Highlights of this issue

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ETHNIC VARIATIONS AND ENGAGEMENT WITH MENTAL HEALTH SERVICES

Mental health services are unattractive to people in some ethnic groups, who complain of more-coercive treatments and adverse experiences. Bhui *et al* (pp. 105–116), in a systematic review, identify ethnic variations in pathways to specialist mental health services, continuity of contact, and compulsory psychiatric in-patient admission. Strong evidence of variation between ethnic groups exists. Black people are over-represented among in-patients, and Asian patients use in-patient facilities less often than White patients do. Black people traverse more complex pathways to care, and in in-patient units are up to four times more likely to experience a compulsory admission compared with White people. Black people do not appear to fall out of contact more often than others do. Tait *et al* (pp. 123–128) find that individuals' recovery styles contribute more than their level of insight to engagement with services.

PERSONALITY DISORDER, DESTRUCTIVE BEHAVIOUR AND DIALECTICAL BEHAVIOUR THERAPY

Verheul *et al* (pp. 135–140) add to the growing evidence that dialectical behaviour therapy (DBT) is an effective treatment of high-risk behaviours in patients with borderline personality disorder. In a randomised controlled trial of DBT *v.* treatment as usual in 58 women with borderline personality disorder, those receiving DBT had a substantially lower attrition rate and displayed a greater reduction in self-mutilating behaviours and self-damaging impulsive acts. The authors suggest that, although probably not effective for other core features of borderline personality disorder, DBT may be the treatment of choice for those who display severe, life-threatening impulse control disorders. Surprisingly, the association between comorbid personality disorder and violence in community-dwelling patients with psychosis has not previously been explored. Using data from the UK700 study, Moran *et al* (pp. 129–134) find that the presence of a comorbid personality disorder significantly predicts the likelihood of assault against others.

DOES IMMIGRATION PREDICT SCHIZOPHRENIA?

An excess of schizophrenia has been found among immigrants. Cantor-Graae *et al* (pp. 117–122) studied immigrant background and history of foreign residence as risk factors for schizophrenia using the Danish Psychiatric Case Register. By studying a cohort of people residing in Denmark by their 15th birthday, the impact of selective immigration was minimised. Foreign birth (first generation) and background (second generation) were found to predict schizophrenia. An increased risk was also found among people with a Danish background who had a history of foreign residence prior to their 15th birthday. The authors suggest that immigration may confer an increased risk of schizophrenia that is independent of foreign birth or background.

UNIVERSAL TRAUMA REACTION DOES NOT EXIST

Disagreement exists as to whether post-traumatic stress disorder existed (known by different names) prior to modern diagnostic classification systems or whether it is a modern presentation resulting from the interaction of trauma and culture. Using random selections of servicemen who fought in wars from 1854 onwards, Jones *et al* (pp. 158–163) test whether one core symptom of post-traumatic stress disorder, the flashback, has altered in prevalence over time in soldiers subjected to intense combat stress. Although flashbacks existed during the First and Second World Wars their incidence was found to be significantly lower. It is suggested that servicemen at that time tended to express the stress of battle in somatic terms. Findings suggest that the psychopathology of trauma is not static and that culture has an impact on the expression of distressing memories.

BIPOLAR DISORDER UNDERRESEARCHED

Debate continues over the most appropriate first-line therapy for acute mania. Although combination therapy is commonly used in clinical practice and may offer advantage over monotherapy, few well-controlled studies of such an approach have been conducted. In a 3-week double-blind placebo-controlled trial, Yatham *et al* (pp. 141–147) find risperidone to be superior to placebo when used in combination with lithium or divalproex in acute mania. Additionally, risperidone was efficacious in patients both with and without psychotic features. The need for further research in bipolar disorder is underlined by Clement *et al* (pp. 148–152), who compared research activity in this disorder with that in schizophrenia using a search of research-related databases. Ratios (bipolar disorder:schizophrenia) ranged from 1:1.3 for the number of research funding awards to 1:7.6 for the number of clinical trials. With no specific consideration in the UK National Service Framework for Mental Health and with very few specialist services for bipolar disorder, research interest may be intertwined with the level of clinical interest in the condition.

COUNSELLING IN THE WORKPLACE: DOES IT WORK?

Our second 'In debate' column (pp. 103–104) proves a lively read. McLeod extols the virtue of this generic form of counselling, highlighting the evidence for employee satisfaction, resolution of problems, positive organisational outcomes and reduced absenteeism. Henderson questions how a single treatment modality can effectively treat such a heterogeneous group of problems. Decide for yourself.

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