small sample) between patients with schizophrenia and controls on either Sephadex G-25 or Biogel P-2. Our findings give no support to the view that the patients with schizophrenia can be readily distinguished from normal subjects by an analysis of the chromatographic profile of peptide excretion in urine.

Although we have not studied patients with unipolar and bipolar depression, autism or the hyperkinetic syndrome we consider that the uncertainties concerning the precise methods adopted by the Norwegian workers and the technical difficulties revealed in the course of our investigation cast their conclusions concerning the role of peptides in these conditions in doubt.

The methods used are complex, with many possible sources of variation, and we suggest that a more rigorous and quantitative approach than that so far adopted by this group of workers is required before these findings can be regarded as reflecting on the nature of the disease processes in question.

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Diazepam abreaction

SIR: Recently, Ellis (1990) made some interesting observations about the role of diazepam and other sedative drugs in abreaction interviews. However, this is not the first time such a practice has been adopted. In fact, this practice has been in routine use for more than 15 years in preference to 'amytal test' at the Department of Psychiatry, All India Institute of Medical Sciences, New Delhi, where some of us trained as psychiatrists in the early 1980s. In India, conversion hysteria is a very common clinical diagnosis not only in psychiatric out-patient clinics but in general practice and medical out-patients as well. Intravenous diazepam abreaction interview is generally much safer as compared with the 'amytal test' and can be useful in primary care settings where facilities for intubation and resuscitation are not very good. It is in this setting that a doctor in India encounters numerous cases of conversion hysteria. The use of diazepam abreaction is so common there that one does not consider it to be a rarity worth publishing. We have, incidentally, mentioned this clinical use of diazepam while discussing case histories of patients with multiple personality disorder (Adityanjee *et al*, 1989).

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Racial stereotypes

SIR: The paper by Lewis *et al* (*Journal*, September 1990, **157**, 410–415), is to be commended as an attempt to elucidate British racial stereotypes that may influence diagnostic practice. However, I do not think the study addresses the issue of racism in psychiatry – at least not very fully – and the title of the paper ("Are British psychiatricts racist?") is a misnomer.

In their report on the influence of racial stereotyping on diagnosis, the authors state that their findings refute the claim that British psychiatrists tend to overdiagnose schizophrenia among Afro-Caribbeans. I do not think that such a conclusion can be drawn from their study as reported. The use of case vignettes is a useful tool in this type of research in spite of the obvious drawback (referred to by the authors) that the

attitude to a hypothetical case may not reflect actual practice; and the method has yielded interesting results in an earlier American study (Loring & Powell, 1988) quoted by the authors. However, in using a vignette, great care must be taken to ensure that it is not itself biased with respect to the factors being studied or else that a sufficient number of vignettes are used to control for such bias. (In the American study the researchers controlled for this sort of racial/gender bias by using two vignettes reflecting real cases of a black male and a white female.) Since Drs Lewis *et al* used only one case vignette (which was varied four-ways by altering gender and race), their methodology should have ensured that it did not carry elements within it that raised images of race or gender (apart from direct designation of race and gender). Unfortunately, the authors do not tell us how their vignette was derived. Did it reflect an actual case and if so what was the original gender and race? How did the researchers ensure that the vignette they used did not contain a racial or gender bias (apart from race and gender stated directly)? For example, did they test the vignette devoid of racial and gender categorisation in pilot studies?

I suggest that in reading the case vignette given in their report the image (via a sort of stereotyping) that may develop in the mind of the psychiatrist is of a *black* person before the point is reached (fairly late in the description) when the race of the person is mentioned. I think that the references to religious interest, to the father being a British Rail ticket clerk and to the smoking of cannabis *taken together* may ensure this happening. Therefore I suggest that if, as seems likely, the case vignette used by the researchers gave an image of a black person, this may well persist in at least some instances even when the person is identified as being white. Hence, some (many?) of the 'white' people diagnosed as schizophrenic may have been visualised (as it were) as 'black'. All this may seem far-fetched to the naive reader/researcher. I suggest that neither racism in psychiatry nor the influence of stereotypes in psychiatric diagnosis is simple or straightforward (Fernando, 1988, pp. 44–49). Research in these fields must be handled with sophistication.

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Stress and puerperal psychosis

SIR: The suggestion by Brockington *et al* (*Journal*, September 1990, **157**, 331–334) that, unlike postnatal depression, pre-natal depression is strongly associated with social stress, particularly life events in their investigation, appears to be supported by a study that we have conducted recently (Kitamura *et al*, in preparation).

Of 120 consecutive women recruited from among those attending an antenatal clinic in the obstetrics department of a general hospital in Japan, 19 (16%) were identified as showing onset of affective disorders during their period of pregnancy according to the Research Diagnostic Criteria (Spitzer *et al*, 1978), mainly major depressive disorder ($n = 13$). Interviews were conducted with the Schedule for the Affective Disorders and Schizophrenia (Spitzer & Endicott, 1978). As compared with women without onset of affective disorders (controls), the depressed women were characterised by (a) either first pregnancy or first delivery with past termination of pregnancy (28% v. 5%), (b) early loss of either parent by death (21% v. 5%), (c) low degree of paternal care and maternal overprotection during childhood (26% v. 8%), (d) high scores on the neuroticism (11.8 [s.d. 4.3] v. 8.7 [s.d. 4.6]) and psychoticism (4.4 [s.d. 2.1] v. 3.1 [s.d. 1.9]), subscales of the Eysenck Personality Questionnaire, (e) living in a flat with the expectation of either staying there after the childbirth or that accommodation would become crowded (29% v. 6%), and (f) negative response to the news of the pregnancy by the husband, with a low degree of intimacy (63% v. 13%). The effects of these factors were additive, since the probability of developing the affective disorders was highly correlated with the number of these factors.

These findings and those of Professor Brockington *et al* (1990) strongly indicate that pre-natal depression is mediated through a variety of psychosocial stressors. It seems, therefore, that pre-natal depression is a long-neglected area, warranting further investigation.

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