Highlights of this issue

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AETIOLOGY AND EPIDEMIOLOGY OF DEPRESSION

Prematurity and low birthweight, known indicators of restricted intra-uterine growth, have previously been associated with emotional disorders in children. In this issue, these results have been extended to demonstrate that the presence of either of these factors results in an 11-fold increase in risk of depressive disorder during adolescence (Patton *et al*., pp. 446–447). This prospective cohort study suggests that the increase in risk is not mediated by poor maternal bonding, but that perinatal stress and consequent exposure to high levels of glucocorticoids may indicate or lead to an early vulnerability, which is later manifested as a lowered threshold for depressive symptoms in response to adversity. The impact of depression on global health has traditionally been difficult to establish but is shown to be considerable, being the fourth leading cause of disease burden worldwide, after perinatal conditions, lower-respiratory infections and HIV/AIDS (Üstün *et al*, pp. 386–392). There are regional differences in the disease burden, calculated using recent disability-adjusted life-years data, with depression being the leading cause within the Americas, but ranked only 13th in Africa. These data demonstrate that not only is it possible to quantify the burden associated with psychiatric disorders, but also that this can then be used to raise the public health profile, avoiding the distortions inherent in previously applied gross outcome measures such as the counting of deaths. A similar epidemiological approach was applied to the assessment of cost-effectiveness of evidence-based depression interventions on the burden of disease (Chisholm *et al*, pp. 393–403). Current burden could be significantly reduced, by up to 30%, with the use of pharmacotherapy. The use of older antidepressants is the most cost-effective option for poorly resourced regions, although even this can only be achieved with a substantial increase in treatment coverage. In an accompanying editorial, Crawford (pp. 379–380) agrees that the existing interventions for depression are likely to be of value in reducing the burden of disease across the globe. However, macroeconomic factors such as the management of international debt and world trade conditions will dictate whether these interventions are made available in resource-poor nations, whatever the outcome of cost-effectiveness research. The international recruitment of medical personnel from these countries is likely to further undermine the development of their local health care.

DIETARY AND CULTURAL INFLUENCES ON MENTAL DISORDER

An elevated national intake of refined sugar and dairy products is associated with worse 2-year outcome in schizophrenia, and a decreased intake of seafood is related to increased prevalence of depression (Peet, pp. 404–408). This study reported on the correlations between two international databases containing dietary and mental health information, and includes the cautionary note that association does not equal causation. However, treatment with omega-3 fatty acids has been effective in the treatment of depression and whether diets low in refined sugar may have similar benefits in schizophrenia is an eminently testable hypothesis. In an accompanying editorial, McIntosh & Lawrie (pp. 381–382) note that dietary explanations are in vogue for 'just about everything', but that dietary factors do deserve further study and wider examination of the role of cultural influences on psychiatric disorders is needed. An example of a cultural influence is the view that somatic manifestations of depression occur more frequently in patients from developing countries and contribute to its underdiagnosis. A study from Nigeria (Okulate *et al*, pp. 422–427) reports that core DSM–IV depressive features are still the optimal indicators of a depressive illness, even in the presence of somatic symptoms. The authors propose that somatic symptoms should be conceptualised as secondary to core depressive symptoms when making a diagnosis. It is recognised that admission rates are higher for Black adult patients with a psychotic illness than for White patients, and Black patients are more likely to be detained under the Mental Health Act 1983. A similar increase is evident among Black adolescent psychiatric in-patients, including a strikingly large number of refugee children (Tolmac & Hodes, pp. 428–431). The implications for increased resources in areas with increased refugee numbers and the need to understand the pathways to care for adolescent patients are highlighted.

COMMUNITY TREATMENT ORDERS AND ADULT IMPACT OF CHILDHOOD ABUSE

The excellent databases recording details of mental health provision are the basis for two studies from Australia. Kisely *et al* (pp. 432–438) report that compulsory treatment orders do not serve to reduce hospital admission rates and question their widespread use in the absence of demonstrated effectiveness. Spataro *et al* (pp. 416–421) report that child sexual abuse is as damaging to boys as it is to girls, and that as adults abused children demonstrate increased rates of affective, personality and childhood mental disorders. The authors suggest that in order to find effective means of assisting these and other disadvantaged children, research should now concentrate on the evaluation of mediating and ameliorating factors across all childhood adversities.

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