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Highlights of this issue

By Derek K. Tracy

Research beyond Brexit

The preponderance of academics and professionals – which by and large covers us as a cohort – were in favour of a 'Remain' position in the recent referendum. A core anxiety is the impact on collaborative science; so how is the research landscape looking at present? Kaleidoscope (pp. 268–269) takes one angle – the impact of collaboration *between specialties* on grant funding. Interestingly, the more interdisciplinary a proposal, the more likely it is to get rejected, a phenomenon that data show hits psychiatry more than some other fields. Vivekanantham *et al* (pp. 257–261) take this further, evaluating whether the phrase 'parity of esteem' has reached the medical literature. Compared with cardiology, oncology, and respiratory medicine, psychiatry is considerably under-represented in the highest-impact general medical journals when the respective burdens of our specialties are compared.

An editorial by Das-Munshi and colleagues (pp. 183–185) considers the so-called 'double-jeopardy' hypothesis wherein the already poor physical health outcomes in those with severe mental illness are worsened in those from Black and minority ethnic (BME) backgrounds. There are findings of, for example, greater rates of obesity in BME cohorts with severe mental illness, but the authors conclude that the topic is currently under-studied. The area is inevitably complex, interfacing potential social and economic disadvantage, lifestyle factors, and putatively higher rates of stigma and discrimination. They propose clinical, policy and research recommendations, including more representative research samples, better proactive screening, and testing the relative contributions of equitable access and health-seeking behaviours. Ingman *et al* (pp. 251–256) take this on in the first comparison of outcomes between White and BME patients receiving cognitive–behavioural therapy (CBT) for chronic fatigue syndrome. BME individuals had significantly higher baseline damage beliefs, all-or-nothing and avoidance/resting behaviour than White counterparts. However, both groups showed significant – and equal – treatment outcomes in fatigue severity, physical functioning, and work/social adjustment. The topic matters: it has been shown that those from BME backgrounds are less likely to be offered talking therapies. As the triumvirate of negotiating Brexiteers commence their new roles liaising with our erstwhile European partners, we can point out these various imbalances and challenges as funding priorities as they look to reinvest the promised £350 million per week in the NHS.

Anxiety matters

Subanalysis of Vivekanantham *et al*'s data show that, among psychiatric research topics, anxiety disorders are particularly under-represented; this month's *BJPsych* is helping to rebalance this, with four papers on the subject. Meier *et al* (pp. 216–221) note that despite their prevalence, little is known about the role of anxiety disorders in predicting mortality. Using a Danish national register, they were shown to result in considerably higher risks of all-cause mortality – with an adjusted odds ratio of 1.7 compared with the general population – from both natural (60%) and unnatural (40%) causes. Of those who died from the latter, about one in eight had comorbid depression. Typically, CBT is considered to be the treatment of choice, but responses to this vary. Coleman *et al* (pp. 236–241) report on the first genome-wide association study (GWAS) on response to this psychological intervention, in almost 1000 children with anxiety disorders. No variants passed the stringent GWAS significance threshold ($P = 5 \times 10^{-8}$), implying there is not a genetic basis to treatment response. Nevertheless, four variants met criteria for *suggestive* significance, and GWAS work in schizophrenia has shown that about 9000 cases are required for robust findings.

Gingnell and colleagues (pp. 229–235) look specifically at social anxiety disorder and test whether the addition of escitalopram improves outcomes in those receiving internet-delivered CBT (ICBT). Both treatments are well-evidenced, but research on their combination is scarce, even though it is common in clinical practice. Their answer was that the addition of the SSRI proved significantly superior to ICBT alone, with both greater numbers of responders, and greater reductions in symptoms. Concomitant neuroimaging demonstrated parallel reductions in amygdalar reactivity to emotional faces. Diefenbach *et al* (pp. 222–228) report on the first randomised double-blind, sham-controlled evaluation of repetitive transcranial magnetic stimulation (rTMS) in generalised anxiety disorder – a neuromodulatory tool more commonly used for treating depression and auditory hallucinations. They applied a 'slow' (1 Hz) inhibitory paradigm to the right dorsolateral prefrontal cortex, and found greater response and remission rates in the active group. The neurophysiology of any induced therapeutic changes will need future elucidation; like most neuromodulatory paradigms, the optimal parameters of the intervention will also require determining.

Borderlines, or barriers of thinking?

Borderline personality disorder (BPD) and bipolar affective disorder have notable similarities, and there has been debate about whether they lie upon a spectrum or are truly distinct. Parker *et al* (pp. 209–215) analysed symptom profiles in participants with either BPD and/or a bipolar disorder: fitting with neuroimaging and genetic data, their findings support the conditions being distinct, and those with comorbidity showed features of two independent conditions. Understandably, patients can find the issue confusing; there has, elsewhere, been an anecdotal argument that some such patients 'want' to be bipolar, but a separate recent study of those individuals actually at the diagnostic interface has rebutted this and found they really just want informed and respectful care. Sanatinia *et al* (pp. 244–250) challenge another diagnostic overlap preconception: does having a personality disorder impair the response to CBT in those with health anxiety/hypochondriasis? These conditions certainly commonly overlap, but in this analysis of over 400 individuals (86% of whom had some personality dysfunction) followed up over 2 years, overall short- and medium-term gains from CBT for health anxiety were clinically significant and less costly than standard care in individuals with personality disorder; indeed, against hypothesis, they showed better improvements in social functioning than those *without* a personality disorder.

Gerome Breen's team (de Jong *et al*, pp. 202–208) continue the theme, looking at genomics overlap between childhood and adult attention-deficit hyperactivity disorder (ADHD), autism spectrum disorder (ASD) and major depressive disorder (MDD). While disorder-specific signatures were elicited for childhood ADHD and MDD, there was also overlap in two immune-related signatures in adult ADHD and MDD. The findings show both condition specificity but also potential shared genomic risk factors.

Finally, finishing on a philosophical note, Kaleidoscope (pp. 268–269) offers an answer to the old chestnut: what is the difference between a hallucination and a dream?

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