References

ESMAIL, A., EVERINGTON, S. & DOYLE, H. (1998) Racial discrimination in the allocation of distinction awards? Analysis of list award holders by type of award, specialty and region. *British Medical Journal*, **316**, 193–195.

MACPHERSON, W. (1999) *The Stephen Lawrence Inquiry*. London: The Stationery Office.

PARKMAN, S., DAVIES, S., LEESE, M., *et al* (1997) Ethnic differences in satisfaction with mental health services among representative people with psychosis in South London: Prism Study 4. *British Journal of Psychiatry*, **171**, 260–264.

PETER L. CORNWALL, *Senior Lecturer in Community Psychiatry, University Department of Psychiatry, Royal Victoria Infirmary, Newcastle upon Tyne NE1 4LP*

Sir: Hickling & Hutchinson (*Psychiatric Bulletin*, March 1999, **23**) are to be congratulated on their attempt to link the experience of racism to mental illness for a general psychiatric publication. Yet, apart from Fanon, there is nothing so very new in this (Parker & Kleiner, 1975; Royer, 1977; Littlewood, 1981; Adebimpe, 1984). Where they have failed is in not suggesting any intermediate pathways between a social and political situation and the neuropsychological consequences of what psychiatry takes as schizophrenia. Not an easy undertaking admittedly: though the apparent high rates in Irish and Maori people, and other groups, might suggest something which links politics to self-depreciating identity via language use.

The authors use of 'pejorative' is puzzling given that they themselves consider an identity as a 'psychosis'. My account of *tabanka* in Trinidad was to show how this type of sexual desertion was locally construed as a form of illness (Littlewood, 1993). Indeed in the early 1980s it was common for country people to maintain there was a ward in the state psychiatry institution specifically for victims of *tabanka*.

References

ADEPIMPE, V. R. (1984) American blacks and psychiatry. *Transcultural Psychiatric Research Review*, **21**, 83–111.

LITTLEWOOD, R. (1981) Anthropology and psychiatry: an alternative approach. *British Journal of Medical Psychology*, **53**, 213–225.

— (1983) *Pathology and Identity: The Work of Mother Earth in Trinidad*. Cambridge: Cambridge University Press.

PARKER, S. & KLEINER, R. (1975) *Mental Illness in the Urban Negro Community*. New York: Free Press.

ROYER, J. (1977) *Black Britain's Dilemma*. Roseau: Tropical Printers.

ROLAND LITTLEWOOD, *Professor of Anthropology and Psychiatry, University College Centre for Medical Anthropology, Gower Street, London WC1E 6BT*

Sir: Hickling & Hutchinson's (*Psychiatric Bulletin*, March 1999, **23**, 132–134) criticism of international classification systems is erroneous. Such diagnostic systems have been internationally piloted (Sartorius *et al*, 1988) and the resulting consensus accounts for the priority given to form rather than content. Thus, the symptomatic concerns of patients from all cultures may map poorly onto rigid diagnostic guidelines. In this and other respects, the proposed 'roast breadfruit psychosis' resembles the descriptions of de Clérambault's, Capras and Othello syndromes (Enoch & Trethowan, 1979). They represent human beliefs and behaviours, which only become classifiable when exaggerated to a psychotic degree. The memorable and symbolic themes of such syndromes make them a favourite of examiners, the topic of coffee room discussions and the inspiration for works of fiction (McEwan, 1998). This attention is, perhaps, out of proportion to their prevalence.

Diagnosis should be a synthesis of classification and understanding. By proposing a content-based diagnostic category, the authors are asking mental health professionals to risk ignoring the meaning of patient's complaints; to act as an arbitrator of cultural authenticity and to adopt a term of intra-racial abuse as an eponym. Do the authors expect that use of the term roast breadfruit syndrome will improve the relationship of psychiatrists and African–Caribbean patients?

References

ENOCH, M. D. & TRETHOWAN, W. H. (1979) *Uncommon Psychiatric Syndromes*. Bristol: John Wright and Sons.

MCEWAN, I. (1998) *Enduring Love*. London: Vintage.

SARTORIUS, N., JABLENSKY, A., COOPER, J. E., *et al* (eds) Psychiatric classification in an international perspective. *British Journal of Psychiatry*, **152** (suppl. 1), 1–52.

TIM BRANTON, *Senior Registrar Old Age Psychiatry, High Royds Hospital, Menston, Ilkley, West Yorkshire LS29 5AQ*

Replicating mistakes in Aboriginal mental health

Sir: Dr Laugharne, in his article about working with an Aboriginal community in Australia (*Psychiatric Bulletin*, February 1999, **23**, 111–113), shows great sensitivity and insight into the historical, political and social context that

Aboriginal communities find themselves in. He, I suspect, rightly asserts that the mental health problems facing Australian Aborigines cannot be understood and worked within, without "reflecting the broader political and social issues". He also notes the positive strengths of Aboriginal people such as strong family ties and the communities increasing confidence and self-empowerment.

Given Dr Laugharne's admirable respect for context and sensitivity to cultural issues why, I must ask, has he appeared to replicate the very mistake he rightly criticised earlier well-meaning non-Aboriginal workers for making. For example, he noted how the view among those who sought the welfare of Aboriginal Australians was that "assimilation of Aboriginal people into the dominant White population was the only way forward", and that such attitudes persisted up to the early 1970s. He recognises that such attitudes marginalise and belittle the Aborigines' own culture and way of life. This is of course the attitude of the colonialist.

Yet, in his own attitude towards understanding mental health problems in Aborigines, Dr Laugharne makes no mention of the Aborigines' own beliefs and practices around mental health issues. Instead he is clear that those in his practice including himself have attempted to use "our Western model psychiatry" and in that respect he states that "I have tried to focus my energies primarily on the diagnoses and treatment of psychiatric disorders".

Surely Dr Laugharne should be aware that he is acting in the same manner as the colonialists he earlier criticised. Western psychiatry has developed through its own historical and cultural context a way of describing mental health problems and subsequently dealing with them. It is as subjective as any other belief system. To impose it on another community who are likely to have their own historical and cultural context within which they have developed their own subjective belief system concerning mental health issues and have to deal with them, has the same effect. It marganialises and belittles the value of the communities' own knowledge on this subject. Dr Laugharne should focus his energies on learning more about Aboriginal communities' own beliefs and practices around mental health issues and help them feel empowered to use this for their benefit.

SAMI TIMIMI *Consultant Child and Adolescent Psychiatrist, Child and Family Consultation Service, 250–252 Katherine Road, Forest Gate, London E7 8PN*

Author's reply

Sir: In response to Dr Timimi's comments I must firstly emphasise that I was recruited into a post within a community-controlled Aboriginal medical service which had been created under the initiative of that service. My managers were Aboriginal and frequent discussions with them made it clear to me that they wanted the best health care for their community through the best of Western medicine alongside traditional practices. My skills are in 'Western psychiatry' and this is what my Aboriginal managers and colleagues wanted from me. Furthermore, I cannot agree with Dr Timimi that Western psychiatry is merely a subjective belief system. I consider it to have a degree of scientific validity which makes it a useful discipline across cultures.

In regard to traditional approaches to healing, these were encouraged in line with the philosophy of my organisation. On several occasions families sought out traditional healers and we supported these approaches. Funds were available to facilitate this.

As I indicated in my article, other initiatives are vital to address the broader mental health issues. These include political change and specific initiatives from within the Aboriginal community such as projects I have worked alongside which are successfully addressing alcohol-related problems within the community.

It is a great challenge for today's Aboriginal communities to integrate traditional lifestyles with those of European Australia in ways which are meaningful and acceptable for them. When Aboriginal Elders choose to employ Western mental health professionals to use their skills within their communities it would smack of cultural arrogance to instead direct them to be more 'Aboriginal' in their solutions. To do so would, in my view, indicate a gross misunderstanding of the current situation.

JONATHAN LAUGHARNE, *Consultant Psychiatrist and Director of Psychiatry, Coffs Harbour Base Hospital, Coffs Harbour, NSW, 2450 Australia*

Prescriptions, licences and evidence: A reply

Sir: Mr Panting, from the Medical Protection Society, has replied to an article by myself and Professor Nutt (1998) on Off-Licence Prescribing (*Psychiatric Bulletin*, March 1999, **23**, 182) He has stated that we have reported that "the Defence Unions would not support the prescriber prescribing off-licence in the event that things went wrong". This selective quote is in danger of being misleading. In our original article it is quite clear that we believe this to be a popularly held

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