Correspondence

EDITED BY KIRIAKOS XENITIDIS and KHALIDA ISMAIL

Contents ■ Combating editorial racism ■ Prevention of psychosis ■ Guided self-change for bulimia ■ What is a traumatic event? ■ Potentially preventable suicide ■ Transcranial direct current stimulation in developing countries ■ Drug combinations for rapid tranquillisation ■ Limitations of rapid tranquillisation trial ■ Who pays the piper? ■ Begetting drunkards

Combating editorial racism

I was delighted to see the editorial on ‘Combating editorial racism in psychiatric publications’ (Tyrer, 2005). You liken this to those from the world’s poorest countries always playing uphill and into a howling gale. How about taking away their football boots?

I applaud Professor Tyrer for addressing this problem and want to reciprocate with this contribution. Black and minority ethnic groups within the wealthy 10% of the world’s population have a responsibility to engage and link with those in the remaining 90% to ensure that knowledge and research are disseminated as widely as possible and, importantly, to ensure that this has an effect on those receiving psychiatric services. An example of this two-way synergy is work my (White) colleague and I have completed on the emotional effects of the troubles in Northern Ireland (Kapur & Campbell, 2004). In applying a psychoanalytic model to the conflict we have attempted to highlight the emotional traumas suffered in everyday life. This suffering is universal. Archbishop Tutu kindly agreed to write the foreword because he knew, half-way across the world, that we had one particular experience in common: playing uphill against a howling gale in our football socks.

But there is hope; as long as people continue to speak out we can make good use of recent research findings which suggest that prejudice is not ‘hard wired’ in the amygdala (Wheeler & Fiske, 2005). If you change the context in which people are seen, prejudice can lessen. For example, contributors from Black and minority ethnic groups are part of a professional community first, rather than part of a particular race. I will now prepare my next paper for submission to the Journal (it has been 17 years since my last one; Kapur et al, 1988).


R. Kapur Threshold, 432 Antrim Road, Belfast BT15 5GB, Northern Ireland. E-mail: loretta@thresholdservices.com

Prevention of psychosis

The Editor is of course right to highlight the potential importance of the work by Morrison and colleagues (2004) and how this must be weighed against possible methodological flaws. While the authors acknowledge most of these, there are some aspects of the study which deserve further clarification. For example, the exclusion of two cases after randomisation to the cognitive therapy group owing to the fact that they had apparently been psychotic at inception could be justified. It is stated that ‘all other participants were questioned about this possibility’ – however, can we be sure that psychosis at that earliest stage was rooted out equally assiduously in both groups, cognitive therapy and ‘control/monitoring’?

Another matter discussed is the randomisation procedure, which resulted in unequal group allocation. The authors state boldly that this was due to chance, and the methodology for randomisation (stratified for gender) as described seems to be sound. However, I am not sure I would be happy to accept a reprieve from a gloomy fate on the basis of ‘tails’ on the toss of a coin, in the knowledge that it had previously yielded ‘heads’ 37 times out of the last 60. Let’s just imagine that somehow a gremlin interfered with the randomisation process so that the patients who seemed less likely to decompensate, the majority, were steered into the therapy group. This would produce the observed pattern. This gremlin need not even be credited with much clinical foresight since prediction of onset of psychosis in a very high-risk group of 20- to 21-year-olds is quite simple given one of the most robust findings in the epidemiology of schizophrenia, namely the later age of onset in females. So, as long as more females find their way into the intervention group, a better short-term outcome is virtually assured. Morrison et al ended up with 40% females in the cognitive therapy group v. 17% in the control group. It may all be due to chance and adjustable in the logistic regression analysis, but given the impossibility of delivering a psychological intervention blindly, the integrity of the randomisation procedure must be beyond question.


A. S. David Section of Cognitive Neuropsychiatry, PO Box 68, Institute of Psychiatry, London SE5 8AF, UK. E-mail: a.david@op.lcl.ac.uk