in-patient spaces are promising steps towards a new perspective on how to deliver integrated mental health care across the lifespan and to whole families.

Second, a public health approach is urgently needed for the children of parents with recurrent depressive episodes, since their risk of developing depression is high. Depression can affect all developmental trajectories from social functioning to educational and occupational attainment. If depression were perceived as a chronic disease such as diabetes, it would be inconceivable that these children would not be screened. Yet stigma still casts its long shadow over mental illness and feeds into a fear of being labelled and what this might entail. Schools and primary care settings are the environments where early identification will be most feasible. However, any screening would need to take place alongside innovative approaches to provide accessible, acceptable, and appropriate interventions and services.

As the global burden of depression is great; interventions to prevent the development, promote the treatment, and limit the effect of depression within families must be seized. The children at highest risk of developing depression include those whose parents have a mental illness; those for whom early social, economic, and emotional deprivation has been present; or those who suffer from another chronic illness or disability. New models are therefore needed to deliver not only reactive but proactive and integrated mental health services (be that in primary care or general hospital settings); in child and family-friendly spaces, including schools and local religious and voluntary organisations; and within existing mental health provision. A focus on protective factors and how to foster these are likely to open new arenas of preventive interventions and help depressive symptoms as well as a broad range of other vital outcomes.

Mina Fazel
University of Oxford, Department of Psychiatry, Warneford Hospital, Oxford OX37JX, UK
mina.fazel@psych.ox.ac.uk

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Post-traumatic stress symptoms 5 years after military deployment to Afghanistan

In The Lancet Psychiatry, Iris Eekhout and colleagues’ present research into post-traumatic stress disorder in a large, longitudinal sample of Dutch military personnel deployed to Afghanistan. Self-rated post-traumatic stress disorder symptoms, alongside potential moderating factors, were assessed at several timepoints from 1 month pre-deployment to 5 years after deployment. Eekhout and colleagues identified three trajectories of post-traumatic stress disorder symptoms: a large group with low, subclinical post-traumatic stress disorder scores after deployment (resilient); a second group with increasing post-traumatic stress disorder symptoms that decreased after the first year (recovered); and a third group that showed moderate post-traumatic stress disorder symptoms initially, but after a long delay displayed marked increases in symptoms (delayed-onset). Importantly, this study has exposed a much longer timeframe for delayed-onset post-traumatic stress disorder symptoms than previous research has suggested. Post-traumatic stress disorder symptoms were significantly higher 5 years after deployment than pre-deployment: 72 (13%) of 559 versus 27 (4%) of 680 (β 1.67, 1.14–2.20).
Several studies have shown an increased risk of post-traumatic stress disorder in military personnel after deployment\(^2\) that continues to be present one decade later.\(^4\) Similarly, research has focused on post-traumatic stress disorder symptoms that emerge shortly after combat exposure, or within the year.\(^5\) Because early psychological or pharmaceutical interventions have shown improved treatment outcomes,\(^7\) examining the early emergence of post-traumatic stress disorder symptoms, and the role of early treatment, is of substantial importance. However, few studies have taken a longitudinal approach to quantify the effects of deployment on post-traumatic stress disorder symptoms over long time periods. Among those that have, weaknesses include not assessing post-traumatic stress disorder symptoms at several timepoints beyond a 3-year time span and not measuring symptom changes relative to those expressed pre-deployment. As such, this study is unique and addresses many gaps identified in previous research.

The finding that delayed-onset post-traumatic stress disorder symptoms increased between 2 and 5 years post-deployment, and were significantly higher 5 years later when compared with pre-deployment scores, is of substantial importance, and adds to previous research into delayed-onset post-traumatic stress disorder, often classified as symptoms emerging within the first year. Results from Eekhout and colleagues’ study provide important implications for long-term symptom monitoring. Crucially, routine screening that ceases after 1–2 years will not identify the diminishing mental health of these individuals.

This Article also underlines some important group differences that might serve to identify individuals at particular risk for delayed-onset post-traumatic stress disorder. Eekhout and colleagues identified a moderating effect of combat stress, such that non-resilient personnel reported higher levels of combat stressors. Their finding that groups deployed between 2007 and 2008—a time period during which Dutch forces had higher levels of battlefield casualties and deaths compared with previous deployments—had significantly increased post-traumatic stress disorder scores 5 years post-deployment suggests that more severe combat exposure might increase the risk of developing post-traumatic stress disorder in the short term, and the long term. Age also had a moderating effect, such that soldiers under the age of 21 had greater symptom increases between 1 and 5 years post-deployment compared with those older than 21 years. Thus, younger soldiers, and those who have more severe combat stress, might particularly benefit from longer-term symptom monitoring.

Despite the important contributions of this study, why some individuals have a delayed increase in post-traumatic stress disorder symptoms that are significantly higher 5 years after deployment is still unknown. Although Eekhout and colleagues suggest that stress adaptation and feelings of military belonging might serve to protect personnel in the short term, post-traumatic stress disorder often presents with other mental health conditions, such as depression, anxiety disorders, and substance misuse disorders.\(^8\) In view of the fact that comorbidity is associated with higher post-traumatic stress disorder symptom severity,\(^2\) and alcohol misuse and depression have been shown to predict post-traumatic stress disorder symptom changes over time,\(^9\) a better understanding of how post-traumatic stress disorder symptoms progress in the context of other co-occurring psychiatric conditions is essential. Whether the exacerbation of delayed-onset post-traumatic stress disorder symptoms pre-dates the presence of other mental health diagnoses, visa versa, or whether their progression proceeds in parallel remains to be investigated.

Future research will also benefit from including longitudinal data for treatment. How treatment factors into the post-traumatic stress disorder symptoms of both non-resilient group types is unclear. Although presumably, post-traumatic stress disorder symptoms in the recovered group decreased as a result of psychological or pharmaceutical intervention, this theory was not examined. For delayed-onset post-traumatic stress disorder specifically, whether symptom increases between 2 and 5 years post-deployment persist despite continuing treatment efforts, or are a result of minimum treatment interventions, remains to be investigated.

This study emphasises that military members might present with increased post-traumatic stress disorder symptoms years after returning from deployment. More importantly, it stresses the importance of routine screening beyond 1–2 years after deployment because effective psychological or pharmaceutical treatments are available for military-related post-traumatic stress disorder.
Psychological therapies for psychosis: a view from the hills

Cognitive behavioural therapy for psychosis and family interventions for psychosis are two of the therapies that show the most convincing evidence of achieving meaningful outcomes for individuals with psychosis and their informal carers. 2015 saw several interesting publications describing applications of these therapies in a variety of contexts.

It is becoming clearer that the non-affective psychoses are in fact full of affect, which increases the risk and maintenance of episodes through driving individual positive psychosis symptoms. Therefore, attempting to treat affect and its associated symptoms directly is both logical and much valued by service users. Findings from the Worry Intervention Trial\(^1\) showed that a six session, manualised treatment for worry was able to improve wellbeing, paranoia, and overall level of psychiatric symptoms in individuals with psychosis, and was well accepted. A pilot trial of individuals with psychosis and insomnia showed large improvements in insomnia (effect size 1.9)\(^2\), and there are promising approaches specifically targeting nightmares.\(^3\) Findings from another study demonstrated that exposure-based treatments for post-traumatic stress disorder (PTSD) were both safe and efficacious in people diagnosed with psychotic disorder.\(^4\) People with psychosis have traditionally been excluded from trials of psychological therapies for PTSD and other emotional disorders, so finding ways to offer effective treatments despite persistent and distressing positive symptoms of psychosis, is an important development.

A further target has been reasoning biases associated with psychosis, on the basis of reports of the positive effects of metacognitive training.\(^5\) A proof-of-principle trial of a brief computerised intervention for those with persistent delusions showed improvements in paranoia and reasoning, moderated by negative symptoms and poor working memory.\(^6\) This “thinking well” approach is feasible,\(^7\) and the intervention is being developed as an interactive app.

In the clinic, impressive improvements were reported for a range of meaningful outcomes for consecutive referrals attending a psychological therapies clinic over a 12 year period, all of which were maintained 1 year later.\(^8\) An ongoing UK initiative (Improving Access to Psychological Therapies—Severe Mental Illness) has funded pilot sites to increase capacity to offer such interventions, with excellent preliminary outcomes.\(^9\)

In family intervention for psychosis, the evidence base and our understanding of its long-term effect on patient and carer outcomes was extended by 14 year follow-up data from a cluster randomised controlled trial of family interventions for psychosis in China, which demonstrated improved treatment adherence outcomes for individuals who received the intervention.\(^10\) Poor accessibility and limited provision of family interventions for psychosis have driven interest in new approaches, including improved flexibility in

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