

Correspondence

EDITED BY LOUISE HOWARD

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Crisis telephone consultation for deliberate self-harm patients

With reference to Evans *et al* (1999), it is not clear from the paper whether the 'green card' treatment group really received a different treatment from the control group. Did the control group receive advice concerning methods of accessing mental health services in the future (e.g. the general practitioner, crisis centre, ward, community psychiatric nurses, Samaritans)? This is particularly relevant as approximately 50% of each group were referred on to mental health services. This would have negated the effect of the green card as a valid different treatment intervention.

It would be helpful to know how many patients used the telephone support service after having been given the green card. It is possible that a poor telephone support service could have caused the apparent lack of positive outcome in the study. One wonders about the availability of on-call psychiatric trainees and their level of expertise in giving telephone counselling; additional information about this in the paper would have been appreciated.

The patients who had a history of repeated deliberate self-harm, probably represent a more vulnerable group, as stated in the paper, but they may also be a group who habitually use deliberate self-harm as a method of communication. Therefore, paying increased attention (in the form of the green card) to this dysfunctional behaviour may have exacerbated the behaviour.

Evans, M. O., Morgan, H. G., Hayward, A., *et al* (1999) Crisis telephone consultation for deliberate self-harm patients: effects on repetition. *British Journal of Psychiatry*, 175, 23–27.

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Author's reply: I wish to clarify some of the points raised by Dr Darely. First, it is

important to remember that both groups in our study received 'treatment as usual', while those subjects randomised to receive a green card also had the facility to access emergency telephone consultation. We know from our data that there were no significant differences between groups with respect to their management following deliberate self-harm (DSH) assessment, and it is important to remember that the management plan was presented to patients before randomisation to avoid any subsequent bias in the treatment offered. We did not document other advice given over and above the main management plan but this is likely in both groups to have included advice to consult with the patient's general practitioner or psychiatric keyworker (if applicable).

Details of how the telephone support system was used, together with its effects on patients' uptake of other routine medical and psychiatric services, are soon to be published in a separate paper (further details available upon request). Speculation about why the green card appears to have a detrimental effect in DSH patients with a previous history of self-harm and a positive effect in 'first-timers' must remain tentative as these were secondary subgroup findings. Further research, in the form of a large multicentre trial, is needed to clarify the effects of the green card on patients presenting with DSH for the first time.

The mechanisms for such effects of the green card are even more speculative at this stage. For first-timers (only a minority of whom will use the card) it is not clear whether knowledge that the card is there to be used should a crisis ensue (the 'safety net' hypothesis) is the most important ingredient or whether the consultation itself makes the difference. Further qualitative work in this area utilising patient interviews would be welcome. For some patients with a history of repeated DSH, it could be suggested that the green card may heighten their experience of gratification resulting

from a use of self-harm as an albeit distorted form of communication. Another hypothesis might be that a brief, focused telephone consultation from a psychiatrist in training is not containing enough and actually increases self-harming behaviour in such individuals. It seems unlikely that this apparent paradox will be explored further in view of ethical considerations when proposing research methodology. However, it may well be a pertinent issue given the projected prominence of 'NHS Direct'.

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Suicide attempts v. deliberate self-harm: a response

Ogundipe (1999), citing Hawton *et al* (1997), states that deliberate self-harm is more common in females than males, although the difference is narrowing. In reply, Isometsä & Lönnqvist (1999) write that Finland is the only country in Europe where males seem to have a slightly higher incidence of parasuicide than females. In Ireland, the National Suicide Research Foundation monitors hospital-treated parasuicide in one-quarter of the country. Forty-seven per cent of those treated are male and the male : female ratio is even closer to parity in urban areas. It is somewhat surprising to find that the Irish situation corresponds more closely to that in Finland as opposed to our British neighbours.

Both the Irish and Finnish data originate from centres of the WHO/EURO Multicentre Study of Parasuicide. The following standardised definition of parasuicide is utilised in all centres participating in this study. "An act with non-fatal outcome, in which an individual deliberately initiates a non-habitual behaviour that, without intervention from others, will cause self-harm, or deliberately ingests a substance in excess of the prescribed or generally recognised therapeutic dosage and which is aimed at realising changes which the subject desired via the actual or expected physical consequences" (Kerkhof *et al*, 1994). It is noteworthy that suicidal intent is not referred to in this definition. However, Isometsä & Lönnqvist indicated that some degree of suicidal intent was required in their study. It is possible for Finnish males to have a slightly higher incidence of parasuicide, as defined by the WHO/EURO Study, and

for females to have higher rates when the presence of suicidal intent is required. If this were the case, it might help to explain how Isometsä & Lönnqvist found a higher proportion of female suicides with previous suicide attempts.

Unfortunately, the issue of definition in suicidology continues to provoke controversy. The lack of standardisation limits our ability to make comparisons and generalisations based on the research findings of others, whether from the same jurisdiction or not.

Hawton, K., Fagg, J., Simkin, S., et al (1997) Trends in deliberate self-harm in Oxford, 1985–1995. Implications for clinical services and the prevention of suicide. *British Journal of Psychiatry*, **171**, 556–560.

Isometsä, E. & Lönnqvist, J. (1999) Suicide attempts v. deliberate self-harm (authors' reply). *British Journal of Psychiatry*, **175**, 90.

Kerkhof, A. J. F. M., Schmidtke, A., Bille-Brahe, U., et al (eds) (1994) *Attempted Suicide in Europe: Findings from the Multicentre Study on Parasuicide by the WHO Regional Office for Europe*, p. 7. Leiden: DSWO Press.

Ogundipe, L. O. (1999) Suicide attempts v. deliberate self-harm (letter). *British Journal of Psychiatry*, **175**, 90.

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Post-abortion mania

I was interested to read the report by Dr Mahe and his colleagues, describing a woman who suffered from five episodes of puerperal mania and two of post-abortion psychosis, one after a therapeutic abortion and one after a spontaneous abortion. This clinical observation is a valuable contribution to the literature.

The association of acute psychosis with abortion in women susceptible to puerperal psychosis has previously been noted in nine reports, starting with Esquirol in 1819. Some of the terminations were carried out in order to prevent a puerperal psychosis! This literature is summarised in my book *Motherhood & Mental Health*, pages 91–93. There is evidence, especially from Denmark (David, 1985), that abortion is a greater risk factor than a full-term pregnancy.

Brockington, I. F. (1996) *Motherhood & Mental Health*. Oxford: Oxford University Press.

David, H. P. (1985) Post-abortion and post-partum psychiatric hospitalization. In *Abortion: Medical Progress and Social Implications*. CIBA Foundation Symposium 115, pp. 150–164. Chichester: Wiley.

Mahe, V., Nartowski, J., Montagnon, F., et al (1999) Psychosis with gonadorelin agonist administration (letter). *British Journal of Psychiatry*, **175**, 290–291.

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Cognitive effects of antipsychotics in schizophrenia and relationship to quality of life

In his overview on cognitive effects of antipsychotics in schizophrenia Sharma (1999) stresses a relationship between cognitive function in schizophrenia and quality of life as an outcome measure. I think that Sharma's use of the concept 'quality of life' has to be clarified to prevent a number of rather common biases. He quotes two studies that are said to support a relationship between cognitive function in schizophrenia and quality of life (Davidson & Keefe, 1995; Green, 1996). The term quality of life is not operationalised in the first study. In the second study, which is in fact an overview of other studies, it is reported by Heinrichs' Quality of Life Scale (Heinrichs et al, 1984). Like most other instruments which have been used to detect the effect of atypical neuroleptics on quality of life in schizophrenia (Priebe et al, 1999) the Quality of Life Scale (subtitled "An instrument for rating the schizophrenia deficit syndrome") assesses clinical judgements of negative symptoms of schizophrenia rather than subjective appraisals of quality of life made by the patient. As it seems reasonable to assume at least a moderate relationship of negative symptoms and cognitive functions in schizophrenia, it is not surprising that a relationship is found between cognitive functioning and quality of life when the quality of life measures seem to be confounded to a considerable extent by psychiatric symptomatology.

We think that it is necessary to make a distinction between quality of life as an evaluation criterion for illness-related phenomena (negative symptoms), and quality of life as a subjective assessment by the patient as a "subjective evaluation of oneself and one's social and material world" (Orley et al, 1998) – that is, subjective quality of life, not as a disease but as a generic concept. Since there are some studies that show that cognitive functioning in schizophrenia may

predict social outcome, and since objective social outcome is moderately (although surprisingly weakly) associated with generic subjective quality of life, some association between cognitive functioning and subjective quality of life is conceivable, but has not yet been supported by empirical evidence.

In a validation study of a German short form of the Lancashire Quality of Life Profile (Kaiser et al, 1999), equivalent to the English short form of the instrument MANSA (see Priebe et al, 1999), we did not find any significant correlation between any of the categories of the Wisconsin Card Sorting Test (WCST; Heaton et al, 1993) (number of categories, perseverative errors and responses, etc.) and the mean value of all satisfactions ratings, satisfaction with life as a whole and with satisfaction with mental health in a carefully selected sample of out-patients with DSM–III–R schizophrenia (American Psychiatric Association, 1987; $n=36$; mean age=47 years; mean illness duration=19 years). Our conclusion so far is that whether or not subjective quality of life is related to cognitive deficits in schizophrenia (in attention or memory, besides deficits in executive functioning, which are seen on a variety of tasks, most notably the WCST) remains unclear and so far is only a hypothesis, although it is widespread as an advertising slogan for atypical antipsychotic medication.

American Psychiatric Association (1987) *Diagnostic and Statistical Manual of Mental Disorders* (3rd edn, revised) (DSM–III–R). Washington, DC: APA.

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Green, M. F. (1996) What are the functional consequences of neurocognitive deficits in schizophrenia? *American Journal of Psychiatry*, **153**, 321–330.

Heaton, R. K., Chelune, G. J., Talley, J., et al (1993) *Wisconsin Card Sorting Test Manual – Revised and Expanded*. Odessa, FL: Psychological Assessment Resources.

Heinrichs, D. W., Hanlon, T. E. & Carpenter, W. T. Jr (1984) The Quality of Life Scale: an instrument for rating the schizophrenia syndrome. *Schizophrenia Bulletin*, **10**, 388–398.

Kaiser, W., Isermann, M., Hoffmann, K., et al (1999) A short assessment of subjective quality of life. Application and results of a short form of the Berliner Lebensqualitätsprofil (BELP-KF) (in German). *Fortschritte der Neurologie und Psychiatrie*, **67**, 413–425.

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Priebe, S., Oliver, J. P. J. & Kaiser, W. (eds) (1999) *Quality of Life and Mental Health Care*. Petersfield: Wrightson Biomedical.