Self-harm during first-episode psychosis

We thank Harvey et al for bringing our attention to the frequency of self-harm during first-episode psychosis.¹ Our data (which we are submitting for publication) indicates an even greater concern in this population. A retrospective review of all psychotic patients admitted to a child and adolescent psychiatry unit from 2003 to 2006 showed that out of 1500 cases reviewed, 102 patients below the age of 18 years who were identified with first-episode psychosis between the ages of 8 and 18 carried a diagnosis of psychosis not otherwise specified, schizophrenia/ment disorder or schizoid personality disorder. A total of 32% of patients had a recent history of self-harm (suicide attempt) just prior to their admission for initial psychosis.

Contrary to Harvey et al we did not find male gender to be associated with a higher incidence of self-harm and violence against others, but it was associated with high severity of the attempt. Interestingly, 28.43% of our sample who had shown violence against others accessed the legal system first and the mental health system second. Poor insight psychosis may predispose those affected to make wrong choices and end up in the legal system before entering the mental health system. Previous non-psychiatric psychiatric history was reported by 74 patients. The most frequent comorbidity was attention-deficit hyperactivity disorder (ADHD) followed by intermittent explosive disorder, separation anxiety, oppositional defiant disorder and emotional instability manifested by depression, explosiveness, or violence against self or others. Labile affect is a key symptom when emotional instability manifested by depression, explosiveness, or violence against self or others. 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and persecutory delusions, and marked thought disorder. He was
diagnosed with DSM–IV schizophrenia. Following treatment with
quetiapine 150 mg twice daily these delusions and the thought
disorder have resolved, although he continues to experience
occupational impairment and has not been able to return to work.
In this case Mr M.A. had a preoccupying belief that the world
had changed in some way that other people were aware of, which
he interpreted as indicating he was the subject of a film and living
in a film set (a ‘fabricated world’). This cluster of symptoms,
which we have termed the ‘Truman syndrome’, is a common
presenting complaint in individuals attending the OASIS clinic
for van Gogh’s paintings and artwork; and Dr Paul Gachet (1828–
1909) who treated van Gogh during his last 10 weeks of life.
van Gogh painted two portraits and an etching of Dr Gachet,
one of which (Portrait of Doctor Gachet, June 1890) was auctioned
in 1990 for an astounding sum of US$ 82.5 million. Young intern
Dr Rey probably maintained distance because he saw van Gogh
during his psychotic state, shortly after the ear mutilation episode.
He failed to value the artist’s creativity and thus was not possessive
of the gift presented to him, which he described afterwards:
‘Vincent was above all a miserable, wretched man, . . . he would talk to me about
complementary colours. But I really could not understand why red should not be
red, and green not green! . . . When I saw that he outlined my head entirely in green
he had only two main colours, red and green), that he painted my hair and my
mustache – I really did not have red hair – in a blazing red on a biting green
background, I was simply horrified. What should I do with this present?’
Dr Gachet was very supportive of van Gogh and valued his
creative instinct. Vincent had found a ‘true friend’ in him. It is
a matter of pride for the medical fraternity that Dr Gachet was
highly admired by van Gogh and that he tried his best to keep
van Gogh’s tormented soul at peace and allow his creativity to
flourish in the village atmosphere of Auvers. van Gogh created a
series of paintings, at least 14, illustrating the Saint-Remy asylum.
Any of them may be appropriate for the Journal to focus on with
regard to his creativity of the use of colour and space to astonishing
effect. Those paintings are carrying the historical value of
mental health perspectives so far as the asylum culture of his time
is concerned.


Truman’ signs and vulnerability to psychosis

Prospective studies indicate that individuals meeting a range of
clinical criteria such as attenuated psychotic symptoms, brief
psychotic episodes or functional decline and family history of
schizophrenia have a high risk of being in the prodromal phase
of a psychotic disorder. However, these studies do not differ-
entiate between different symptom characteristics. Understanding
the phenomenology of attenuated psychotic symptoms may aid
the discrimination of truly prodromal from low-risk individuals.
Mr M.A., a 26-year-old postman, presented with the feeling
there was something subtle going on around him that others knew
about but he didn’t. He had a vague sense that people around him
were ‘acting’, he was the focus of their interest and they knew a
secret that was being kept from him. Furthermore he felt ‘detached
from the environment’ and had a sense the world was slightly
unreal, as if he was the eponymous hero in the film The Truman
Show. He was preoccupied with the belief that he was the focus of
something that he couldn’t quite understand. At no point did his
conviction reach delusional intensity. There was no evidence of
hallucinations, thought disorder, odd behaviour or other features
of psychosis. The symptoms met the criteria for an ‘at risk mental
state’, which is associated with a 25–45% risk of developing
psychosis in the next 12 months. Over the ensuing 9 months these
preoccupations became more pronounced; he developed grandiose
and persecutory delusions, and marked thought disorder. He was
diagnosed with DSM–IV schizophrenia. Following treatment with
quetiapine 150 mg twice daily these delusions and the thought
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