to be compared. Dr Brook's assessments of the results are subjective and hence debatable.

We welcome Dr Brook's suggestions that trainees rate their experiences at intervals as this would remove the bias due to retrospective recall; and trainees should continue to identify inadequacies in their training.

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## Are British psychiatrists racist?

SIR: Lewis *et al*'s study of racial bias in psychiatric perception (*Journal*, September 1990, **157**, 410–415) is valuable. While bias may, of course, be elicited with one particular vignette and not with another, it is significant that neither their study nor a similar one of mine (*Journal*, September 1990, **157**, 451–452) found any greater tendency to diagnose schizophrenia among black patients when stated ethnicity was the sole variable. A problem remains, however, of the relationship between the leisurely rating of vignettes and the actual clinical decision-making (in which the differential perception of dangerousness, which Drs Lewis *et al* find, may well be rationalised subsequently through a diagnosis of schizophrenia, on the way to custodial and neuroleptic treatment).

Acute psychotic reactions were rated marginally more frequently in the Afro-Caribbean vignettes than in those of the whites, but I am not certain that Lipsedge and I are as responsible for this as they gently hint. Take the characteristics identified by their respondents, especially in the black vignette: duration less than three months, risk of violence to staff, neuroleptic treatment indicated, and to be charged with criminal damage. Only the first – 'acute' course – corresponds to anything in the clinical profile we derived in the paper (Littlewood & Lipsedge, 1981*b*) accompanying the one they cite (1981*a*). Our profile was based on those patients clinically given a diagnosis of schizophrenia who did not have core symptoms as rated by the research Present State Examination. Furthermore we specified acute 'psychosis' as a stay in hospital of less than three weeks, not three months. In their study, however, schizophrenia is preferentially diagnosed among whites. If there has indeed been a switch in diagnostic preferences among British psychiatrists since 1981 from schizophrenia to acute psychotic reactions for black patients, as a consequence of our paper, this does not seem to have been reflected in recent epidemiological studies. Our use of the term 'acute' was directly related to a Jasperian notion of 'reactivity', not just to duration of the illness. The idea of psychotic reactions of short duration among Afro-Caribbean patients in Britain had been around since at least Tewfik & Okasha's (1965) study. In its stereotyped form this category was criticised for its racism by Lipsedge and myself in a book (Littlewood & Lipsedge, 1982) arguably better known than our papers.

The rather more difficult question is: how and why do psychiatrists use stereotyped judgements? Are they indeed something specific to a psychiatric theory still embedded in imperial fancy, or is it that psychiatric care simply replicates the social power and prejudice located outside medicine? My own vignette study, which showed that medical students before and after they studied psychiatry, and psychiatrists themselves, all had similar perceptions, argues against the ideological power of specific psychiatric theories in themselves.

Both vignette studies would seem to dispute such a power. If transcultural psychiatry in Britain has correctly shifted from its exclusive focus on the black patient to examine the role of the white psychiatrist, we have to be prepared to look at the particular social context of power within which psychiatry operates, which determines the perceptions and responses of both patient and doctor, and their interaction.

Such studies would hardly be independent of an understanding of racism in its wider economic, ideological and coercive forms.

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### References

LITTLEWOOD, R. & LIPSEDGE, M. (1981*a*) Some social and phenomenological characteristics of psychotic immigrants. *Psychological Medicine*, **11**, 289–302.

—— & —— (1981*b*) Acute psychotic reactions in Caribbean-born patients. *Psychological Medicine*, **11**, 308–318.

—— & —— (1982) *Aliens and Alienists: Ethnic Minorities and Psychiatry*. Harmondsworth: Penguin.

TEWFIK, G. T. & OKASHA, A. (1965) Psychosis and immigration. *Postgraduate Medical Journal*, **41**, 603–612.

## ECT following clozapine

SIR: The safety of electroconvulsive therapy (ECT) following clozapine therapy has not been documented. The potential for spontaneous seizure phenomena is of particular concern in light of

https://doi.org/10.1192/bjp.158.1.135a Published online by Cambridge University Press