physicians' discomfort at being presented with conclusions rather than the more usual critical appraisal, and what would this imply for the 'reformed' National Health Service. The new emphasis on local management will bring doctors into much closer contact with the sort of skills seen in business, based often it seems on charisma, people-management ability and ideology, rather than the familiar (safer?) 'medical model' of a broad-balanced review and hypothesis testing. Could be a bit of a culture shock for all of us!

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Multiple Personality Disorder

SIR: Coons (*Journal*, March 1990, **156**, 449) and Ross (*Journal*, March 1990, **156**, 450) criticise Simpson's assertion that multiple personality disorder (MPD) is an "iatrogenic, largely culture-bound condition" (*Journal*, October 1989, **156**, 565). Professor Simpson may overstate the case for the iatrogenic component, but more striking is the readiness of Drs Coons and Ross, both prominent writers in the field, to dismiss this consideration out of hand. Dr Coons suggests that MPD occurs in all countries, but his evidence is anecdotal and is at odds with the experiences of clinicians in the UK. It is my view that the type of patient reported in the American literature is extremely rare in this country.

However, I would accept that short-lived dissociative reactions occur when patients insist for a limited period that they have assumed the identity of another personality. Indeed, it would be odd if such a presentation was not one of the almost infinite variety of dissociative reactions. The evidence in support of this assertion comes from my own clinical experience (Fahy *et al*, 1989) and from the recent paper by Adityanjee *et al* (1989) from India who report three patients with short-lived dissociation of personality. In the Indian cases, as well as our own, the symptoms were seen as stress related, and they resolved without attempting to interview the alternates at length.

It is my contention that these relatively benign reactions may not be uncommon, and are most likely commoner in patients with other neurotic or post-traumatic syndromes. However, to attain the complexity of psychopathology seen in American cases of MPD, some element of reinforcement from therapists, relatives or the media is necessary. MPD researchers have largely ignored this factor in their investigations. Instead, Dr Ross suggests that variations in diagnostic rates between countries may be a reflection of the differing rates of childhood trauma, a theory which is unlikely to be relevant in differences between the UK and USA and which is supported by no evidence whatsoever.

Finally Dr Coons falls back on the tautological argument that the comments of sceptical observers of the MPD scene are rendered invalid because they are not seeing large numbers of real cases. The problem with this argument is simply that sceptics may well be seeing these patients but are coming to different opinions on diagnosis. If the diagnosis of MPD is to gain widespread credibility, then it is up to workers like Drs Ross and Coons to provide evidence of conceptual validity through *controlled* trials studying aetiology and treatment of this enigmatic condition.

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ECT for pseudodementia

SIR: I read with interest the good review article by Benbow (*Journal*, August 1989, **155**, 147–152). Although Dr Benbow talked about the use of electroconvulsive therapy (ECT) in treating the patients who are demented as well as depressed, I was surprised that she did not mention the good response of ECT in 'depressive pseudodementia'.

The term 'pseudodementia' is a controversial one, but it is a fact that in some patients 'functional' depressive disorder may show intellectual impairments and memory difficulties resembling those of organic disorder. Pseudodementia is frequently encountered in elderly patients with the more severe kinds of affective illness (Post, 1982). Post reported that 10% of elderly depressed patients present with pseudodementia. The increased severity of depression could explain the good response of these patients to ECT.

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Psychiatry and ethnic groups

SIR: In their paper on police admissions to a psychiatric hospital, Dunn & Fahy (*Journal,* March 1990, **156,** 373–378) report that for both black and white patients, "treatment does not appear to be independent of diagnosis". We recently completed a survey (Lloyd & Moodley, 1990) in the Bethlem and Maudsley Hospitals of 138 catchment-area in-patients, comparing white patients of British origin with black patients of Caribbean origin, and found important differences as well as similarities in the treatment received by these two ethnic groups in terms of types, routes, and frequency of administration of psychotropic medication, diagnosis, detention under the mental health act, and episodes of violent behaviour, self-harm and absconding. Some of these differences were dependent on diagnosis, others were not.

Black patients of both sexes were more likely to receive a clinical diagnosis of schizophrenia (Yates' $\chi^2 = 3.91$). Black patients with a diagnosis of schizophrenia were more likely to be compulsorily detained than their white counterparts matched for age and sex (Fishers exact test $P < 0.05$). Black patients with a diagnosis of schizophrenia were more likely to have been involved in a violent incident during the index admission (Fishers exact test $P < 0.05$) whereas white patients were more likely to have been involved in an episode of self-harm.

Without matching for diagnosis, significantly more black than white patients received antipsychotic drugs (Yates' $\chi^2 = 6.351$, $P < 0.05$) and depot antipsychotic preparations ($\chi^2 = 8.96$, $P < 0.01$). When matching for diagnosis, age and sex, black patients with a diagnosis of schizophrenia were no more likely to receive antipsychotic medication either orally or by depot injection than their white counterparts.

The dosages of differing antipsychotic drugs given by various routes and frequencies were converted to their equivalents in daily milligrams of oral chlorpromazine using conversion factors derived from a number of sources (Lloyd & Moodley, 1990). Without matching for diagnosis, black patients received higher oral and depot dose equivalents than their white age, sex-matched counterparts ($P > |Z| = 0.04$). These differences disappeared when patients were matched for diagnosis.

White patients who had been involved in a violent incident or were detained under the mental health act received significantly higher doses of antipsychotic medication than informal white patients who had not been involved in a violent incident ($P > |Z| = 0.0080$). This was not the case for black patients who received similar doses of medication whether formal or informal, violent or not.

This suggests that black in-patients were more likely to receive antipsychotic medication, especially depots, because they were more likely to have a diagnosis of schizophrenia. The accuracy of those diagnoses is of central importance. Even if the diagnoses are correct, black patients with a diagnosis of schizophrenia were more likely to be detained under the mental health act than their white counterparts, and to have been involved in a violent incident. It could be argued that this reflects higher levels of disturbance among the black group. Alternatively this could be due to the predominantly white staff's perception of the dangerousness of the black in-patient group. One prevalent myth we discovered while conducting this study was that many of the black schizophrenics in the hospital were "big, dangerous and chronically psychotic". In fact, there were no statistically significant differences between the two ethnic groups for age, height, weight, length of stay, number of previous admissions or length of illness from first presentation. Speculatively, it may be that myths of this sort contribute to differential access to the services and to black patients receiving more coercive means of treatment.

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HLA-DR2-frequencies in affective disorders

SIR: Rieman *et al* (*Journal,* February 1988, **152,** 296) reported on HLA-DR2-frequencies in patients with endogenous depression (bipolar and unipolar type). Seven of 11 patients studied (64%) were DR2-positive compared with a population rate of about 16% (Albert *et al*, 1984).

Serologically-detectable HLA-DR-specifities arise from genetic variation at the $DR\beta_1$-locus coding for the β-chain of the DR-antigens. Since $DR\beta_1$-cDNAs have been cloned (Long *et al*, 1983) and can be used