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 to our book and here we have an example of a synergy that has facilitated ideas from psychoanalysis, which has struggled with cultural diversity (Littlewood, 1988; Littlewood & Lipsedge, 1997), being shared and validated by a nation, South Africa, which like Northern Ireland has suffered its own experiences of political oppression with the consequent infliction of trauma.

The problem with playing the 'race card', as you note, is that it can be seen as an excuse for work that may not reach the standards of a particular journal. Or, vice versa, the work might be of too high a standard and thus 'show up' lesser publications of the other 10%, mainly White contributors! The problem with not protesting is that there is an institutional collusion with racism which opposes merit and excellence and only leaves feelings of injustice which we suggest (Kapur & Campbell, 2004) is a major cause of terrorism. Maybe Archbishop Tutu 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).

Kapur, R. & Campbell, J. (2004) *The Troubled Mind of Northern Ireland: An Analysis of the Emotional Effects of the Troubles*. London: Karnac.

Kapur, R., Miller, K. & Mitchell, E. (1988) Therapeutic factors within in-patient and out-patient psychotherapy groups. Implications for therapeutic techniques. *British Journal of Psychiatry*, **152**, 229–233.

Littlewood, R. (1988) Towards an intercultural therapy. *Journal of Social Work Practice*, **3**, 8–19.

Littlewood, R. & Lipsedge, M. (1997) *Aliens and Alienists: Ethnic Minorities and Psychiatry* (3rd edn). London: Routledge.

Tyrer, P. (2005) Combating editorial racism in psychiatric publications. *British Journal of Psychiatry*, **186**, 1–3.

Wheeler, M. & Fiske, S. (2005) Controlling racial prejudice: social–cognitive goals affect amygdala and stereotype activation. *Psychological Science*, **16**, 56–63.

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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 cogntive 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.

Morrison, A. P., French, P., Walford, L., *et al* (2004) Cognitive therapy for the prevention of psychosis in people at ultra-high risk. Randomised controlled trial. *British Journal of Psychiatry*, **185**, 291–297.

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