drake *et al* (pp. 511–515) show that poor insight, social isolation and preserved coping skills are associated with longer duration of untreated psychosis (DUP), but do not explain the known association with poor outcome. The benefits of reducing DUP were much greater in the early stages of the illness: reducing DUP from 6 months to 1 month produced gains in outcome similar to reducing it from 6 years to 1 year. Tennakoon *et al* (pp. 529–533) found that the level of psychiatric morbidity among carers of patients with first-episode psychosis was no higher than that among the general population. However, carers who were from higher social classes or who were divorced had higher GHQ scores.

UNCONSCIOUSNESS DOES NOT PREVENT PTSD

Contrary to their previous findings, Mayou and colleagues (pp. 540–545) report that a brief period of unconsciousness following a road traffic accident has no protective effect on subsequent development of PTSD.

SUICIDE – WHAT'S SEX GOT TO DO WITH IT?

An epidemiological, register-based study from Denmark examines gender differences in risk factors for suicide. Qin *et al* (pp. 546–550) find that socio-economic risk factors for suicide, such as unemployment, retirement and sickness absence, are prominent among men. Marriage is a protective risk factor for men, but having a child less than 2 years of age, (rather than marriage *per se*), is a protective factor for women. Hawton (pp. 484–485) reminds us that gender differences in suicide extend also to the type of suicidal behaviour and response to treatment. There is evidence that fewer male than female patients benefit from treatments offered after an episode of deliberate self-harm.

CITIES ARE GOOD FOR MENTAL HEALTH (IN PAKISTAN)

Individuals living in a slum area of Rawalpindi, a city of 900 000 people in Pakistan, had lower rates of psychiatric disorder than individuals living in the surrounding rural areas. Mumford *et al* (pp. 557–562) offer two explanations for this rather surprising result. First, healthier people migrate to the cities, and second, urban living is less constrained and, ultimately, offers greater opportunities for financial and social advancement. Sadly, even in the city, the rate of psychiatric illness is twice as high among women than men. The type of household and their position within it affects women – in particular, polygamy seems bad for women's mental health but good for men's! Piccinelli & Wilkinson (pp. 486–492) discuss the topic of gender differences in depression further in a comprehensive review.

SEASON'S GREETINGS!

And finally . . . the Editor, Editorial Board and staff of the *British Journal of Psychiatry* would like to wish all our readers a very happy Christmas.

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