Correspondence

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Mental health and incapacity legislation

The laudable aim of Dawson & Szmukler (2006) of eliminating discrimination against those with mental illness by a fusion of mental health and incapacity legislation may not be achievable with their proposals. They address the ethical difficulties of treating ‘patients with fluctuating mental conditions who temporarily regain their capacity after medication, and again refuse necessary treatment’. They suggest that ‘where the patient has been treated involuntarily on several occasions with a positive response, and a sustained course of treatment is again considered necessary, sustained resumption of capacity on the part of the patient might be required for the patient’s refusal to be honoured’.

In my opinion this highlights two issues. First the authors fail in their aim to stop the discrimination against patients with mental illness who retain capacity. In their proposed legislation they suggest permitting the coercive treatment of patients with mental illness despite the presence of capacity but decry this principle in the Mental Health Act 1983. Second their proposal of using a past history of successful coercive treatment to allow further treatment is unworkable. It is impossible to implement for new patients as no previous history of successful treatment can be demonstrated.


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Dawson & Szmukler (2006) raised a number of interesting points but assumed that general medical patients who lack capacity and object to medical intervention have serious consequences for their actions as those that refuse psychiatric care. However, we believe that for psychiatric patients objection to intervention could increase risks to self and others. This justifies involuntary treatment under the Mental Health Act 1983. Studies have shown that mental disorder is a risk factor for violent offending in the community (Monahan et al., 2001).

Earlier intervention in mental disorders as a result of using ‘incapacity criteria’ will not confer any advantage, as the Mental Health Act 1983 already makes provision for such early intervention (allowing detention on the basis of the nature or degree of the disorder). Nature in this context represents the pattern of the disorder, allowing for earlier application of the Act.

Finally, we believe that returning patients who have mental disorder and capacity to prison because they refuse hospital treatment is wrong. The prison health services are at best basic (Wilson, 2004). It seems unethical to return vulnerable patients to an environment which can exacerbate their mental disorder and even increase their risk of suicide (Shaw et al., 2004).


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Authors’ reply: Dr O’Muirithe notes that we propose a modified legal test, based on sustained resumption of capacity, to cover people with fluctuating mental disorders and a history of successful treatment who recover for short periods and then refuse treatment. We take this approach because we doubt the wisdom of immediately ceasing treatment of patients whose resumption of capacity may be temporary and whose sustained treatment is required. This approach also avoids the potential for an ‘infinite regress’ of resumptions and losses of capacity.

Nevertheless, when he argues that this requirement of sustained resumption of capacity is discriminatory, Dr O’Muirithe forgets that the legislation we propose applies to incapacity owing to any condition. This test would therefore apply as much to elderly patients with confusion hypertension and cardiac failure, as to those with a post-ictal confusional state, or to those recovering from a manic episode. We accept this is a compromise of pure capacity principles, but one which is required in practice.

Drs Adeshina & Sule note the ethical problems in the decision to return a convicted person to prison from hospital if they recover capacity and refuse treatment (i.e. to decide that the patient is fit for punishment unless they accept treatment). Psychiatrists make similar decisions when returning offenders to prison who have gone to hospital for acute treatment, and when they inform the authorities that a patient has ‘breached’ the treatment conditions of probation or parole. However, the matter remains troubling. So we also offered an alternative: that forensic patients with capacity may be treated involuntarily, for a limited period, when they have committed acts constituting a serious crime, are suffering from a serious mental disorder that contributed significantly to those acts, and effective treatment could reduce the risk of its recurrence. However, this would also compromise pure capacity principles.

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Acute psychotic presentations and acute psychosis

We agree with Marneros (2006) that the concept of acute psychosis challenges the traditional Kraepelinian dichotomy. Clinical experience suggests that this condition is heterogeneous with the only similarity being the acuteness of onset. On longitudinal follow-up acute psychoses are separated into different categories; many resolve rapidly; some resolve only to recur again in a similar fashion; and others present differently over time to be reclassified as schizophrenia or mood disorders. It is therefore difficult to identify demographic or other characteristics that define this group.

The majority of patients who received this diagnosis in our study were young adults (mean age 29.75 years, s.d. = 10.95) and male (52%) (Thangadurai et al., 2006). This is in contrast to Marneros (2006) who reported a later age at onset and a predominance of women. A large group of our patients were later given a diagnosis of affective disorder (9.2%), schizophrenia (26.4%) or recurrent episodes of acute psychosis (11.5%); others did not present with psychotic symptoms over the follow-up period. Although these results suggest that it is difficult to predict response to medication, course and outcome, it is well known that acuteness of onset is a good prognostic factor in both schizophrenia and mood disorders.

We argue that the concept of acute psychosis is necessary since many patients may present soon after the onset of illness, when the clinical features may not allow them to be categorised into any of the more classic disorders. Although many patients recover, some relapse with similar acute psychotic presentations; a significant proportion also develop schizophrenia and mood disorders. The difficulty in reaching a diagnosis at the initial presentation arises because it is often difficult to recognise the classic syndromes at this time. However, these can be identified over time. Thus, acute psychoses can be a presentation of the more traditional syndromes but can also be separate clinical entities which may or may not recur. Assuming that those who present with acute psychosis confirm to a homogeneous group does not fit with the clinical reality.

Psychopathological consequences of ketamine

Pomarol-Clotet et al. (2006) reported a range of perceptual distortions in healthy volunteers following ketamine administration but did not report hallucinations. They concluded that ketamine does not reproduce the full picture of schizophrenia, but there are similarities in terms of referential thinking and negative symptoms.

We also recently studied healthy volunteers following ketamine administration (Stone et al., 2006) and, although previously unpublished, recorded phenomenological changes, including verbatim descriptions of their experiences. In keeping with Pomarol-Clotet et al, ketamine induced a wide range of abnormal perceptual experiences. However, no volunteers reported true hallucinations, although several reported eidetic imagery, and most reported visual illusions. Most experienced severe distortions of time, believing that a minute was several hours in duration. They also showed blunting of affect and loss of emotional reactivity. A few showed a marked disinhibition, with facetious replies to questions and apparent euphoria in the first 10–20 min after administration of ketamine. Several participants reported the belief that they were composed solely of thoughts, and that their bodies had either become non-existent or were separate from them. One reported that he believed he could control people in the room by pointing with his hands, and another reported persecutory delusions.

Although we agree with Pomarol-Clotet et al. that these drug-induced effects do not correspond directly to schizophrenic symptoms, we feel it would be remarkable if ketamine administration were to completely reproduce the idiopathic condition. Ketamine induces a syndrome which is much closer to schizophrenia than other classes of psychotogenic substance, and, along with other NMDA receptor antagonists, is unique in inducing negative symptoms (Vollenweider & Geyer, 2001). As ketamine has direct effects at receptors other than the NMDA receptor (Kapur & Seeman, 2002), we believe that the next step should be to elucidate which particular receptors are responsible for each of the symptoms observed following ketamine administration. This may be achieved using similar analyses of psychopathology to those employed by Pomarol-Clotet et al combined with in vivo neurochemical imaging.


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Author’s reply: Kuruvilla et al. emphasise a point that we have also made in our study of acute and transient psychoses (Marneros & Pillmann, 2004), namely the heterogeneity of ‘acute psychoses’ which are diagnosed only on the basis of acute presentation. Unfortunately, the ICD–10 diagnosis of acute and transient psychoses relies primarily on mode of onset and uses symptomatology only for sub-classification. As we have shown (Marneros & Pillmann, 2004), a ‘polymorphic’, rapidly changing psychotic picture seems to be characteristic (as earlier authors always suggested) of the core group of acute polymorphous psychoses with good prognosis. In contrast, schizophrenia-like symptoms in the absence of polymorphic symptoms indicate a higher probability of later transition to schizophrenia. We believe that samples containing many of these patients with acute schizophrenia-like psychosis tend to lack the generally found female preponderance and show high rates of transition to schizophrenia early in the course. This is true for the sample of Amin et al. (1999) and may also apply to that of Thangadurai et al. (2006). Thus, although we agree with Kuruvilla et al. about the heterogeneity of acute psychosis, we feel that further refinement of our diagnostic criteria might help better delineate the core group of acute polymorphous psychoses.


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investigated to date. To address this question we performed a cross-sectional study of 300 consecutive in-patients admitted to the psychiatric clinic of the Central Institute of Mental Health, Mannheim (a medium-sized German city). We found a lifetime prevalence for stalking victimisation that was twice as high (21.3%) as that in a community sample from the same region (11.6%); Dressing et al, 2003). In only 4 out of 64 cases (6.2%) was the treating psychiatrist aware of the stalking history. This needs confirmation in further studies.

Current scientific evidence stresses the need to introduce formal educational training on stalking for all doctors. This should include information about the high lifetime prevalence of stalking victimisation in patients as well as the high risk of the doctor becoming a stalking victim. The results of our cross-sectional pilot study underscore the urgent need for advanced educational programmes for psychiatrists. The question ‘Have you ever been stalked?’ should be routinely asked in the psychiatric interview in the same way as questions about past suicide attempts.

**Stalking – a significant problem for patients and psychiatrists**

Community-based studies on stalking have revealed a high lifetime prevalence of stalking victimisation ranging from 12 to 32% among women and 4 to 17% among men (Dressing et al, 2006). There is also growing evidence that stalking may have deleterious economic, social, medical and psychiatric consequences (Dressing et al, 2006). About 20% of stalking victims consult doctors about mental or somatic symptoms but often fail to inform them about the stalking (Dressing et al, 2005). Doctors receive little or no training in the concept of stalking and its management (McIvor & Petch, 2006), hence the causes of these symptoms remain undetected and treatment is insufficient. Moreover, doctors themselves are much more likely than other professionals to be stalked by their clients, but they are not adequately prepared for the professional handling of this situation (Galeazzi et al, 2005; Purcell et al, 2005; McIvor & Petch, 2006).

In most industrialised countries stalking is considered a form of violent criminal behaviour. It is well known that people with serious mental illness are far more likely to be victims of violence than healthy people and it could be hypothesised that this might also be true for stalking victimisation. To the best of our knowledge this has not been

**Moderate alcohol use and mental health**

Tait & Hulse (2006) conclude from their prospective cohort study that there was tentative evidence that moderate alcohol use was associated with a reduction in mental health admissions compared with abstinence. They cite evidence for more favourable physical, mental and cognitive health in moderate drinkers compared with both problem drinkers and abstainers (the so-called J-shaped curve of alcohol use). They speculate that any association between moderate alcohol use and improved health may be mediated by improved general or cardiovascular health, improved psychological well-being, or as yet unidentified causal variables such as increased social stability. However, they do not speculate on the potential role of personality differences between the different drinking categories. Preliminary evidence from the Dublin Healthy Ageing Study has demonstrated that, when assessed using the Eysenck Personality Inventory, lifelong alcohol abstainers have higher levels of introversion and neuroticism compared with moderate drinkers. This may have an impact not only on measures of social stability, but also mental and physical health characteristics such as depression and hypertension.

Another study has demonstrated that abstinence was more common among people who scored higher on social inadequacy, rigidity and self-sufficiency subscales of the Dutch Personality Inventory and the amount of alcohol consumed was higher in drinkers who scored lower on rigidity and social inadequacy (Koppes et al, 2001). Rodgers et al (2000) demonstrated higher depression and anxiety levels in non-drinkers and occasional drinkers compared with moderate drinkers, along with contributory factors such as lower-status occupations, poorer education, more current financial hardship, poorer social support and more recent stressful life events. Furthermore, abstainers and occasional drinkers scored lower on extraversion, fun-seeking and drive.

Therefore the personality types and temperaments of abstainers, and not simply their zero alcohol consumption, may account for their relatively poorer health characteristics in comparison with moderate drinkers.


Authors’ reply: Since our study had an observational design, with participants not randomised into groups, we adopted a cautious approach to interpreting findings, and there is the possibility that confounding factors might account for the effect. Questions have now been raised concerning the previously well-accepted belief that moderate alcohol consumption confers protection against ischaemic heart disease, with the possibility that either uncontrolled confounding or unmeasured effect modification in observational studies may account for the purported protective association (Jackson et al., 2005). Therefore, we welcome the suggestion of Dr O’Connell that personality differences may partially account for the difference in outcomes for non-drinkers and moderate drinkers, which increases the plausibility of our findings. Nevertheless, we reiterate the need for a conservative approach when interpreting non-experimental data.


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Chronomics of suicides and the solar wind

Salib & Cortina-Borja (2006) report an association between month of birth and suicides and this complements findings concerning the season of death in Minnesota. Along the scale of a calendar year, suicides peaked in April to June, which was later than mortality from heart disease and earlier than mortality from accidents. Our results from another continent, with a mid-continental climate, encourage generalisation to people born outside England and Wales. Both studies stacked data, at the outset of analyses, along the scale of the calendar year (Halberg, 1973) or as monthly counts (Salib & Cortina-Borja, 2006), a limitation subsequently remedied by focus upon broader chronomes (Halberg et al., 2005).

In unstacked data, chronomics resolves (along with trends and deterministic or other chaos) a spectrum of rhythms with many frequencies, in various fields (Halberg et al., 2001), including cis- and transyears, shorter or longer than a year (Halberg et al., 2005).

Richardson et al (1994) reported a periodicity of about 1.3 years for the speed of the solar wind measured by satellites. We found the same and other components of non-photic origin in physiological variables such as blood pressure and heart rate, each studied around the clock for up to decades (Halberg et al., 2001). Such components, also confirmed in the sigma of the speed and the proton content of the solar wind are variable, both in biomedicine and in physics, but they deserve the attention of those concerned with behaviour and can be revealed to the naked eye if the stacking is done after rather than before chronomics. The task remains to compare, before stacking, the chronomes of suicides at birth r. death on the same population and thereby to examine any contributions of space weather, among others, to a fatal as well as fetal hypothesis (Salib & Cortina-Borja, 2006), as attempted in Fig. 1, albeit with data from different populations.


Fig. 1 (a) Suicides in Minnesota according to calendar date of death (1968–2002); (b) suicides in England and Wales according to calendar month of birth. *Validated non-linearly: period = 0.727 years (95% CI 0.703–0.751). Data from Salib & Cortina-Borja (2006).
In their analysis of suicides in Minnesota from 1968 to 2002 they claimed to have confirmed the concept of transyears, both a near-transyear and a far-transyear. They also claimed to have found the 1-yearly component to be bigger in the longer dataset (Halberg et al., 2005). They also reported a 20-year cycle in Minnesota suicides, which is not dissimilar to what they believe exists in many other phenomena of psychiatric interest such as religiosity, wars and crime. Halberg et al. (2005) stated that the ‘photic and thermic calendar year which have been the main focus in suicide research, should now be extended to include not just the effect of seasons but magneto-periodisms, including the newly discovered near-transyear.’

Cornellissen & Halberg are therefore interested in looking at the data from England and Wales to investigate not only whether transyears can be aligned with 1-yearly or the transyear is larger in calendar year or the transyear is larger in amplitude. Interestingly they have made almost identical comments regarding another study on autism (Bolton et al., 1992). We are not sure whether they had access to the unstacked data for autism and month of birth, and if so what was the outcome of their analysis?

Providing that we have definitive evidence to substantiate the above claims, we agree that it would be most interesting to compare, before stacking, the chronomes of suicides at birth and death on the same population.


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