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**Seenan, G. (2004)** Hidden toll of a justice system in crisis. *Guardian*, 21 January 2004. Available at [http://www.guardian.co.uk/uk\\_news/story/0,3604,1127369,00.html](http://www.guardian.co.uk/uk_news/story/0,3604,1127369,00.html)

**Shaw, J., Baker, D., Hunt, I. M., et al (2004)** Suicide by prisoners: national clinical survey. *British Journal of Psychiatry*, **184**, 263–267.

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### Ethnicity and suicidality

Gunnell *et al*'s (2004) interesting study came with useful learning points. However, while known as important factors that influence development and amelioration of suicidal thoughts, ethnicity and religion were not included in the study. As the world has become a small, or big, village, and as we live in a multi-ethnic and multi-religious society, I feel this should be considered as an additional limitation to the study. The relationship between religion and suicide became famous through Durkheim's study in the 19th century.

In European countries, evidence suggests that the prevalence of suicide continues to vary in accordance with international differences in traditions, customs and religious practices (Cavanagh & Masterton, 1998). Cavanagh & Masterton suggested that the strength of these differences is decreasing because of homogenisation among countries. In my opinion, it is unlikely that this influence will completely disappear. In a modern secularised society, religion is still a meaningful and protective factor for many individuals in a suicidal crisis (Lonnqvist, 2000).

Makinen & Wassermann (2001) believe that much of the difference in suicidal behaviour between national groups can be connected with differences in cultural outlook, and state that 'traditionally religion has been considered to be the matrix of culture'.

Various factors that influence development and amelioration of suicidal thoughts do not function separately. I wonder, had ethnicity and religion been included, how would this have affected the outcome?

**Cavanagh, J. T. O. & Masterton, G. (1998)** Suicide and deliberate self-harm. In *Companion to Psychiatric Studies* (6th edn) (eds E. Johnstone, C. Freeman & A. Zealley), pp. 751–783. Edinburgh: Churchill Livingstone.

**Gunnell, D., Harbord, R., Singleton, N., et al (2004)** Factors influencing the development and amelioration of suicidal thoughts in the general population. Cohort study. *British Journal of Psychiatry*, **185**, 385–393.

**Lonnqvist, J. K. (2000)** Suicide: epidemiology and causes of suicide. In *New Oxford Textbook of Psychiatry*, vol. 1 (eds M. G. Gelder, J. J. López-Ibor & N. Andreasen), pp. 1033–1039. Oxford: Oxford University Press.

**Makinen, I. H. & Wasserman, D. (2001)** Some social dimensions of suicide. In *Suicide: An Unnecessary Death* (ed. D. Wasserman), pp. 101–108. London: Martin Dunitz.

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**Authors' reply:** We agree with Dr El-Adl's comment that both ethnicity and religion may influence the incidence of, and recovery from, suicidal thoughts. Data on ethnicity were collected in the Office for National Statistics Survey that formed the basis of our paper (Singleton *et al*, 2001). Because of the relatively small sample size, only 122 (5.1%) of the individuals who reported ethnicity were from a Black or minority ethnic group and only seven of these experienced incident suicidal thoughts. Thus, specific investigation of the impact of belonging to a particular ethnic group was not possible. If the Black and minority groups are combined to give a single group, the odds ratio for incident suicidal thoughts in this group compared with the White group in analyses adjusted for age, gender and score on the Clinical Interview Schedule – Revised is 0.77 (95% CI 0.27–2.17). The breadth of the confidence interval indicates that the data are compatible with either a threefold reduction or a doubling in risk. Data on religion were not collected in the Office for National Statistics Survey of Psychiatric Morbidity.

**Singleton, N., Bumpstead, R., O'Brien, M., et al (2001)** *Psychiatric Morbidity among Adults Living in Private Households, 2000*. London: Stationery Office.

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### Attention deficit disorder in adults

The editorial on attention-deficit hyperactivity disorder and life-span development (McArdle, 2004) is timely. However, it highlights the issues from the perspective of clinicians who may be directly involved in treating the disorder.

In general adult psychiatry, however, it is not widely recognised that (adult) attention-deficit disorder (ADD) is not uncommon and that people presenting with diagnoses of psychotic disorders, mood disorders, anxiety disorders, etc., may also be suffering from unrecognised ADD. This has profound implications for both treatment and outcome. For example, if a person develops a hypomanic or manic episode superimposed on ADD, it is possible that the clinician unaware of ADD may end up overtreating the mood episode, as the baseline ADD may mislead the clinician into believing that the talkativeness and hyperactivity (of ADD) are an indication of elevated mood. The consequences include higher than necessary doses of medications, combination pharmacotherapy and increased length of stay in hospital. In patients with schizophrenia it is possible that the impairments in functioning caused by independent ADD may potentiate the poor functioning caused by schizophrenia. Again, if ADD is not recognised, it is possible that the poor outcome may be attributed to 'resistant' or 'residual' schizophrenia or perhaps to poor motivation. It is important to assess comorbidity such as ADD at the very first contact with mental health services, and early intervention service providers are ideally placed for this.

Regarding treatment, new strategies (other than stimulant medications) need to be developed, as stimulants may have destabilising effects on the baseline mental illness.

**McArdle, P. (2004)** Attention-deficit hyperactivity disorder and life-span development. *British Journal of Psychiatry*, **184**, 468–469.

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### Risk reduction studies in schizophrenia

Niemi *et al*'s (2004) report does not truly address the implications of their findings. Their clinical implications (p. 16)

summarise their results, but one fails to draw clinical sense of it or be in a position to use the information in clinical practice. One could be cynical about their findings; the offspring of mothers with schizophrenia or psychotic disorders are expected to be at increased risk, which could vary across studies owing to a multitude of factors, so the findings of the study are no surprise. The increased risk could be genetic, psychosocial or both.

The clinical implications of high-risk studies ought to help identify those at high risk and prevent health problems in them. A number of studies on risk reduction strategies have been reported for common medical problems, including diabetes (Parillo & Ricardi, 2004), cardiac disorders (Ferdinand, 2004) and atherosclerotic vascular disease (Heckam & Anand, 2003) and even complex multi-factorial disorders such as hypertension (Sheridan *et al*, 2003), to name a few. Although little can be done about the genetic component of the risk, the psychosocial and environmental effects can definitely be minimised. Multiple appropriate lifestyle alterations and stress protective strategies may be relevant. Furthermore, one expects that over time, the more recent studies should report relatively lower rates of elevated risk compared with those done decades earlier. Incidentally, Niemi *et al* found an incidence of 6.7%, lower than the 16.2% found in a study reported in 1993, and 13.1% in one reported in 1995, showing a gradually decreasing receding trend. Niemi *et al* attribute these differences to methodological factors, but one wonders whether the reduction can be attributed to preventive measures being implemented with those at high risk, advertently or inadvertently.

What is the point of knowing that people are at increased risk of developing a disorder if nothing can be done with this knowledge?

**Ferdinand, K. C. (2004)** The importance of aggressive lipid management in patients at risk: evidence from recent clinical trials. *Clinical Cardiology*, **27** (suppl. 3), 12–15.

**Heckam, D. G. & Anand, S. S. (2003)** Emerging risk factors for atherosclerotic vascular disease: a critical review of evidence. *JAMA*, **290**, 932–940.

**Niemi, L. I., Suvisaari, J. M., Haukka, J. K., et al (2004)** Cumulative incidence of mental disorders among offspring of mothers with psychotic disorder. Results from the Helsinki High-Risk Study. *British Journal of Psychiatry*, **185**, 11–17.

**Parillo, M. & Riccardi, G. (2004)** Diet composition and the risk of type-2 diabetes: epidemiological and clinical evidence. *British Journal of Nutrition*, **92**, 7–19.

**Sheridan, S., Pignone, M. & Donahue, K. (2003)** Screening for high blood pressure: a review of the evidence for the US Preventive Services Task Force. *American Journal of Preventive Medicine*, **25**, 151–158.

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**Author's reply:** Dr Chaturvedi questions the clinical relevance of knowing that offspring of mothers with schizophrenia are at increased risk of developing both psychotic and non-psychotic disorders, particularly because preventive measures are not available. However, preventive measures may be available in the future. Clinical high-risk studies already suggest that using specific preventive interventions, it is possible at least to delay the onset of psychosis in patients at incipient risk of psychosis (McGorry *et al*, 2002). However, the criteria for being clinically at high risk require that the individual is already showing psychotic-like symptoms or impaired functioning (McGorry *et al*, 2002). One of the goals in high-risk studies (including ours) is to identify early indicators of emerging psychotic disorders that could be detected before any impairment starts to develop.

Family interventions are rarely targeted at children of mothers with psychotic disorders, who often remain uninformed about

their parent's illness and have to cope alone with their parent's symptoms and take additional responsibility for the family (Valiakalayil *et al*, 2004). We hope that the knowledge that the children are themselves at increased risk of developing mental disorders will enhance the planning and implementation of supportive measures and parental education for families where the parent(s) suffer from psychotic disorder. Such support should begin during pregnancy and continue through childhood and adolescence. These measures could also turn out to be preventive: the Finnish Adoption Study showed that the risk of developing schizophrenia-spectrum disorders among adoptees whose biological mothers had schizophrenia was much lower if they were raised in adoptive families with 'healthy' rearing patterns (Tienari *et al*, 2004).

Finally, Dr Chaturvedi suggests that there might be a genuine decline in the risk of developing schizophrenia among high-risk children. We discussed this possibility in our article, but the method of identifying the mothers in our study differs so much from those of the Copenhagen and New York high-risk studies that we still consider it premature to draw such a conclusion.

**McGorry, P. D., Yung, A. R., Phillips, L. J., et al (2002)** Randomized controlled trial of interventions designed to reduce the risk of progression to first-episode psychosis in a clinical sample with subthreshold symptoms. *Archives of General Psychiatry*, **59**, 921–928.

**Tienari, P., Wynne, L. C., Sorri, A., et al (2004)** Genotype–environment interaction in schizophrenia-spectrum disorder: long-term follow-up study of Finnish adoptees. *British Journal of Psychiatry*, **184**, 216–222.

**Valiakalayil, A., Paulsen, L. A. & Tibbo, P. (2004)** Burden in adolescent children of parents with schizophrenia. The Edmonton High Risk Project. *Social Psychiatry and Psychiatric Epidemiology*, **39**, 528–535.

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## One hundred years ago

### The care of the feeble-minded

THE problem of the care of the feeble-minded may be said first to have received

attention on anything approaching a general scale in Europe and America towards the middle of the last century. In France the attempt to deal with this question may be

traced to the beginning of that century and that country has been called the birth-place of the new education as it applies to the mentally defective class. Switzerland is