

Highlights of this issue

By Sukhwinder S. Shergill

Diagnosis and capacity in psychiatry

This edition of the *Journal* starts with the big questions in psychiatry: what is a diagnosis? And how does one justify treatment against the will of the individual? The next version of the World Health Organization's bible, the ICD-11, is being prepared at the same time as the American Psychiatric Association's fifth edition of the DSM. The push for harmonising these two different systems is discussed by First (pp. 382–390) in a special article. It is illuminating that only one diagnostic category is identical (of the 176 in these systems); but it is more promising that many more criteria are relatively closely aligned (78%) although one-fifth show more significant conceptual differences. It is unusual to refer readers to the appendices of an article – but this is one case where this is likely to pay dividends. An accompanying editorial by Jablensky (pp. 379–381) addresses the different purposes served by these publications, and argues that their ultimate value lies in their utility and validity, not only for clinicians but also for researchers and service users. Both articles emphasise the need for further research to fill the gaps where there are true conceptual divides in diagnostic practice. A reappraisal of the preparations for DSM-V by Frances (pp. 391–392), formerly Chair of the DSM-IV Task Force, highlights perceived problems with both the development process and its target. This makes for an illuminating discussion of the clinical utility of dimensional approaches, and of biological markers, in psychiatric diagnosis. Ethical principles propose that an individual has the right to refuse treatment; this right is suspended where the individual lacks capacity, and is thus unable to make an informed decision. Psychiatric treatment often takes place in the latter scenario; Owen and colleagues (pp. 403–407) assessed patients' views on treatment decisions taken by psychiatrists, once they had regained capacity for their own decision-making. Interestingly, 83% of patients gave retrospective approval for their treatment, and the proportions did not differ between those detained under the Mental Health Act and patients admitted informally; however, patients who had not regained capacity demonstrated lower levels of approval.

Obsessive-compulsive disorder, social anxiety and alcohol use disorders

There are prominent biological models of obsessive-compulsive disorder (OCD) which suggest that the symptoms arise as a consequence of dysfunctional fronto-striato-thalamic connections. A meta-analysis of grey matter changes in OCD (Radua & Mataix-Cols, pp. 393–402) provides some support for this

premise. In the basal ganglia there were grey matter density increases that were positively related to increased severity of illness, and there were significant decreases in density in medial frontal and anterior cingulate regions. The authors suggest that alterations in other regions identified in earlier studies, such as the orbitofrontal cortex, may occur as a consequence of secondary compensatory change. Social anxiety has been treated with limited success with the use of self-help programmes; Furmark *et al* (pp. 440–448) compared pure bibliotherapy with that augmented with online group discussions, in addition to a multimodal internet-delivered cognitive-behavioural therapy (CBT). They found that bibliotherapy alone was as successful as internet-based CBT, with the addition of an online discussion group making little difference. The authors conclude that unguided bibliotherapy produced enduring improvement in social anxiety. Screening and stepped care for the treatment of alcohol use disorders was examined in primary care by Drummond and colleagues (pp. 448–456). They found that there was reduced alcohol use in both their intervention and control groups after 6 months, and greater motivation for change along with cost savings in the stepped care group. However, the group receiving stepped care did not show significantly better outcome than the controls – who received a short session with the practice nurse and a self-help booklet (also a possible bibliotherapy intervention). The authors conclude that the screening and stepped care approach is feasible and warrants a larger-scale study.

Familial risk for bipolar disorder, outcome in rural India and antipsychotic long-acting injections

Children of individuals with bipolar disorder were followed prospectively for up to 15 years. Duffy *et al* (pp. 457–458) report that almost a third of the children fulfilled criteria for a major mood disorder, with onset at a mean age of 17 years, and there was an initial depressive episode in 90% of these individuals. The authors suggest that identification and surveillance of children at familial risk of bipolar disorder could serve a valuable purpose. Services for severe mental disorders are often a low priority in low- and middle-income countries. Chatterjee *et al* (pp. 433–439) demonstrate that where a community-based rehabilitation service was provided, there was not only a good uptake, but also a demonstrable improvement in service user disability; this in turn is influenced by adherence to medication and participation in self-help groups. Antipsychotic long-acting injections (LAIs) are the focus of a supplement to the *Journal* this month; papers discuss current UK practice, review the psychopharmacology of the currently available, and soon to be available, second-generation antipsychotic LAIs and their accompanying research base. These are highlighted and examined in turn by two highly recommended editorials by Burns (pp. s5–s6) and by Patel and colleagues (pp. s1–s4).