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Highlights of this issue

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Persona

Outcomes in psychosis are disheartening. We know this as clinicians, and we have all had patients for whom our best efforts appear to be failing. Do we risk projecting such pessimism, and does that matter? Rodrigo Bressan and colleagues (pp. 1–3) say yes it does. They counsel that an attitude lacking in hope impairs mutual faith in treatment and recovery, and hinders the implementation of evidence-based interventions. We are cautioned not to confuse hope with 'hype' or optimism, but to view it as the capacity to overcome barriers and choose appropriate clinical courses. Moreover, they propose that there is a science of hope, which reminds me of recent pieces in Kaleidoscope on the science of placebo. Just because it's not a medication causing something doesn't mean it doesn't occur, isn't real, or can't be measured. The authors challenge us that we may be suffering the fallacy of the 'clinician's illusion' – read the piece and test yourself.

More on measuring. Howard et al (pp. 50–56) investigate the prevalence of mental illness in early pregnancy, and compare the screening 'Whooley' questions with the Edinburgh Postnatal Depression Scale (EPDS) and the Structured Clinical Interview DSM-IV-TR. 27% of their cross-sectional survey, interviewed at the first ('booking') antenatal appointment, screened positive – depression and anxiety disorders accounting for the majority – and the Whooley and EPDS were about equally effective in identifying depression. The Whooley questions, also known as the PHQ2, appear a useful screen, and they're certainly simple, with yes/no answers to just two questions: 'during the past month have you often been bothered by feeling down, depressed, or hopeless?'; 'during the past month have you often been bothered by having little interest or pleasure in doing things?'

Keetharuth et al (pp. 42–49) report on a new patient-reported outcome measure (PROM), the 'ReQoL' that focuses on recovery, capturing themes of: activity, hope, belonging and relationships, self-perception, well-being, autonomy and physical health. Tested on over 6,500 services users, a shorter- and longer-version both showed good psychometric properties. There are similar health status measures such as the EQ-5D and SWEMWBS, but the ReQoL has the strength of being specifically developed for use in mental health populations. Kaleidoscope (pp. 62–63) looks at data on social inclusion and outcomes in some of society's most excluded populations, which takes us to an editorial by Jed Boardman (pp. 4–5). He reminds us how PROMs, despite the 'P', have not always captured patient priorities, yet the quality of a healthcare system is surely judged by the help it provides to those who need it. Rolling out the ReQoL, or similar tools, at a wider service-level with real-time digitised capture are the next steps in the outcomes world. The debate continues in this month's Mental Elf blog, with Martyna Sawicka asking how we get to the PROM at: https://elfi.sh/bjp-me11.

The magician

Outcomes in electroconvulsive therapy (ECT) are often excellent. A simple statement that over-glosses a world of controversy in the wider media – amply illustrated by vastly contrasting pieces in the UK's *Independent* and *Guardian* newspapers in early 2017 – and, to a far lesser degree, in the peer-review literature. Our scientific challenge is a truly double-blinded randomised controlled trial, but working around this limitation, and beyond image problems, effectiveness data are good. Helping us with that stumped feeling when people ask 'yeah but how does it work', Takamiya and colleagues (pp. 19–26) meta-analysed eight neuroimaging studies (n = 193), and found the intervention associated with bilateral hippocampal and amygdalar volume increases. Diffusion tensor work suggest that post-shock oedema does not explain this. The data may better fit with animal model studies: neurogenesis, gliogenesis, and angiogenesis. Intriguingly, ECT-induced changes were age-dependent, being more prominent in younger individuals.

Prader-Willi syndrome (PWS) occurs once in about every 50,000 births. It manifests with distinct physical appearance that includes short stature and a characteristic facial appearance; behavioural disturbances that can involve repetitive speech, mood lability and temper tantrums; and psychopathology, notably affective psychosis. It is caused about three quarters of the time by a deletion/lack of paternal contribution to chromosome region 15q11-13 (del PWS), and about a quarter of the time by maternal uniparental disomy (mUPD PWS). The biological mechanism driving any psychopathology has been unclear, but now neuroimaging work by Krishnadas et al (pp. 57–58) has determined differences in brainstem serotonin transporter (5HTT) availability in these two PWS variants; the mUPD cohort having lower brain-stem 5HTT availability that may account for the greater rates of affective psychosis in this subgroup. A maternally expressed/paternally imprinted gene appears to account for the difference in PWS phenotypes.

Through a glass darkly

Outcomes in mental health vary geographically, as do people, priorities, and practice. I now join in marriage the aforementioned Bressan and Boardman (they may speak now or forever hold their peace) to unite hope and something that matters to many people: prayer. Ofori-Atta et al (pp. 34–41) report on a remarkable and provocative piece: randomising residents with mental illness at a traditional faith healing camp so that half additionally received psychiatric care, including medications. Adding to the contentious element, the residents in the Ghanaian prayer camp were regularly subjected by camp staff (but not the research team) to being chained as part of their routine care. Those who received the additional psychiatric care showed a significant reduction in measured symptomatology, but did not have fewer days spent in chains. Ghana is a low income country with one psychiatrist per million population; religious orders often fill a gap professional services cannot – as they did in the past in high income countries – and they are trusted by the local population. Nevertheless, the work jars us, assimilating complex and uncomfortable issues including the lack of resources faced my many countries, potentially historical legacies and whispered inferences of colonialization or imposition of 'developed world' models, and, perhaps, a closer proximity of religion and science than many of us might be used to.

This unsettling piece attracts two editorials. Julian Hughes (pp. 9–10) asks if engaging in such work equates to researching torture. He concludes that even in uncomfortable domains there may be areas from which we can learn, but that strict boundaries are needed, stating "If we wish to improve mental healthcare worldwide, we shall need to engage with practices that will test our ethical inclinations". Patel and Bhui (pp. 6–8) call chaining of individuals with mental illness an affront to psychiatry and humanity, and argue that cognisance of local cultural and social contexts does not abrogate human rights violations. Thoughtfully, they return the issue home, highlighting how the UK's Mental Health Act is currently being debated, with arguments about our own practices of restraint and seclusion. Finally, from hope through prayer, to the supernatural, Kaleidoscope discusses the science of detecting the paranormal, and why you may at times get that uncomfortable feeling that there is something out there watching you…