weeks following discharge from abstinence-oriented residential treatment.

In common with centres in Britain and Australia, addiction treatment services in Dublin are oriented towards harm reduction. However, there is no conflict between a goal of harm reduction yet continuing to provide patients with the option of an abstinence-based treatment such as that examined in our study. In all medical specialties, doctors are charged with the responsibility of weighing up the advantages and disadvantages of various treatment options. There are many circumstances in which patients will have to choose between a more conservative treatment option and a more aggressive approach with a higher risk but a greater reward.

In the case of opiate dependence, both clinicians and patients in Dublin are fortunate to have the option of both methadone maintenance and abstinence-based treatments. Although there are real risks of accidental overdose associated with the latter, we believe that in a therapeutic relationship that is collaborative and respectful, the patient should be given the choice. Denying them the choice of an abstinence-based treatment would represent a retreat to a paternalistic approach to medicine which was so commonplace a generation ago and which is criticised by patient groups today. At the other end of the spectrum, there are many countries where patients are denied, or have very restricted access to, methadone maintenance treatment (Kakko *et al*, 2003; World Health Organization, 2004). This has occurred when treatment options have been determined by politicians instead of clinicians and decisions have unfortunately being driven by ideology rather than evidence.

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Diagnostic stability and status of acute and transient psychotic disorders

We read with interest the article by Pillmann & Marneros (2005). Acute and transient psychosis is a common clinical presentation in the developing world. We retrieved medical records of all patients with psychotic disorders (F06.0–06.3, F20–29, F30.2, F31.2, F31.5, F32.3, F33.3) who attended our unit from 1 January to 30 September 2003. There were 87 patients (13.9%) with a diagnosis of acute psychosis (ICD–10 F23). The majority were young adults (mean age 29.75 years, s.d.=10.95), male (52%) and without a history of precipitating stress (71%) or similar illness (93%). The mean duration of follow-up was 13.2 months (s.d.=11.7). The diagnosis was revised to affective disorder in 8 patients (9.2%), schizophrenia in 23 (26.4%), and 10 patients (11.5%) presented with recurrent episodes of acute psychosis.

The high drop-out rate has been attributed to a good response to antipsychotic medication, spontaneous remission and/or preference for indigenous treatments (Raguram *et al*, 2002). Most studies of acute psychosis have small samples (Susser *et al*, 1998; Marneros *et al*, 2003; Pillmann & Marneros, 2003; Singh *et al*, 2004) and there are no large long-term follow-up studies of acute psychosis from the developing world.

The introduction of the categories acute and transient psychotic disorders in ICD–10 and brief psychotic disorder in DSM–IV has allowed for coding of patients with a single episode of illness. However, there is also a need to categorise people who present recurrently with such episodes. Future classification should consider such a category.

Acute psychotic presentations can be secondary to organic psychoses and substance dependence. Psychiatrists often subscribe to the Kraepelinian dichotomy and attempt to label all functional psychosis as schizophrenia or affective disorders. However, clinical presentations of acute psychosis challenge such categorisation. Although many patients recover, some relapse with similar acute psychotic presentations, and a significant proportion also develop classic schizophrenia and mood disorders. The difficulty in reaching a diagnosis at the time of the initial presentation is because it is often difficult to recognise the classic syndromes at the onset of the illness. However, these can be identified over time as they become more obvious. Thus, acute psychoses can be a presentation of organic psychoses, substance-induced disorders, schizophrenia, affective illness or may be 'micro-psychotic' episodes that occur in some personality disorders. They can also be separate clinical entities. Clinicians working in the developing world are often aware of this distinction.

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White matter in liars

Yang *et al* (2005) propose a neurodevelopmental theory of pathological lying, finding increased prefrontal white matter and lower prefrontal gray/white ratios in pathological liars compared with antisocial and normal controls. Spence (2005) asks whether these findings represent cause or effect. Since lying is a criterion symptom for childhood conduct disorder, we re-examined a structural magnetic resonance imaging study of early-onset conduct disorders (Kruesi *et al*, 2004 plus unpublished data).

Youths had been classified as liars or not based upon structured interviews and collateral information when documenting criterion symptoms of conduct disorder. Liars (n=6) were compared with individuals with conduct disorder (n=4) and with healthy volunteers (n=10). The mean ages of the three groups (191.5, 195 and 190.8 months) were similar ($F(2,19)=0.015$). In accordance with developmental differences, ratios of prefrontal white volume to total