Of the 273 patients (4.2% of sample) diagnosed with personality disorder, 23 (8.4%) were Black and minority ethnic patients and 250 (91.6%) were White British patients. The most common diagnosis was emotionally unstable personality disorder (184 cases).

The results of the survey have led us to further consider why there is underdiagnosis of personality disorder in Black and minority ethnic groups. There is a dearth of research evidence and literature examining personality disorder in those groups and existing evidence refers to studies not representative of the UK population.

National Health Service evidence for mental health in Black and minority ethnic populations states cultural differences exist in the way in which psychological distress is presented, perceived and interpreted, and different cultures develop different responses for coping with psychological stressors. The evidence base on risk and protective factors for mental illness is largely drawn from research on White European or North American populations and hence cannot be generalised to Black and minority ethnic populations.[2]

Cultural and racial stereotyping is a common experience in the context of assessment and decisions concerning treatment, and influences the types of services and diagnoses that Black and minority ethnic individuals seek and receive. A Sainsbury Centre for Mental Health report found that there is a cycle of fear fuelled by prejudice, misunderstanding, misconceptions and sometimes racism in mental health services for this group of users.[3]

The concept of personality disorder in itself poses problems with diagnostic uncertainty and is perceived as a stigmatising label. Attempting to redress the balance with regard to personality disorder within Black and minority ethnic groups is made more difficult due to the pre-existing attitudes towards mental illness in these communities. Mental illness can be regarded as a non-entity, a stigma or a taboo. However, it is not only the patients that need educating but also the professionals responsible for detection and management of personality disorders.

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Integrating research into the career of a psychiatrist in the past, present and future?

Following the maelstrom of Modernising Medical Careers and changes to postgraduate training in the UK, trainees' exposure to research has changed significantly. At an early stage, those interested in a research career apply for a limited number of academic clinical fellow and clinical lecturer posts through academic programmes. The latest version of the Royal College of Psychiatrists' Occasional Paper 65, *Specialist Training in Psychiatry*,[1] advocates two sessions of 'protected time' for higher trainees for both research and special interest sessions (unlike the four sessions advocated in the past).[2] Anecdotal feedback from trainees across the country suggests that significant numbers of higher trainees are therefore not conducting research (favouring audit), and although provision is made in the curriculum for research, deaneries are not compelled to enforce this.

Australian colleagues have pointed to this problem in the past[3] and used the analogy of knowledge of research methods and statistics without conducting actual research being akin to that of practising medicine based solely on theoretical knowledge, without patient contact.

Furthermore, at a time when recruitment into psychiatry is in the spotlight, one of the accepted reasons for students neglecting psychiatry as a career choice (perceived lack of a scientific basis)[4] may be accentuated.

The ramifications of this shift could be that an entire generation of psychiatrists stop asking (and testing) the clinically relevant questions and that aspiring students do not enjoy the enriching experience of research.

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