Correspondence

EDITED BY TOM FAHY

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Confidential Inquiry into Suicide and Homicide by People with Mental Illness

Sir: Morgan (1997) offers welcome support to the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness but expresses concern that the identification of suicides following inquest will lead to delays that will compromise the collection of complete and reliable data. Although we considered this possibility when planning the new notification system, there has been no evidence for it – consultants appear to have little difficulty in completing our questionnaires. Nevertheless, we agree that an early multi-disciplinary review following a likely suicide would benefit the Inquiry as well as local services.

The present way of identifying suicides (Appleby *et al*, 1997) was introduced because most eligible cases were not notified by the previous 'voluntary' system, and the aims of the Inquiry were therefore undermined. The use of public health records derived from inquest verdicts has allowed us to collect a comprehensive national sample, using an objective definition of suicide. The majority of inquests take place within a few months of a death; a great deal of suicide research accepts this delay, and its quality does not appear to be compromised. There may even be an advantage in asking mental health service staff about their care once their initial reactions to a death and their anxiety about an imminent inquiry have been allowed to settle.

Returns from the first years of the new Inquiry suggest that we shall collect detailed data on almost 1000 cases annually, and we are grateful to consultants who take the time to complete our questionnaires. They can be assured that the information they submit will provide a sound basis for our recommendations on clinical practice and training.

Appleby, L., Shaw, J. & Amos, T. (1997) National Confidential Inquiry into Suicide and Homicide by People with Mental Illness. *British Journal of Psychiatry*, **170**, 101–102.

Morgan, H. G. (1997) National Confidential Inquiry into Suicide and Homicide by Mentally Ill People (letter). *British Journal of Psychiatry*, **170**, 579–580.

L. Appleby, J. Shaw & T. Amos National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, The University of Manchester, School of Psychiatry and Behavioural Sciences, PO Box 86, Manchester M20 2EF

Psychiatry and the Church

Sir: I read with interest Archbishop Carey's editorial (Carey, 1997) and agree with Sims (from whom Carey quotes) that for too long psychiatry has avoided the spiritual realm. However, I would point out that the Church does not have a monopoly on addressing this area. If the individual is considered from a developmental point of view, organised religion as a psychosocial construct certainly has a role to play in promoting stability, validating and confirming an individual at their particular stage of development, and providing a socially legitimate world view. The Church is excellent at helping people in fulfilling their need to belong (Maslow, 1971) and is becoming better at addressing self-esteem needs. Similarly, it promotes conscientious/conformist self-sense (Loevinger, 1976) and Kohlberg's (1981) conventional moral sense. What it does not do is encourage growth from each stage of development (with respect to needs, self-sense and moral sense) to higher levels. For example, it does not promote the fulfilment of the individual's need for self-actualisation/self-transcendence. It could be argued that by making existence at a lower level more comfortable, it is actually inhibitory to further development.

There are certainly religions that do promote such growth and an increasing number of individuals at higher developmental levels, either within organised religious structures or who have made their progress alone. Wilber (1983) distinguishes between religions promoting vertical growth, which he calls 'authentic', and those that provide a lateral expansion or consolidation at a particular level of development, which he calls 'legitimate'. It is religion of the latter sort that Archbishop Carey describes.

Psychiatry needs to become a discipline capable of providing a service in the future. However, far from linking itself to an organisation which legitimately caters for the needs of an individual and society at a given developmental level, it should remain flexible enough to be of value to people at all levels of development, from the most regressed, psychotic individual at the pre-personal end of the spectrum, to the rare but increasing number of people who are suffering with disorders of mind at above 'normal' levels of development. While I welcome the cooperation between Christianity and psychiatry that Archbishop Carey proposes, I would be keen to ensure that this was not a strictly monogamous relationship, but that links are made between psychiatry and other potentially helpful psychosocial constructs, both legitimate and authentic.

Carey, G. (1997) Towards wholeness: transcending the barriers between religion and society. *British Journal of Psychiatry*, **170**, 396–397.

Kohlberg, L. (1981) *The Philosophy of Moral Development*. San Francisco, CA: Harper and Row.

Loevinger, J. (1976) *Ego Development*. San Francisco, CA: Jossey-Bass.

Maslow, A. (1971) *The Farther Reaches of Human Nature*. New York: Viking.

Wilber, K. (1983) *Eye to Eye: The Quest for the New Paradigm*. Boston, MA: Shambhala.

P. Daborn Hamilton West Community Mental Health Service, Collingwood House, 206 Collingwood Street, PO Box 1372, Hamilton, New Zealand

Paroxetine withdrawal syndrome in a neonate

Sir: We report a suspected case of neonatal withdrawal syndrome after maternal use of paroxetine throughout the third trimester of pregnancy.

A 36-year-old woman had been treated with clomipramine for several years. She

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