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We are pleased to announce that beginning with this issue all materials in each issue of the *Shanghai Archives of Psychiatry* will be translated into Chinese and a translated version of the complete issue will be made available (free of charge) on the journal's website (www.saponline.org) within one month of the publication of the English version. Having dual-language content available for the full journal should help us achieve the goal of being a platform for communication between Chinese and international clinicians, researchers and policy makers. Chinese authors who want their work seen by international colleagues are able to submit manuscripts in Chinese which are sent to our content expert reviewers and, if accepted, translated into English and edited; the final English version is then translated back into Chinese and placed on the website. Conversely, international authors who want their work seen by Chinese colleagues can submit English-language manuscripts which will be reviewed and, if accepted, first edited and published in English and then subsequently translated into Chinese and distributed around China. We are the first – and only – mental health journal to do this in China. If authors have any questions about this process, please contact our editorial office at: shtougao3296@163.com

The review article in this issue by Cheng and Xiao^[1] addresses an issue that is of intense interest both in China and globally: mild cognitive impairment (MCI). The downside of the spectacular improvements in China's overall health has been that with rapidly increasing life expectancy the proportion of elderly in the community has also increased rapidly. This trend has been accelerated by China's one child per family policy, which is only now being gradually relaxed. The result of this demographic transition is that the old-age dependency ratio (i.e., number of persons 65 years of age or older for every 100 persons 15 to 64 years of age) in large urban centers like Shanghai is approaching – and in some cases surpassing – the ratio in high-income countries. The prevalence of Alzheimer's Disease and other dementing illnesses increases in stepwise fashion with age, so the ageing of China's population is being accompanied by a dramatic increase in the prevalence of dementia. Given the much smaller families, there is a serious concern about how the community will provide the support services needed by this rapidly growing cohort of disabled elderly. In this environment it is not surprising that China has focused substantial research talent and resources on understanding and preventing MCI – the precursor condition for Alzheimer's Disease. The review discusses Chinese researchers' multifaceted efforts in this field over the last decade, which have focused on the epidemiology, neuropsychological characteristics, diagnosis, genetic etiology, neuroimaging

and electrophysiological changes, and treatment of MCI. To date this work has provided some new insights but few breakthroughs. China can contribute most to the international efforts to address the global issue of dementing illnesses by using its relative advantage of a large, stable population of elderly and focusing more research resources on conducting multi-disciplinary prospective studies that use internationally standardized methods of assessing cognitive functioning with large, representative samples.

The first original research article in the issue by Zhao and colleagues^[2] is a randomized controlled, double blind trial that compares different methods of administering repetitive transcranial magnetic stimulation (rTMS) to treat the negative symptoms of schizophrenia. The negative symptoms of schizophrenia – which are closely related to the level of disability of the condition – have largely remained resistant to neuroleptic treatment so a number of different approaches are being evaluated, including rTMS. In this study 96 patients were randomly assigned to four groups: three active rTMS conditions using different stimulation methods (10 Hz, 20 Hz and theta burst stimulation) and one mock rTMS group (the control group). rTMS was administered five times per week for four weeks to the left dorsolateral prefrontal cortex of the patients, all of whom remained on a stable dosage of medication. The four-week trial convincingly demonstrated that rTMS is a safe and effective treatment for reducing the severity of negative symptoms. Among the three stimulation methods, the theta burst stimulation method proved more effective than the 10 Hz and 20 Hz stimulation methods but all three methods were significantly better than the control condition (mock rTMS). More work is certainly needed to refine the rTMS treatment protocols and, most importantly, to determine the treatment interval that will best ensure a sustained treatment effect. But this study confirms the importance of this exciting new approach to addressing the negative symptoms of schizophrenia and, potentially, of substantially reducing the social dysfunction and disability that so frequently occurs in individuals with the disorder.

The second original research article by Zhang and colleagues^[3] reports on the relationship of psychotic symptoms, disability and family burden in schizophrenia. Unlike many high-income countries, the over 90% of individuals with schizophrenia in China live with family members. Family members are typically the most important long-term care givers for persons with schizophrenia and, thus, a substantial component of the social burden associated with the condition is borne by families – a component that is not considered in the Global Burden Diseases estimates of the health

burden associated with different health conditions. This cross-sectional study assessed 101 individuals with schizophrenia with a median duration of illness of 5 years who were clinically stable at the time of assessment. Patient's symptoms were assessed using the Positive and Negative Syndrome Scale (PANSS) and their level of disability was assessed using the WHO Disability Assessment Scale (WHODAS II), and the family burden was assessed by interviewing the primary family care-giver for the patient using the Family Burden Interview Schedule (FBIS). They found that after adjusting for a number of demographic and illness-related variables both the level of current symptoms and, independently, the level of social disability were significantly associated with the level of family burden. The correlation of patient disability and family burden is not surprising, but its independence from symptom severity is surprising. This result highlights the point that treatments for individuals with schizophrenia must focus both on the symptoms of psychosis and on disability. The conventional assumption that treating symptoms will automatically improve disability is only partially the case; there is a substantial residual level of disability that is both resistant to standard symptomatic treatment and a core component of the burden experienced by families.

The third original article by Feng and colleagues^[4] is a 5-year follow-up study to determine whether or not there are any residual benefits of a 3-month cognitive training program for elderly subjects five years after providing the training. Ninety community residents 70 years of age or older were provided with twice-weekly training in reasoning, memory and strategy for 12 weeks. These individuals and 60 other elderly who did not receive the intervention were assessed using the Neuropsychological Test Battery for Elderly persons (NTBE) and the Stroop Color-Word Test at baseline. Forty-nine individuals (54%) from the intervention group and 33 (54%) from the control group were re-assessed with these instruments 5 years after completion of the training. There were no significant differences in the baseline characteristics of those who did and did not dropout over the five years. After five years the remaining intervention group subjects performed better than the remaining control group subjects on only 5 of the 61 measures assessed by the neurocognitive battery, and none of these differences achieved the pre-determined level specified for statistical significance. Thus the intervention did not have a noticeable effect on the cognitive function of elderly subjects five years later. Most research supports the value of cognitive training as a means of preventing or retarding the onset of cognitive decline in the elderly, but the intensity and duration of the training and the appropriate interval for booster sessions remains unclear. This study shows that 24 hours of training over three months is not sufficient to have an observable effect 5 years later.

The last original article by Qin and colleagues^[5] addresses an issue that is a perennial favorite of

schizophrenia researchers – the relationship of the duration of untreated psychosis (DUP) to subsequent outcomes. The reason for this interest is related to the theoretical model of schizophrenia: if schizophrenia is the final outcome of a *progressive* neurological injury that starts at the onset of the condition (i.e., when psychotic symptoms first appear) and if neuroleptic medication halts this ongoing injury, then early identification and treatment with neuroleptic medication can limit the severity of the condition. Based on this thinking, the longer the DUP the greater the neurological damage and, thus, the more severe and chronic the illness. Decades of research have not definitively resolved this issue. The current study identified 43 first-episode patients with schizophrenia who had a late age of onset (mean age of onset was 33), classified them into a short DUP group (≤ 24 weeks) or a long DUP group (> 24 weeks) and followed the two groups of patients for 3.2 years and 3.9 years, respectively. The long DUP group had less severe psychotic symptoms (as measured by the Brief Psychiatric Rating Scale) at the time of first diagnosis – which may have been one of the reasons that it took family members longer to bring them in for psychiatric treatment. Unlike previous studies, during the follow-up period there were no differences in the levels of positive psychotic symptoms or in the rate of relapse between the two groups. However, despite a similar pattern of positive psychotic symptoms and relapses, patients in the long DUP group were more than twice as likely to require re-hospitalization during the first two years of treatment than patients in the short DUP group (67% v. 32%), and at the end of follow-up they had significantly poorer social functioning (as assessed by the Social Disability Screening Schedule). The increased number of hospitalizations in the long DUP group despite the similar level of positive symptoms is an interesting finding that has not been reported elsewhere: this could be an artifact of the small sample size or of the late age of onset in this sample (which occurred because all patients were working, not students, at the time of first diagnosis). This study identifies another factor that may influence the relationship between DUP and subsequent outcomes – age of onset. It is certainly theoretically possible that age of onset could influence the progression of the neurological damage initiated by a psychotic illness. Larger studies that compare the relationship of DUP and subsequent outcomes in subgroups of first-onset patients with early or late age of onset will be needed to determine whether or not age of onset is an important independent factor in the causal pathways that link DUP and outcome.

The Forum by Liu and Lu^[6] discusses the current situation regarding transsexualism in China. Prior to 1990 the stigma related to the condition effectively suppressed its identification and treatment but the gradual lifting of sexual taboos that has accompanied the rapid opening of the country has changed things dramatically. There are now more the 100,000

individuals who have requested sex change operation and over 1000 individuals who have completed sex re-assignment surgeries. The post-surgery transition to a new social role and the requirement of long-term use of immunosuppressants and sex hormones can result in serious physical and psychological consequences that the individual may or may not be psychologically prepared to deal with. Thus extensive education of the patient and his or her family members is needed before the operation and regular psychological evaluation and, if needed, support should be provided for years after the surgery. However, the intense demand for the surgery has encouraged the opening of small private plastic surgery centers that do not conduct the extensive pre-surgery evaluation and follow-up that is needed. To minimize these problems the authors recommend developing national standards for the evaluation, diagnosis and treatment of transsexualism and the creation of an integrated network of state-of-the-art treatment centers around the country.

The case report by Sun and Wang^[7] present a case of severe, intractable tardive dystonia in a 22-year-old male with schizophrenia that was initially triggered by treatment with olanzapine. The patient developed lip puckering, persistent torticollis, pain, axial dystonia and unstable gait after one year of treatment with olanzapine. Olanzapine-induced tardive dystonia is rare, but it has been reported previously. The patient's family members did not recognize the importance of these symptoms for 18 months and initial treatment at a local hospital was inappropriate, so it took two years before the condition was recognized and aggressively treated. Conversion to clozapine and adjunctive treatment with magnesium valproate, vitamin E, tiapride and lorazepam for four months did not improve the condition; so the patient remained severely disabled. There is no guarantee that earlier recognition and treatment can result in improved outcomes for patients who develop tardive dystonia, but the case highlights the importance of teaching patients, family members and medical professionals about the occurrence and management of all types of adverse responses to antipsychotic medications, including the rare but severe side effects like tardive dystonia.

This issue also includes a Biostatistics in Psychiatry piece by Lin and Lu^[8] (two of our three Biostatistical Editors) about establishing data monitoring committees for clinical trials. In the United States the Food and Drug Administration requires the formation of these data-monitoring groups in all studies of new interventions and they are strongly recommended for studies that have substantial concerns about safety or that are

expected to have an important effect on clinical care. Such committees provide additional protection for patients and enhance the scientific validity and integrity of clinical studies. The paper describes the formation, membership, activities and responsibilities of data-monitoring committees.

The issue concludes with a brief report on the meeting of the ICD-11 Field Trial Coordinating Group recently held in Shanghai,^[9] and an updated version of our Instructions to Authors.

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