outcome of a research project" (Royal College of Psychiatrists, 1998). However, many trainees find it difficult to undertake a significant research project, and the experience of a failed attempt to achieve publication can be demoralising.

It is important to distinguish between actually doing research, and appraising and applying the results of research in everyday clinical practice. There is a need to shift the emphasis away from publication as the solitary goal of research time. The CTC suggests that clear individual objectives should be set for the use of a trainee's research time, allowing far greater flexibility over the methods by which these are met. Such objectives may include the ability to formulate answerable questions from clinical situations, to confidently appraise research findings, and to use research evidence in developing service provision or evaluating clinical practice. Documented training objectives allow trainees to monitor their own progress and, in conjunction with their research tutor or supervisor, to ensure that their individual needs are appropriately met during higher training.

While undertaking a research project is one way of meeting these aims, other specific training experiences have an important role. Courses and seminars, clearly focused smaller projects (including audit) and other forms of scholarship can enable trainees to reach the consultant level with a clear grasp of the skills needed to inform and improve their practice. The CTC still believes that the research day forms a crucial part of a fully balanced training but needs to be used more effectively and in an individually tailored manner.

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Acquisition of skills during higher specialist training

Sir: Many skills have to be assimilated during training to equip psychiatrists for the role of consultant. A survey was carried out in 1995 (Haddad & Creed, 1996) in the North-West Region among newly appointed consultants in general and old age psychiatry. While consultants in their cohort felt senior registrar (SR) training had adequately trained them in areas of clinical, research, teaching and group work they felt poorly trained in areas of general management, personal management and information technology. As a result of this survey trainers were encouraged to use the poorly rated skills as a menu of topics for discussion in supervision, the deficit areas were used as themes for SR training days and SRs were encouraged to attend management training courses.

The survey was recently repeated using the same methodology. Newly appointed consultants in old age and general adult psychiatry who had trained on the Manchester specialist registrar rotation and were appointed between 1995 and 1999 were contacted. Twenty-three consultants out of a total of 33 (70%) completed the questionnaire. Of the 14 (out of 39) skills rated as poorly prepared, 11 of these were in areas of general management, personal management, working with groups and information technology. Newly appointed consultants also felt less than moderately well prepared in three specific clinical areas: (a) use of cognitive–behavioural techniques; (b) dealing with patient/relative complaints; and (c) giving evidence in court. These three clinical areas had also been rated poorly in the 1995 survey. Of the 14 skills rated as being 'poor' in the 1995 survey 12 of these remained rated as poor.

Despite the introduction of several changes as a result of the previous survey of newly appointed consultants to the training scheme it was evident that there had been little change in the pattern of response. While training courses no doubt play an important part in training it was clear that the areas where consultants felt most confident were areas where they were likely to have had most practical exposure in training. It maybe that the old medical adage 'see one, do one, teach one' has as much relevance to learning management skills as to learning clinical skills. More novel, 'hands on' learning experiences need to be developed to address these areas of perceived deficit.

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The wisdom of Ali G

Sir: Why do Hickling & Hutchinson (*Psychiatric Bulletin*, March 2000, **24**, 94–95) insist on naming what is essentially a delusion of racial identity "roast breadfruit psychosis"? Not only is the term offensive, akin to having named it "bounty bar psychosis", but as Hari Maharaja's erudite response (*Psychiatric Bulletin*, March 2000, **24**, 96–97) pointed out they have simply "extrapolated a cultural concept – into a diseased state".

Confusion over identity is not unique to Black people and racial identity is only one aspect of one's identity that individuals and groups in society struggle to define. In our complex multi-cultural society 'White' culture is increasingly aware of, exposed to, and influenced by 'non-White' culture. We now have 'trustafarians' and comedic characters such as Ali G. A trustafarian is a derogatory term used to describe White teenagers who have both trust funds and Rastafarian hairstyles! Ali G is a comedic caricature of a White man mimicking Black rap/reggae street style and is the invention of a White Jewish comedian.

Ali G became famous after a series of televised spoof interviews with prominent people in the public eye. The interviewees did not realise that Ali G was not the real thing and answered his increasingly ridiculous questions in a naïve, serious or patronising manner. I believe Hickling & Hutchinson have been taken in by a similar spoof – they have decided to analyse the delusional content of individuals with psychosis and in so doing have revealed more about themselves than any new insight into psychotic illness.

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The 'Hitchcock factor' in advertising

Sir: I would be interested in the College's view on pharmaceutical advertising in relation to the current campaign to reduce stigma in mental illness. I have recently been struck by the increasing use of negative images by some of the atypical neuroleptic manufacturers.

The black and white images with stark lighting and plenty of shadow seem designed to provoke feelings of fear and menace. Photographing patients as gaunt almost lupine individuals with sunken eyes, angular cheekbones, long hair and humourless, irritated expressions all seem to emphasise the perceived 'differentness' and threat of people with severe mental illness. Likewise 'case histories' laced with suggestions of suicide or danger to emotive groups such as children alongside pictures of a young woman mutilating herself or a frightened girl huddling behind her mother seem to play on misunderstanding and prejudice about schizophrenia.

The risks of alienation, marginalising and stigmatising people suffering with a severe mental illness by using adverts to

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