psychiatry often reflect a relationship between colonisers and colonised. It is especially alarming when findings may be utilised in the psychiatric care of large immigrant population in Britain and other countries. We sincerely hope that future excursions into transcultural psychiatry will be undertaken with approved and ethical collaborations and with the recognition that to observe a cultural mechanism and interpret it are two entirely different things. It is clear that a multitude of images and observations must take place and they must be seen through the eyes of both the observers and participants, as the former can only reveal a partial knowledge of the subject at hand. If the purpose of transcultural psychiatry is to impress upon Europeans the differences between themselves and the rest of the world, then certainly Dr Littlewood will agree, there is no difference between transcultural psychiatry and comparative zoology.

HARI D. MAHARAJH
THERESA ANN CLARKE
GERARD HUTCHINSON

St Ann's Hospital
Port of Spain
Trinidad

References

LITTLEWOOD, R. (1985) An indigenous conceptualization of reactive depression in Trinidad. *Psychological Medicine*, **15**, 275–281.

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DEAR SIRS

The letter from Dr Maharajh and his medical colleagues contains so many errors of fact and interpretation that I doubt your columns could bear a detailed riposte.

Suffice to note that these psychiatrists label a local Afro-Caribbean religion as 'schizophrenia'. Whose (post) colonialism? Whose schizophrenia?

ROLAND LITTLEWOOD

University College &
Middlesex School of Medicine
London W1N 8AA

Administration of rectal diazepam

DEAR SIRS

I write to let Dr Kearns know that I encounter a similar problem with the administration of rectal diazepam (*Psychiatric Bulletin*, June 1989, **13**, 314). Recently one ATC (Adult Training Centre) Manager wanted an instructor to be taught how to administer rectal diazepam to a client who was going on holiday with the instructor. The family doctor contacted earlier had asked the manager to put his request across to me as the client in question occasionally comes into hospital for respite care and drug monitoring. When I sought the opinion of the Director of Nursing Services, he reminded me that the UKCC code forbids his nurses to pass on this skill to any person who is not a nurse or a trainee nurse.

It was suggested that a community nurse should fulfil this role. In districts where community nurses are thin on the ground and have never made any input into the training centres, it seems unrealistic to rely on them to respond to emergency calls at the training centres. I entirely agree with the suggestion that a clinically trained member of staff be jointly appointed to the training centres.

I did, in consequence, put in a bid for District Joint Finance for the employment of a liaison nurse between the Health Service and the ATC. The following problems that such an appointment would solve were highlighted:

(a) Afternoon tablets for our clients attending the ATC are handed over to the ATC once every three weeks, except where there has been a change of medication. Senior managers in Social Services ask for week's supply at a time, possibly to limit losses due to break-ins at the centres on week-ends. The pharmacy issues these tablets in individual bottles for three weeks, and nurses are not allowed to decant the tablets or remove a week's supply from the three week stock. I feel that such a liaison nurse between the pharmacy and the ATC would make co-ordination much easier.

(b) Following the nurse grading exercise, our nursing auxiliaries refuse to transport tablets to the training centres, even though they accompany clients to these centres. Currently a staff nurse on the ward has to take these tablets to the training centres. Given that trained nurses are very scarce, it seems an unnecessary way of deploying ward staff. A liaison nurse would correct this anomaly.

(c) Slow recovery after a severe fit and status epilepticus are sometimes grounds for sending epileptic patients back home from the training centres. I think that a liaison nurse could give continued guidance on the management of severe epileptics and so reduce the frequency of these impromptu returns to residential units.

(d) Management of the doubly incontinent client poses a problem to instructors at the training centres. A liaison nurse could pass on skills of their management to these instructors.

(e) When our joint funded special needs unit was opened in 1984 at the training centre, I identified a group of clients in the Health Service

day care who would benefit from a transfer to the new service. Most of them were epileptics well controlled with medication. But their parents objected to the transfer on the grounds that there were no nurses and no ambulances at the training centre. To date, there are still no nurses and no ambulances and the parents have not changed their opinion. The appointment of a liaison nurse could make such transfers easier in the future.

Unfortunately, when all the bids for joint finance were considered, this bid came fifth on the priority list. I know from experiences in the past, that the first two bids get funded only for the next year, but I plan to resurrect this bid every year until it becomes a top priority. As a way forward towards an integrated use of personnel at the service of mentally handicapped persons, it ought to become a priority. It is one facet of Griffith's integrated care in the community. I agree with Dr Kearns that a similar appointment elsewhere would solve the problem he has highlighted.

B. N. NWULU

Beachcroft Unit
District General Hospital
Rotherham, S. Yorks.

Request for ideas for feature films

DEAR SIRS

We are a film company looking for contemporary or historic stories with personal injustice themes to be developed into feature film ideas. These stories could be set within the perimeters of corporate or political prejudices across the spectrum to love tangles, racial discrimination and others.

We feel that the medical profession would be privy to some fascinating case histories ranging from physical injury to mental illness, including memory loss, that would not only be interesting to the public but would also give them a greater understanding of these disabilities.

We would be grateful if readers could come forward with brief outlines of patients that have stood out in their minds. We realise the difficulty in discussing these confidential cases, but do assure respondents of the utmost discretion and in the event of our discussing this with the person concerned, we would of course deal with it in a most tactful way.

One should consider that the most powerful stories are nearly all based on truth, sympathy for the main character being essential, and the simplest of ideas can become very strong film material. Three obvious examples are 'Children Of A Lesser God', 'One Flew Over The Cuckoo's Nest' and more recently 'Rainman'.

If any respondent feels that it would be more beneficial to have a face-to-face discussion on this matter, we would be very happy to do so.

JIM LEE

The Jim Lee Film Company
71 Summer Place Mews
London SW7 3EF

Open letter – Review of research on family therapy and family based intervention

DEAR COLLEAGUE

This is a note requesting your help.

I am currently carrying out a literature review of research into family therapy and other forms of family intervention in the British Isles. I should appreciate it if you would send me references to your work in this field or, preferably, offprints of your papers.

I am particularly interested in tracking down unpublished dissertations and papers. If you, or indeed your students or colleagues, have written unpublished work, I should be grateful if you would let me know how this may be accessed.

Let me outline the scope of the review.

All traceable unpublished and published empirical studies carried out in the British Isles between 1959 and 1989 that fall within the areas outlined below will be included. Case studies and anecdotal accounts of treatment process and outcome will be excluded. All other studies, however methodologically weak, will be considered.

Although the central concern of the review is family therapy, studies of other forms of family intervention are also being traced. The following is a list of those forms of intervention covered by the review.

Family therapy with families where the child, the parents or the grandparents have a presenting problem or where relationship difficulties are identified as the reason for seeking therapy.

Marital therapy with distressed couples or couples seeking to enrich their relationship.

Family conciliation counselling with families where separation or divorce is occurring.

Family bereavement counselling with families where a member has died or suffers from a fatal illness.

Sex therapy for couples who present with psychosexual difficulties.

Psychosocial family interventions to prevent relapse in schizophrenia where a high level of expressed emotion is present in the patient's family.