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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

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