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Author's reply: In the article[1] we presented data describing the clinical stages in developing bipolar disorder based on longitudinal repeated assessment of the offspring of well-characterised parents with bipolar disorder. The findings emphasise the importance of including family history and clinical course in the diagnostic formulation to improve early identification, given that early risk syndromes are non-specific and include anxiety and depressive syndromes. We also showed that offspring of lithium-responsive parents develop classic episodic mood disorders, whereas offspring of parents with a lithium non-responsive illness follow a trajectory that overlaps with psychotic disorders – both in early and end-stage disorders. We did not suggest that 'a history of lithium use in relatives changes the trajectory', rather we used an operationalised published protocol to identify a more homogeneous subtype of bipolar disorder based on the excellent response to long-term lithium in the affected parent.[2] Second, the staging model proposed by McGorry and colleagues[3] was originally based on clinical observations in help-seeking youth (clinically high risk) and only later validated by conversion rates to psychosis and more recently neurobiological findings. Our cohort is a genetically high-risk cohort and we are intensively investigating markers of illness predisposition and progression through the clinical staging model.[4] In regard specifically to neuroanatomical markers, in collaboration we have reported that enlarged right inferior frontal gyrus volumes may be a marker of bipolar disorder predisposition in high-risk offspring.[5]

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Correction

Stimulant treatment for attention-deficit hyperactivity disorder and risk of developing substance use disorder. *BJP*, 203, 112–119. In Table 1 (p. 115): of those with ADHD in the no-stimulant treatment group, the percentage of males is 59%.

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100 words

Trauma and memory

Jonathan I. Bisson

Anyone can experience a major traumatic event; some are more likely to than others but most of us will suffer trauma at some time in our lives. Most traumatic experiences are processed through a normal response, with or without distress but without the development of mental disorder. Traumatic memories characteristic of post-traumatic stress disorder are unbidden, intrusive, vivid, distressing and accompanied by avoidance of them and their triggers. They are often amenable to treatment; trauma-focused psychological therapies are the treatments of choice. Some medications and non-trauma-focused psychological therapies can reduce the intensity of traumatic memories and their impact on functioning.

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