Highlights of this issue

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EATING DISORDERS

'Anorexia nervosa has the highest mortality of all psychiatric conditions; this is a result of both physical ill health and suicide' – a comment from Treasure *et al*'s editorial (pp. 398–400) reviewing recent guidelines on the treatment of eating disorders. They emphasise the benefits of early intervention in anorexia, with 90% of patients having a good longer-term outcome when treated within 3 years of onset, compared with 20% when treatment was initiated after 3 years. They highlight the need for all adult and child psychiatrists to have a training that includes the core skills and competencies to deal with eating disorders, and the need for transparent treatment policies, involving early liaison with medical colleagues for those patients at high risk. Carers of patients with mental disorders commonly find themselves in a difficult situation, expected to be understanding when they may not fully understand the illness themselves. This may be more problematic for parents of children with eating disorders. Whitney *et al* (pp. 444–449) examined detailed narratives prepared by parents, as part of a family intervention in anorexia, and found that while parents recognised anorexia to be a chronic and disabling disease, they held negative views of themselves, believing that they had contributed to their child's illness, and also being helpless in aiding recovery. The authors suggest that parental training in managing the illness may reduce these unhelpful interpersonal beliefs, with a beneficial effect for the patient.

AUTISM AND ALZHEIMER'S DISEASE

Autistic-spectrum disorder includes classical autism and Asperger syndrome, with patients exhibiting qualitative deficits in social interaction and delayed language development, or learning disability. While the cause remains unknown, twin studies suggest autism to be among the most heritable of the neuropsychiatric disorders. Toal *et al* (pp. 395–397) regret that poor science contributed to the reports of the measles, mumps and rubella vaccine causing autism, with the concomitant drop in immunisation; and they go on to highlight that this vaccine protects against one of the established causes of autism – intrauterine exposure to rubella. They review brain imaging studies, covering the finding of increased brain volumes reported in the original studies by Kanner, and more recent functional imaging studies highlighting hypofunction of brain regions associated with 'theory of mind' tests. They suggest that an early habit-type memory commonly seen in babies and younger children may persist abnormally into adulthood in autism; and a more comprehensive research approach combining genetic, environmental and neuropharmacological systems is necessary in the future. While genetics and pharmacology have contributed significantly to our understanding of the aetiology and management of Alzheimer's disease, there has been less emphasis on environmental influences. Onder *et al* (pp. 450–455) demonstrated that reality orientation therapy, combined with cholinesterase inhibitors, may enhance the effects of pharmacological treatment. They found a modest improvement in cognitive performance with the reality orientation programme, provided by trained carers to patients in their own homes, although there were no significant functional or behavioural improvements.

COGNITION AND COGNITIVE TREATMENT OF DEPRESSION

People with depressive illness show low self-esteem, perhaps unsurprisingly, but people with bipolar disorder also show a similar pattern, rating themselves significantly lower than healthy individuals, but higher than people with unipolar depression on self-esteem measures. Jones *et al* (pp. 431–437) also found people with bipolar disorder to have a fragile cognitive style similar to that of people with depression. They suggest that this may be the reason why psychological treatments effective in depression may also be usefully applied in bipolar disorder. Although the usefulness of psychological therapy in the treatment of depression is proven, the availability of skilled therapists can be a limiting factor. Andersson *et al* (pp. 456–461) show that an internet-administered self-help cognitive–behavioural programme was effective in reducing depressive symptoms.

SUICIDE AND VIOLENCE

Suicide reduction is often set as a target or used as an index of improvements in mental health strategies. Owens *et al* (pp. 470–475) use a cohort study of people attending accident and emergency after a suicide attempt to demonstrate that the severity of self-poisoning and the relevant previous history were the only clinical predictors of subsequent successful suicide. They suggest that it is hopeless to rely on a strategy that identifies high-risk individuals, as the predictive values of the patient characteristics are too poor to be useful. Their more prosaic prescription, based on their data, is to ensure that a good basic assessment is offered to all those attending hospital following self-harm. McKenzie *et al* (pp. 476–480) demonstrate that there is an unusual clustering in time and space in those who had recent contact with mental health services prior to death by suicide. They propose that this may reflect imitative suicide patterns, which could account for 10% of suicides, and that professionals should be aware of the risk of imitative suicide after such deaths. The risk of violence in patients with schizophrenia has been suggested to be increasing, especially related to increasing substance misuse and rising violence in the general population. Vevera *et al* (pp. 426–430) show that the violence rate in the Czech Republic has remained relatively constant over half a century and did not find substance misuse to be a major contributory factor. They suggest that patients with schizophrenia may have benefited from the high level of control typical of a totalitarian state – with no homelessness, good access to free healthcare and a high level of state supervision.

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