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From the Editor's desk

By Peter Tyrer

Smart kids grow up

When I was 10, I was insufferable. I knew everything I felt needed to be known and if I didn't, I could always claim I was my twin brother.[1] At my primary school I repeatedly piped up with infantile remarks both to show off and to rile the teachers. One poor supply teacher responded by saying, 'since you're so clever, Tyrer, perhaps you could take over the class'. I responded with alacrity and half an hour later I had destroyed the poor teacher's credibility when the bell for the lunch break sounded and I was still in full flow. So, if Gabrielle Carlson had come up to me and asked at that time 'have you ever felt you were the smartest kid in your class?' (p. 172), I would probably have said 'yes', assuming that I would have understood that in American English 'smart' means clever and not elegantly attired. (If the latter, I would have been in the lowest centile). I hope I would not have scored as manic on the rest of the questions in her rating scale as I am sure that, although insufferable, I was not suffering in any psychiatric sense of the word. But if I had been growing up in a US state now, it is more than likely that as my behaviour was irritating it might well have been regarded as pathological. The diagnosis of bipolar disorder in children has increased 40-fold in the US in the past 15 years and it takes a strong physician to buck the trend. As Gabrielle herself put it colourfully, if reported correctly in the *New York Times*, 'We are just inundated with stuff from drug companies, publications, throwaways, that tell us six ways from Sunday that, Oh my God, we're missing bipolar'.[2] So we all pile in, like lemmings on a path to potential disaster.

Diagnostic classifications have been criticised heavily in recent years for their many failings, and particular attention has been paid to the role of drug companies in promoting those categories that are linked to drug treatment; around half of children with a diagnosis of bipolar disorder receive antipsychotic drug treatment. But folks, please hang on a bit, before we press the alarm button remember that our two classification systems, ICD and DSM, are still the best we have at the moment and while we may cavil and complain we should not discard them lightly. They clearly need reform[3] but they have to be replaced by something better, and we must not create more disruption by changing without having what Craddock and Owen describe as 'an appropriately high threshold'[4] for any changes we do recommend. Biological and genetic studies offer promise but are far, far away from diagnostic solutions[5,6] and, however much we may want to abandon categories of illness, they are fundamental to making decisions in our trade.[7] Diagnosis may lead to overuse but also may highlight disorders that otherwise would go unnoticed. I have always thought that if domestic violence had been reformulated with operational criteria and highlighted as 'the Desdemona syndrome', it might have brought the hidden epidemic described by Hegarty (pp. 169–170) and Rose *et al* (pp. 189–194) much more into the open and led to better corrective action than we have had to date. A very useful check on the usefulness of a diagnosis is its distribution across cultures and populations, and when these differ greatly it is fair to question its status. This disparity certainly applies to childhood bipolar disorder, for which prevalence rates in different countries vary greatly,[8,9] and which is exemplified by the low rate found by Hassan *et al* (pp. 195–198) in their study. Carlson asks for a similar cross-national study to that of the landmark US/UK study[10] that changed the face of schizophrenia world-wide, and certainly a similar study of all forms of bipolar disorder could have a similar impact. Open and collaborative international discussions keep us both humble about our individual contributions and provide a solid basis for the future.[11] Perhaps if I had had just a little more understanding of life beyond the classroom, I would not have been so bumptious at the age of 10.

Rating scales and clinical judgement

In the jungle of uncertainty we all look for something firm to grasp in order to feel secure. Rating scales are the common and attractive lianas that tempt us to swing airily over the rank undergrowth of mental illness and provide what at first appears to be a better orientation and perspective. But as Gabrielle Carlson points out (pp. 171–172) it is the interpretation of these scales that is the key to good practice. We celebrate in this issue the achievements of John Wing (Brugha *et al*, pp. 176–178), an icon of assessment since his pioneering work with Cooper and Sartorius with the Present State Examination (PSE), and his work demonstrates rating scale methodology at its best. This is because John always aimed to get to the core of what was intended to be measured, dispensing with all unnecessary chaff in the process. As John Cooper points out, instruments such as the PSE and SCAN provide 'a comprehensive catalogue of the experience of the patient, expressed in terms of symptoms' (p. 177); there is no superfluous flannel. Good clinical judgement and observation do the same and can be combined very effectively with rating scales and interviews. Stewart *et al* (pp. 199–205) nicely show that the complaint of poor memory in older people, despite associations with depression and other disturbance, is probably a better index of neurodegeneration than a raft of seemingly objective measures and neuropsychological tests. This clearly needs replication, but still emphasises that we must talk to patients and listen to them carefully before pretending they can be diagnosed by measures masquerading as more objective.

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