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Stalking – a significant problem for patients and psychiatrists

Community-based studies on stalking have revealed a high lifetime prevalence of stalking victimisation ranging from 12 to 32% among women and 4 to 17% among men (Dressing *et al*, 2006). There is also growing evidence that stalking may have deleterious economic, social, medical and psychiatric consequences (Dressing *et al*, 2006). About 20% of stalking victims consult doctors about mental or somatic symptoms but often fail to inform them about the stalking (Dressing *et al*, 2005). Doctors receive little or no training in the concept of stalking and its management (McIvor & Petch, 2006), hence the causes of these symptoms remain undetected and treatment is insufficient. Moreover, doctors themselves are much more likely than other professionals to be stalked by their clients, but they are not adequately prepared for the professional handling of this situation (Galeazzi *et al*, 2005; Purcell *et al*, 2005; McIvor & Petch, 2006).

In most industrialised countries stalking is considered a form of violent criminal behaviour. It is well known that people with serious mental illness are far more likely to be victims of violence than healthy people and it could be hypothesised that this might also be true for stalking victimisation. To the best of our knowledge this has not been

investigated to date. To address this question we performed a cross-sectional study of 300 consecutive in-patients admitted to the psychiatric clinic of the Central Institute of Mental Health, Mannheim (a medium-sized German city). We found a lifetime prevalence for stalking victimisation that was twice as high (21.3%) as that in a community sample from the same region (11.6%; Dressing *et al*, 2005). In only 4 out of 64 cases (6.2%) was the treating psychiatrist aware of the stalking history. This needs confirmation in further studies.

Current scientific evidence stresses the need to introduce formal educational training on stalking for all doctors. This should include information about the high lifetime prevalence of stalking victimisation in patients as well as the high risk of the doctor becoming a stalking victim. The results of our cross-sectional pilot study underscore the urgent need for advanced educational programmes for psychiatrists. The question 'Have you ever been stalked?' should be routinely asked in the psychiatric interview in the same way as questions about past suicide attempts.

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Moderate alcohol use and mental health

Tait & Hulse (2006) conclude from their prospective cohort study that there was tentative evidence that moderate alcohol use was associated with a reduction in

mental health admissions compared with abstinence. They cite evidence for more favourable physical, mental and cognitive health in moderate drinkers compared with both problem drinkers and abstainers (the so-called J-shaped curve of alcohol use). They speculate that any association between moderate alcohol use and improved health may be mediated by improved general or cardiovascular health, improved psychological well-being, or as yet unidentified causal variables such as increased social stability. However, they do not speculate on the potential role of personality differences between the different drinking categories. Preliminary evidence from the Dublin Healthy Ageing Study has demonstrated that, when assessed using the Eysenck Personality Inventory, lifelong alcohol abstainers have higher levels of introversion and neuroticism compared with moderate drinkers. This may have an impact not only on measures of social stability, but also mental and physical health characteristics such as depression and hypertension.

Another study has demonstrated that abstinence was more common among people who scored higher on social inadequacy, rigidity and self-sufficiency subscales of the Dutch Personality Inventory and the amount of alcohol consumed was higher in drinkers who scored lower on rigidity and social inadequacy (Koppes *et al*, 2001). Rodgers *et al* (2000) demonstrated higher depression and anxiety levels in non-drinkers and occasional drinkers compared with moderate drinkers, along with contributory factors such as lower-status occupations, poorer education, more current financial hardship, poorer social support and more recent stressful life events. Furthermore, abstainers and occasional drinkers scored lower on extraversion, fun-seeking and drive.

Therefore the personality types and temperaments of abstainers, and not simply their zero alcohol consumption, may account for their relatively poorer health characteristics in comparison with moderate drinkers.

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Authors' reply: Since our study had an observational design, with participants not randomised into groups, we adopted a cautious approach to interpreting findings, and there is the possibility that confounding factors might account for the effect. Questions have now been raised concerning the previously well-accepted belief that moderate alcohol consumption confers protection against ischaemic heart disease, with the possibility that either uncontrolled confounding or unmeasured effect modification in observational studies may account for the purported protective association (Jackson *et al*, 2005). Therefore, we welcome the suggestion of Dr O'Connell that personality differences may partially account for the difference in outcomes for non-drinkers and moderate drinkers, which increases the plausibility of our findings. Nevertheless, we reiterate the need for a conservative approach when interpreting non-experimental data.

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Chronomics of suicides and the solar wind

Salib & Cortina-Borja (2006) report an association between month of birth and suicides and this complements findings concerning the season of death in Minnesota. Along the scale of a calendar year, suicides peaked in April to June, which was later than mortality from heart disease and earlier than mortality from accidents. Our

results from another continent, with a mid-continental climate, encourage generalisation to people born outside England and Wales. Both studies stacked data, at the outset of analyses, along the scale of the calendar year (Halberg, 1973) or as monthly counts (Salib & Cortina-Borja, 2006), a limitation subsequently remedied by focus upon broader chronomes (Halberg *et al*, 2005).

In unstacked data, chronomics resolves (along with trends and deterministic or other chaos) a spectrum of rhythms with many frequencies, in various fields (Halberg *et al*, 2001), including cis- and transyears, shorter or longer than a year (Halberg *et al*, 2005).

Richardson *et al* (1994) reported a periodicity of about 1.3 years for the speed of the solar wind measured by satellites. We found the same and other components of non-photic origin in physiological variables such as blood pressure and heart rate, each studied around the clock for up to decades (Halberg *et al*, 2001). Such components,

also confirmed in the sigma of the speed and the proton content of the solar wind are variable, both in biomedicine and in physics, but they deserve the attention of those concerned with behaviour and can be revealed to the naked eye if the stacking is done after rather than before chronomics. The task remains to compare, before stacking, the chronomes of suicides at birth *v.* death on the same population and thereby to examine any contributions of space weather, among others, to a fatal as well as fetal hypothesis (Salib & Cortina-Borja, 2006), as attempted in Fig. 1, albeit with data from different populations.

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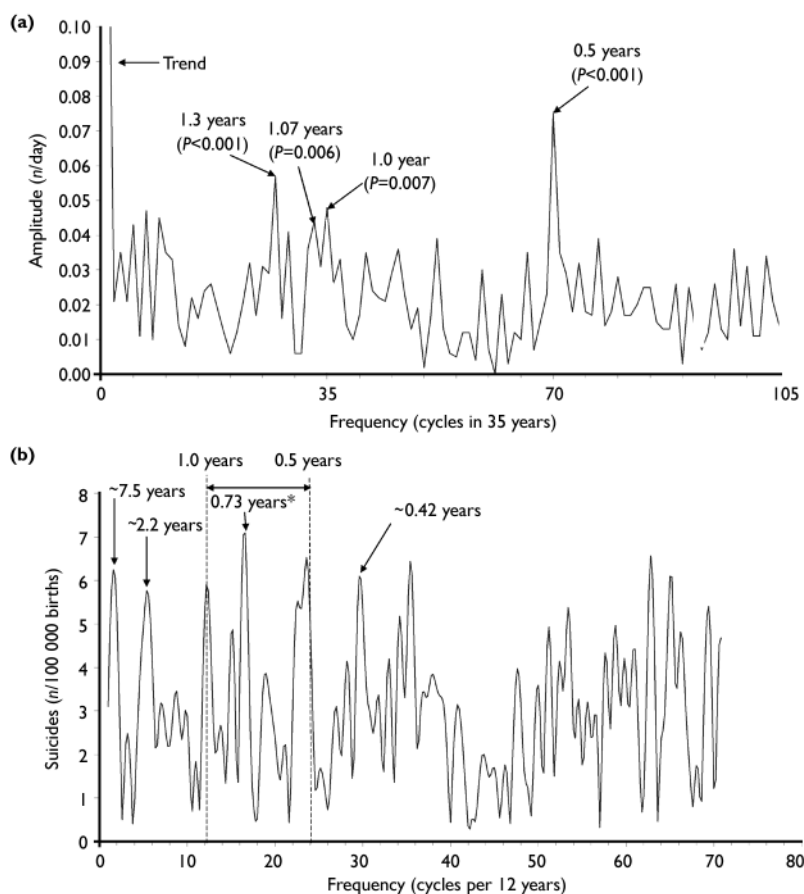


Fig. 1 (a) Suicides in Minnesota according to calendar date of death (1968–2002); (b) suicides in England and Wales according to calendar month of birth. *Validated non-linearly: period=0.727 years (95% CI 0.703–0.751). Data from Salib & Cortina-Borja (2006).