Reference

POST, F. (1982) Functional disorders. In *The Psychiatry of Late Life* (eds F. Post & R. Levy). London: Blackwell Scientific.

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.

KEITH LLOYD
Department of Psychological Medicine
Kings College Hospital
London SE5

PARIMALA MOODLEY
Maudsley Hospital
London SE5

Reference

LLOYD, K. & MOODLEY, P. (1990) Ethnicity and psychiatric in-patient medication (submitted for publication).

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

as hybridisation probes, RFLP patterns can be detected which correlate with known HLA-DR-specifities. As devised by Cox *et al* (1988), identification of most specifities is possible by analysis of RFLP patterns obtained after digestion of genomic DNA with the restriction endonuclease TaqI. There are only two exceptions: DR3 cannot be distinguished from DRw6, nor DR7 from DRw9 by this procedure.

In order to re-examine the hypothesis of a possible association of HLA-DR2 to affective disorders in a larger sample, we investigated 88 patients (53 females, 35 males) diagnosed according to DSM–III criteria (American Psychiatric Association, 1980). Fifty-seven of the patients had bipolar illness and 31 had major depression. Thirty-two showed a family history of affective disorders. Age-of-onset ranged from 14 to 64 years.

One hundred people recruited from medical students and medical and laboratory staff served as control probands, and those who had first-degree relatives with affective disorders or a personal history of psychiatric illness were excluded from the study. The female:male ratio was 51:49. All the subjects tested were Caucasians of European origin. The laboratory procedures followed standard protocols.

In our sample of patients with affective disorder, HLA-DR2 is less frequent (8%) than in healthy control probands (16%). The other DR-specifities were not different between patients and controls. Calculation of a 2×2 χ^2 statistic for the frequencies of HLA–DR2 in patients and controls even reaches borderline statistical significance ($\chi^2 = 4.245$; $P = 0.039$) without correction for multiple testing.

Obviously, our results do not confirm those found by Riemann *et al*. Since population association studies are well known to be affected by stratification effects, we would not claim a negative association of DR2 to affective disorders. In any case, we could not replicate the reported association of HLA-DR2 to affective disorders.

Acknowledgements

JK is a recipient of a fellowship of Northrhine-Westphalia. We thank Professor Bernard Mach, Geneva, for kindly providing us with the DRβ-probe.

JUDITH KÖRNER
PETER PROPPING
Institute of Human Genetics of the University
Wilhelmstraße 31
5300 Bonn 1, FRG

JÜRGEN FRITZE
Department of Psychiatry of the University
Füchsleinstraße 15
8700 Würzburg, FRG

References

ALBERT, E. D., BAUR, M. P., MAYR, W. R. (eds) (1984) *Histocompatibility Testing 1984*. New York: Springer-Verlag.

AMERICAN PSYCHIATRIC ASSOCIATION (1980) *Diagnostic and Statistical Manual of Mental Disorders* (DSM–III) (3rd edn). Washington, D.C.: APA.

COX, J. N., MELA, A. P., ZMIJEWSKI, C. M., *et al* (1988) HLA-DR typing "at the DNA level": RFLPs and subtypes detected with a DRβ cDNA probe. *American Journal of Human Genetics*, **43**, 954–963.

LONG, E. O., WAKE, C. T., GORSKI, J., *et al* (1983) Complete sequence of an HLA-DRβ chain deduced from a cDNA clone and identification of multiple non-allele DRβ chain genes. *EMBO Journal*, **2**, 389–394.

Clomipramine for OCD

SIR: The points raised by Chiu *et al* (*Journal*, January 1990, **156**, 112–115) that clomipramine may be useful in treating delusions, and that there may be an association between monosymptomatic delusional states and obsessive–compulsive disorder (OCD), possibly involving an underlying abnormality in serotonin function, are not new.

Over the past few years ideas concerning the identity of OCD have been changing. Treatment studies in OCD, which consistently demonstrate a selective response to drugs with 5-hydroxytryptamine-(5-HT)-reuptake inhibitor properties and a failure to respond to other conventional antidepressants, anxiolytics and antipsychotic drugs (Montgomery *et al*, in press) suggest a distinct, principally serotonergic abnormality underlying the illness, and an identity separate from the anxiety disorders (with which OCD is currently classified in international diagnostic systems), from depression and from schizophrenia.

Phenomenological studies of OCD also indicate that some of the traditionally-accepted diagnostic criteria – notably the need to resist and to be constantly aware of the senselessness of the symptoms – may not be as important as previously thought. Patients who have been suffering with chronic obsessions and compulsions for many years often, understandably, lose the urge to resist (Stern & Cobb, 1978). The need for complete insight into the absurdity of the phenomena remains a rather more controversial subject. Again, patients with long-standing severe OCD may, at times, appear to fail to recognise the senselessness of their behaviour, while, at other times, may retain complete insight. Insel & Akiskal (1986) review a number of individual cases of OCD where a shift from 'obsessions' to 'delusions' was monitored as the illness became more severe and insight was lost. Interestingly, these 'deluded' patients still responded best to treatment with clomipramine.