Highlights of this issue

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ABCD: ALTERNATIVE GENETICS, BIAS, CANNABIS, AND DIMENSIONAL CLASSIFICATION

When, and how often, does depression become bipolar disorder? An editorial by Angst (pp. 189–191) offers a dimensional approach towards viewing these and related symptoms within a bipolar spectrum: a two-dimensional mood/affective spectrum. He discusses the additional value in taking this dimensional approach, which accounts for more recent clinical and genetic data indicating a large overlap, blurring the traditional distinction, between schizophrenia and bipolar disorder. McClellan *et al* (pp. 194–199) challenge the belief that schizophrenia arises partially as a consequence of people possessing an unfortunate selection of multiple common genes, each having a small effect. They suggest that the data can be interpreted to support the idea of schizophrenia stemming from a few rare genes with high penetrance. They examine the evidence supporting this hypothesis and conclude that a more informative approach may be to focus in more detail on the genome of individuals and families with schizophrenia or exposed cohorts, rather than current research designs that combine large samples of unrelated individuals, which will miss these rare genes of large effect. Case–control studies are one of the standard approaches to investigating interesting differences between patients and controls; the importance of ensuring that the design of the study minimises any systematic bias is often overlooked. Lee *et al* (pp. 204–209), in their literature survey of bias in psychiatric case–control studies, demonstrate that genetic studies were relatively poor in describing and controlling for selection bias. Neuroimaging studies showed good control of information bias, and one such study demonstrates that the volume of the grey matter within the anterior cingulate gyrus is reduced in patients with first-onset schizophrenia who used cannabis. Szeszko *et al* (pp. 230–236) suggest that this may be associated with the role of this region in decision-making and assessing risky outcomes.

STIGMA AND RISK FACTORS FOR REOFFENDING

Service users report that the rejecting behaviour of others may bring greater disadvantage than the primary condition itself. Thornicroft and colleagues (pp. 192–193) examine the underpinnings of stigma in their editorial, noting that this negative reaction is sufficiently powerful to cause significant autonomic arousal in people when they have been asked to imagine meeting a stigmatised individual. They emphasise that the focus needs to move from a more conceptual, or cognitive, appraisal of stigma to the functional consequences of stigma as evidenced by discriminatory practice. Continuing with this theme, King *et al* (pp. 248–254) describe the development of the Stigma Scale, a standardised instrument to measure stigma in mental illness. The three factors within the scale assess discrimination, disclosure and potential positive aspects of illness; it is of little surprise that the scores on the scale correlated negatively with self-esteem. One group that is arguably more stigmatised than others is patients who have been detained in secure forensic facilities. Coid *et al* (pp. 223–229) followed up a large group of these patients post-discharge and report that patients with two or more previous violent convictions, primary diagnosis of personality disorder, or comorbid antisocial personality disorder were more at risk of violent reoffending. They also suggest that sex offenders required particular vigilance in the 3–4 years after discharge, and that longer periods in security and restrictions on patients lifestyles following discharge were related to significant reductions in the risk of reoffending.

BACK TO BASICS: BRIDGES, EATING, CASE-LOADS AND ANTIDEPRESSANTS

Many acts of self-harm are impulsive in nature and restricting access to common methods, such as limiting the purchase of large numbers of tablets of commonly ingested analgesics, can result in reductions in suicides. Bennewith *et al* (pp. 266–267) report that the number of suicides dropped from eight down to four per year following the installation of barriers on the Clifton suspension bridge. Although the immediate risks associated with eating disorders are well recognised, there is less awareness of the longer-term sequelae, particularly related to perinatal outcomes. Micali *et al* (pp. 255–259) examined a large longitudinal cohort and found bulimia to be associated with an increased rate of miscarriages, and anorexia nervosa to be associated with significantly lighter babies at birth. They comment that advising women with eating disorders about the possible effects on future fertility and adverse outcome for their offspring may provide an additional motivating factor to change their behaviour. Smaller case-loads are considered to offer improved service provision in psychiatric practice, but at least one recent study found no benefit of smaller (1:15) versus larger (1:35) case-loads. Burns *et al* (pp. 217–222) re-examine the data from this study and find a dose–response relationship between case-loads 1:10 and 1:20 and interpret this to support the value of smaller case-loads (below 1:20) for certain patient groups. Recent reports have indicated the value of antidepressants in reorganising neural circuits. Narushima *et al* (pp. 260–265) report that antidepressant treatment improved longer-term executive functioning following stroke. However, there were no improvements after acute treatment, and they interpret this later change as supporting the role of antidepressants in reorganising neural networks modulated by monoaminergic transmission.