Highlights of this issue

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ETHNICITY, VIOLENCE, CULTURE AND SUICIDE

Psychiatry is concerned with providing humane care to all and avoiding discrimination on any grounds. Gudjonsson *et al* (pp. 258–262) examined how ethnicity influenced the management of in-patients who had been involved in violent incidents – documented on all the general psychiatric wards in one psychiatric hospital. Black patients were more likely to receive emergency medication and be secluded than were White patients. However, this difference was not evident once confounding variables such as age, gender, section type and nature of target were accounted for. The conclusion is that racial stereotyping was unlikely to have been major factor in patient management following a violent incident. Racial stereotyping may be involved in the elaboration of culture-bound syndromes, which are often perceived as esoteric phenomena lying outside the mainstream. Sumathipala *et al* (pp. 200–209) review the literature on *dhat* syndrome and conclude that the syndrome is currently prominent in south Asia, but a similar syndrome was evident in Europe in the 19th century. They suggest it is neither a culture-bound syndrome nor a homogeneous entity; and it is more valuable to interpret symptoms within the cultural background of the individual so as to understand its effect on the expression and evaluation of symptoms and dysfunction. A distinct subculture is thought to exist within prisons, and the medical care of prisoners has often been marginalised; the number of suicides in prison in England and Wales has increased over recent years. All self-inflicted deaths over a 2-year period were examined by Shaw *et al* (pp. 263–267) who go on to propose several measures to reduce risk in the future. The measures include the provision of dedicated supervised reception wings for prisoners identified at risk; that high-risk prisoners should be kept in cells without window bars and that the bed linen provided should be of a type that cannot be used for hanging or strangulation. Other suggestions echo those of 'untoward incident inquiries' and include better communication with other agencies, particularly for prisoners with previous contact with primary and secondary care, access to prison detoxification services and the organisation of timely follow-up especially for those discharged from prison in-patient facilities. The continuing increase in the numbers within prisons places an ever-increasing load on medical care and these strategies should serve to reduce risk of suicide.

GENES, ENVIRONMENT AND PSYCHOPATHOLOGY

A multifactorial aetiology, including genes and environmental factors, has been postulated in many psychiatric disorders, including eating disorders and schizophrenia. In this issue, the relationship between feeding problems in childhood and eating disorder in the mother is examined within a general population. Cooper *et al* (pp. 210–215) show that two environmental factors, the degree of mealtime disorganisation and the level of maternal 'strong control and disharmony', mediate the association between maternal eating disorder and child feeding disturbance. In a related editorial Lacey & Price (pp. 195–196) review the important concepts involved, ranging from the historical psychopathogenic mother to the more recent elaboration of psychosomatic families and contemporary longitudinal family studies. They suggest that the most fruitful therapeutic direction is to adopt a supportive, educational and non-critical approach, together with family therapy where indicated. This is probably relevant to psychiatric disorders beyond the treatment of eating disorders in childhood. Within schizophrenia-spectrum disorder, it is demonstrated that adopted-away offspring of mothers with schizophrenia-spectrum disorder are significantly more sensitive to an adverse family rearing pattern than the adoptees of healthy mothers (Tienari *et al*, pp. 216–222). The same data can be interpreted as showing the protective effect of being reared in a healthy adoptive family, with the morbid risk for these high-genetic-risk adoptees developing schizophrenia in healthy families at 1.49% compared with 13% for those reared in dysfunctional families. This lends significant support to the stress–diathesis model of the aetiology of schizophrenia-like psychopathology, in which environmental stressors have a particularly deleterious effect only on individuals with a genetic vulnerability.

COGNITIVE–BEHAVIOURAL THERAPY REVISITED

Cognitive–behavioural therapy (CBT) has been recommended for the treatment of positive symptoms in schizophrenia. The evidence from an 18-month follow-up of a randomised controlled trial of CBT shows no benefit of the CBT or of supportive counselling over routine treatment on outcome measures such as relapse or re-hospitalisation. Also, CBT was not superior to supportive counselling on symptom measures at 18-months, although both interventions were better than routine treatment. Tarrier *et al* (pp. 231–239) suggest that the duration of psychological therapy may have been too brief, at an average of 8 hours over 5 weeks, which was well below the target and recommended therapy time of 15–20 hours. While this study used highly trained therapists, Huibers *et al* (pp. 240–246) used general practitioners to deliver a CBT package aimed at treating unexplained severe fatigue in 151 patients off work on sick leave. After the intervention, delivered in 5–7 sessions over 4 months, there were no differences in fatigue severity, absenteeism and clinical recovery between the treated and an untreated comparison group. The authors draw two main conclusions; first, that effective trials in secondary care do not necessarily translate successfully into primary care and second, that it may be difficult for CBT to be delivered effectively by non-specialists, even after providing limited training and ongoing supervision. The process of the delivery of CBT would require further attention.

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