Why are people from ethnic minority groups designated 'psychotic' more often than white people are?" At least that would have shown what their study is all about and allowed researchers and clinicians to benefit from the findings.

SUMAN FERNANDO
Honorary consultant psychiatrist
Enfield Community Care NHS Trust,
Chase Farm Hospital,
Enfield,
Middlesex EN2 8JL

1 King M, Coker E, Leavey G, Hoare A, Johnson-Sabine E. Incidence of psychotic illness in London: comparison of ethnic groups. *BMJ* 1994;309:1115-9. (29 October.)
2 Fernando S. *Mental health, race and culture*. London: MIND/Macmillan, 1991.
3 Kleinman A. *Rethinking psychiatry. From cultural category to personal experience*. New York: Free Press, 1988.
4 Loring M, Powell B. Gender, race and DSM-III: a study of the objectivity of psychiatric diagnostic behavior. *Journal of Health and Social Behavior* 1988;29:1-22.
5 Kleinman A. Depression, somatization and the new cross-cultural psychiatry. *Soc Sci Med* 1977;11:3-10.

Biological is not synonymous with genetic

EDITOR,—The finding by Michael King and colleagues that the incidence of schizophrenia is as high in the Asian as in the African Caribbean population in north London is intriguing.¹ They should perhaps be cautious in making this assertion as it is based on only seven Asian patients with schizophrenia and is not replicated by larger (although less methodologically satisfactory) previous studies.

I find their interpretation of their results rather puzzling. They quote my paper,² which says that biological rather than psychosocial factors may account for the higher incidence of schizophrenia among African Caribbean immigrants. They seem to assume that biological is synonymous with genetic or constitutional. My argument was that environmental biological factors, notably obstetric complications and intrauterine infections, could be implicated in raising the risk of schizophrenia among African Caribbeans. By contrast, King and colleagues say that if the increased risk arises through environmental factors this means such things as discrimination, racism, and cultural change. Unlike obstetric complications and intra-uterine infections, there is no evidence that psychosocial factors can cause schizophrenia.

Indeed, most psychiatrists now regard schizophrenia as a brain disease, while agreeing that psychosocial stress can contribute to precipitating relapses, just as it can in multiple sclerosis. To extend the analogy between schizophrenia and multiple sclerosis, Dean *et al* found that African Caribbean and Asian immigrants to London had significantly lower rates of multiple sclerosis than did the indigenous white population.³ Proposed explanations related to biological risk factors. No one suggested that racial discrimination was protective. Why do we think so differently about schizophrenia?

JOHN M EAGLES
Consultant psychiatrist
Grampian Healthcare National Health Service Trust,
Cornhill Hospital,
Aberdeen AB9 2ZH

1 King M, Coker E, Leavey G, Hoare A, Johnson-Sabine E. Incidence of psychiatric illness in London: comparison of ethnic groups. *BMJ* 1994;309:1115-9.
2 Eagles JM. The relationship between schizophrenia and immigration: are there alternatives to psychosocial hypotheses. *Br J Psychiatry* 1991;159:783-9.
3 Dean E, McLaughlin H, Brady R, Adelstein AM, Tallet-Williams J. Multiple sclerosis among immigrants in greater London. *BMJ* 1976;i:861-4.

Census categories of ethnic group are limited

EDITOR,—Michael King and colleagues address the issue of ethnic minority group and schizophrenia.¹ Their work raises questions both about

social class and schizophrenia and about the Office of Population Censuses and Surveys' ethnic groupings.

It is uncertain whether the low social class of those with diagnosed schizophrenia is a cause or a consequence of their illness.^{2,3} This potential confounding factor has received scant attention in research on schizophrenia and ethnic group despite the association of certain ethnic minority groups with low social class as determined by occupation.⁴ King and colleagues' focus on first presentation to psychiatric services is the ideal epidemiological framework to examine social class and schizophrenia. However, they do not discuss how typical their cases were in terms of social class in comparison with the local population (which scores highly on the Jarman indices) or the national population.

They may have had insufficient cases to comment on the possible correlation of ethnic group and social class in their sample. This weakens their assertion that belonging to any ethnic minority group predisposes to schizophrenia and other non-affective psychosis. It also reduces the power of their explanation that the "personal and social pressures of belonging to any ethnic minority group . . . are important determinants of the excess of psychiatric disorders. . . ."

Office of Population Censuses and Surveys' categories are an unsatisfactory description of ethnic group. King and colleagues ignore this difficulty and follow the office's guidelines, even when subjects "were unable" to categorise themselves in this system. Intracultural differences can be as important as intercultural differences, which is ignored by the Office of Population Censuses and Surveys' categories. They are administratively convenient, but their interrater reliability is not routinely considered. If this were true of other research instruments they would be discarded on methodological grounds. The degree to which the categories are of doubtful validity as indicators of subjects' self concept has not been examined. Our unpublished research in a court population addresses this.

One hundred subjects were asked to indicate their ethnic group. This generated 31 categories, including seven people who refused to ascribe themselves a category, indicating that they thought it an inappropriate concept; a further seven people said that they were unable to understand the concept. Office of Population Censuses and Surveys' categories assigned by the researcher were occasionally wildly at odds with the subjects' unrestricted assertions. If mental health research is

truly concerned with cultural rather than political categories it must do better than to reduce cultural diversity to eight choices, one of which encompasses an entire continent.

ANNIE BARTLETT
Wellcome Trust research fellow
MATTHEW FIANDER
Research assistant

Department of Mental Health Sciences,
St George's Hospital Medical School,
London SW17 0RE

1 King M, Coker E, Leavey G, Hoare A, Johnson-Sabine E. Incidence of psychotic illness in London: comparison of ethnic groups. *BMJ* 1994;309:1115-9. (29 October.)
2 Hollingshead AB, Redlich FC. *Class position of mental illness. In: Social class and mental illness, a community study*. New York: Wiley, 1958:220-50.
3 Goldberg EM, Morrison SL. Schizophrenia and social class. *Br J Psychiatry* 1963;109:785-802.
4 Ineichen B, Harrison G, Morgan HG. Psychiatric hospital admissions in Bristol. I. Geographical and ethnic factors. *Br J Psychiatry* 1984;145:600-11.

Some ethnic groups may be more vulnerable to extremes of social deprivation

EDITOR,—Michael King and colleagues report a strikingly increased risk of psychotic disorders of new onset across all ethnic minority groups.¹ Their data do not allow an examination of the relative risks of long term psychotic illness within these groups. By analysing data from a register of long term users of services we are able to estimate the relative risk of receiving diagnosis of a long term psychotic disorder for white (United Kingdom/Irish), black (African/African Caribbean), and Asian (Indian/Pakistani/Bangladeshi) groups living in two London boroughs.

Pathfinder provides a locality based specialist mental health service to most of the inner London borough of Wandsworth (Jarman index 23.1) and all of the outer London borough of Merton (Jarman index 13.4). For the past five years an annual census of people aged 16-75 who are currently in contact with the service and who had their first psychiatric contact two or more years ago has been completed by one of us (RP). This long term case register includes the psychiatric diagnosis and ethnic group in addition to data on accommodation, role disturbance, and use of services.

We have analysed the data for the past five years to give estimates of the prevalence and relative risk, by ethnic group, of schizophrenia (table). Overall, the data for chronic psychosis parallel the findings of King and colleagues. The relative risk of being a long term service user with a diagnosis of

Numbers of white, black, and Asian people with schizophrenia on long term case register in Wandsworth and Merton

Year	White		Black		Relative risk* (95% CI)	Asian		Relative risk* (95% CI)
	No	No/1000	No	No/1000		No	No/1000	
Wandsworth								
	<i>n</i> =113 211			<i>n</i> =15 631			<i>n</i> =8290	
1990	205	1.8	111	7.1	3.92 (3.1 to 4.9)	41	4.9	2.7 (1.9 to 3.8)
1991	248	2.2	136	8.7	3.97 (3.2 to 4.9)	41	4.9	2.26 (1.6 to 3.1)
1992	266	2.3	141	9.0	3.84 (3.1 to 4.7)	45	5.4	3.31 (1.7 to 3.2)
1993	248	2.2	152	9.7	4.4 (3.6 to 5.4)	43	5.2	2.37 (1.7 to 3.3)
1994	257	2.3	150	9.6	4.23 (3.5 to 5.2)	51	6.2	2.71 (2.0 to 3.7)
Merton								
	<i>n</i> =105 001			<i>n</i> =6270			<i>n</i> =6387	
1990	182	1.7	26	4.1	2.39 (1.6 to 3.6)	31	4.9	2.80 (1.9 to 4.1)
1991	205	2.0	34	5.4	2.81 (2.0 to 4.0)	35	5.5	2.78 (1.9 to 4.0)
1992	196	1.9	44	7.0	3.76 (2.7 to 5.2)	31	4.9	2.60 (1.8 to 3.9)
1993	205	2.0	34	5.4	2.78 (1.9 to 4.0)	33	5.2	2.65 (1.8 to 3.8)
1994	179	1.7	27	4.3	2.53 (1.7 to 3.8)	33	5.2	3.03 (2.1 to 4.4)

CI=Confidence interval.
*Risk relative to that of local white population.