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Correspondence

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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, schizophreniform 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-psychotic 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 suspecting an organic brain disorder, as are poor attention and motor abnormalities. When psychosis presents earlier in life, are there more physiological factors at play than presented in the third or fourth decade?

Future research is needed to detect any differences that trigger psychosis in childhood *v.* adulthood. Observations that children are often more disinhibited than adults is consistent with this higher percentage of 32% particularly from in-patient services. Our results are double those identified in adult studies. Major depressive disorder (n=36) and ADHD (n=49) were the two most frequent comorbidities in the group who attempted suicide. Patients with longer duration of untreated psychosis had more severe suicide attempts. Although the number of attempts made by females and males in our sample were similar, females were more likely to repeat an attempt and to use less severe methods, which is consistent with prior reports.

Our patients more often carried a historical diagnosis for depression prior to admission for psychosis, which may account for our higher rate of suicidal behaviour prior to admission.

Duration of untreated psychosis has been an independent indicator of self-harm.[1] Our sample demonstrated an interesting pattern with patients with the highest suicidality having had 7 months or more of untreated psychosis.

The immature brain continues to develop into young adulthood when myelination, pruning and other neuronal maturation remain incomplete. It is understandable then that there may be a difference in rates of self-harm with even a higher number of cases in children and adolescents. Male gender, negative symptoms and persecutory delusions are clearly linked to greater treatment delay; this could also explain the increased rate in males. The quality of the initial treatment intervention for the first psychotic episode is critical. Each progressive psychotic episode affects brain development, social and family relationships. Investing efforts in improving the approach to treatment of the first psychotic episode may improve the eventual life outcome. There should be a low threshold for hospitalisation of children with psychosis, since the suicide attempt rate was so high in this population. This further supports the importance of a strong psychosocial plan and close follow-up for both patient and family. Perhaps the most critical factor in the treatment of these children is engaging the family early enough to enhance their understanding of the role of medication in addition to close follow-up and the consequences of inadequate or partial treatment.

1 Harvey SB, Dean K, Morgan C, Walsh E, Demjaha A, Dazzan P, Morgan K, Lloyd T, Fearon P, Jones PB, Murray RM. Self-harm in first-episode psychosis. *Br J Psychiatry* 2008; **192**: 178–84.

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Authors' reply: We thank Falcone *et al* for their interest in our paper. The results they share from their own review of self-harm among children and adolescents with first-episode psychosis are both interesting and concerning. They report nearly a third of young patients engaged in self-harm immediately prior to their first admission to hospital. Although this is significantly higher than the 11% in our study, it is difficult to make direct comparisons without knowing more about the comparability of the two services and populations. It should also be noted that our study included all individuals with psychosis presenting to any mental health service, whereas their study only included admissions, thus focusing on a potentially higher-risk group.

Despite this, their results did prompt us to re-examine the effect of age within our data. As we initially reported, young age did not seem to confer any increased risk of self-harm in our sample. Our sample included 44 adolescents between 16 and 18 years of age. Of these, 6 (13.6%) engaged in some form of self-harm during the pre-treatment period of psychosis. We were not able to determine whether adolescents with first-episode psychosis presented with a different range of risk factors for self-harm.

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Vincent van Gogh and mental illness

Many thanks to the *Journal* for printing Vincent van Gogh's work on Dr Felix Rey[1] and honouring this genius artist who despite his episodic mental illness creatively contributed to the repertoire of

impressionist art. But I wonder why this painting was chosen? I think a different choice could have been more meaningful. Three medical doctors were involved with the treatment of van Gough: Dr Felix Rey (1867–1932), who diagnosed van Gogh's epilepsy; Dr Théophile Zacharie Auguste Peyron (1827–95) of Saint-Remy asylum who also diagnosed 'a type of epilepsy' – he was a very understanding physician who arranged facilities within the asylum 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?'[2]

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.

1 Front matter. Portrait of Dr Rey. *Br J Psychiatry* 2008; **192**: (4).

2 Brauman M. With friends of van Gogh's in Arles. In *Van Gogh: A Self-portrait: Letters Revealing his Life as a Painter* (selected by WH Auden): 353–54. New York Graphic Society, 1961.

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'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.[1] However, these studies do not differentiate 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 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 people who may be in the prodromal phase of schizophrenia. Underlying the phenomenology of these symptoms are several features that are consistent with theories of delusion formation resulting from a process of aberrant salience.[2] First, there is the sense that the ordinary is changed or different, and that there is particular significance in this. This is coupled with a searching for meaning, which, in this case, results in the 'Truman explanation'. The third feature is a profound alteration of subjective experience and of self-awareness, resulting in an unstable first-person perspective with varieties of depersonalisation and derealisation, disturbed sense of ownership, fluidity of the basic sense of identity, distortions of the stream of consciousness and experiences of disembodiment.[3] We suggest that these experiences characterise the earliest clinical manifestation of aberrant salience leading to delusion formation. The qualitative phenomenology of the prodrome has not been widely studied, but may, as in this case, be a useful indicator of impending psychosis.

1 Rossler W, Riecher-Rossler A, Angst J, Murray R, Gamma A, Eich D, van Os J, Gross VA. Psychotic experiences in the general population: a twenty-year prospective community study. *Schizophr Res* 2007; **92**: 1–14.

2 Kapur S, Mizrahi R, Li M. From dopamine to salience to psychosis–linking biology, pharmacology and phenomenology of psychosis. *Schizophr Res* 2005; **79**: 59–68.

3 Sass L, Parnas J. Self, consciousness, and schizophrenia. *Schizophr Bull* 2003; **29**: 427–44.

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