Highlights of this issue

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LA BELLE INDIFFÉRENCE AND SUICIDE

Conventional textbooks describe the sign of *la belle indifférence* as indicative of conversion disorder or hysteria. Stone *et al* (pp. 204–209) examined the usefulness of this concept by carrying out a systematic review of all relevant studies since 1965 and found that the frequency of *la belle indifférence* was similar in studies of organic disease and of conversion disorders. They suggest that it may not be a useful clinical sign, and highlight the relatively poor quality of some of the previous studies. Suicide rates in schizophrenia are reported to be on the increase, with contemporary reported lifetime suicide rates of 10%. Earlier studies suggest that rates were much lower before current treatments became available. Healy and colleagues (pp. 223–228) examined a database of admissions to the North Wales Asylum from 1875 to 1924 and found that suicide rates have indeed increased significantly since then. They suggest that the real current lifetime risk is likely to be around 4%; however, even this figure is significantly higher than the 1% in their earlier sample. They discuss various factors such as deinstitutionalisation, social change and the introduction of psychotropic drugs as possible contributory factors. These issues are examined in a commentary by Turner (pp. 229–230), who suggests that considerable caution needs to be exercised in evaluating such historical comparisons. He questions whether some aspects of asylum practice were protective for the patient and whether modern antipsychotic medication has different effects on suicide prevention as opposed to symptom alleviation. Japan has one of the highest suicide rates in the world and both being middle-aged and consuming excessive amounts of alcohol have been associated with increased suicide risk. Akechi *et al* (pp. 231–236) used data from a large cohort to examine the relationship between alcohol consumption and suicide in their sample of middle-aged Japanese men. Surprisingly, the found a U-shaped relationship – higher relative risk in regular drinkers correlated with the amount of alcohol consumed, but also an equally increased risk in non-drinkers. However, they note that they did not have adequate data on potential confounding factors such as the frequency of psychiatric disorder in their sample.

DEPRESSION: LIFE EVENTS, ADOLESCENCE AND SEROTONIN GENES

Although both genetic and environmental factors are associated with psychiatric disorders, there has been little clear evidence of an interaction effect. One recent study has demonstrated that adverse life events may interact with a polymorphism of the serotonin transporter gene to increase the risk of developing major depression. Wilhelm *et al* (pp. 210–215) successfully replicate this result in this issue of the *Journal*; they raise the question of whether identification of the high-risk genotypes can inform decisions about psychological or pharmacological treatment. In an accompanying editorial, Zammit & Owen (pp. 199–201) discuss the caveats associated with this approach, highlighting negative studies and the statistical and cost implications of such studies. It is recognised that adolescent depressive disorder increases the risk of subsequent adult affective disorder. Dunn & Goodyer (pp. 216–222) found that continued affective disorder was present in more than half of their cohort of depressed children when followed up after 7 years; 18% remained persistently unwell into adulthood. They suggest that depression in this group requires early detection in the community. Peveler *et al* (pp. 202–203) comment on the artificial distinction between psychological and physical symptoms in the classification and diagnosis of depression, particularly in the case of pain symptoms. They describe high rates of pain symptoms in patients with depression and suggest that techniques that may be effective in alleviating these symptoms should be more widely disseminated.

SCHIZOPHRENIA, CLOZAPINE RECHALLENGE, VIOLENCE AND SUBSTANCE MISUSE

Clozapine remains the gold standard medication for treatment-resistant schizophrenia and recent guidelines advocate its use earlier in the illness. As more patients are being treated with clozapine, the chance of coming across patients who have experienced leucopenia or neutropenia after taking clozapine is also increasing. Dunk *et al* (pp. 255–263) examined the outcome of rechallenging 53 such patients with clozapine and show that 38% of these experienced a similar, but more severe, adverse reaction during this rechallenge. However, 55% were able to be maintained on clozapine. There were no clear prognostic indicators to aid the selection of patients and the authors point out that they selected their patients very carefully before entry into the study and advocate extreme caution in rechallenging patients. Clinicans should be aware that the risk of violence in schizophrenia may be higher in women than men; Dean *et al* (pp. 264–270) show that the 2-year prevalence of physical assault in a female sample with psychosis was 17%. As in previous studies, the risk was higher in those with a prior history of violence, cluster B personality disorder, previous conviction for a non-violent offence, having been a victim of assault and being of African–Caribbean origin. They did not find the oft-quoted increased risk of violence associated with substance misuse. Barnes *et al* (pp. 237–242) found a strong association between self-reported cannabis use and earlier onset of psychosis in their sample of patients with first-episode psychosis. A significant percentage of patients also reported a history of problems with alcohol. The authors suggest that there needs to be heightened awareness of substance misuse during the assessment of patients presenting with a first psychotic episode, as substance misuse tends to predict poorer initial outcome.

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