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 post-natal 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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Erotomania in relation to childbirth

SIR: Murray *et al* (*Journal*, June 1990, **156**, 896) do not discuss the possible role of alcohol in the illness of their patient. Organic factors are well known in the aetiology of this disorder, as described in a number of the references they list. Their patient is described as "never a heavy drinker, she drank two cans of beer most nights in the six months before referral". A statement like this by a 40-year-old mother of two children should have made one press harder about the history of alcohol consumption. For instance, what does "never a heavy drinker" mean? Did she drink spirits? What beer did she drink – some beers are approximately equivalent to six units per can? Is there any independent confirmation of the alcohol history? Is there any question of other drug abuse? In this connection one is bound to note that there were financial problems and that her husband was anxious and irritable and one wonders whether he might have been drinking as well.

Symptoms caused by alcohol would be expected to subside within a matter of weeks in most cases. If alcohol had been considered then she would have been kept in hospital for some weeks for diagnostic purposes before beginning drug treatment, and only if symptoms persisted would other diagnostic possibilities have been considered. One would therefore like to know how long after admission was the trifluoroperazine started, and how soon the resolution of symptoms began.

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Effect of beliefs on grief

SIR: Kavanagh (*Journal*, September 1990, **157**, 373–383), in his otherwise stimulating review of adult grief reactions, almost totally ignores the effect of an individual's belief or not in an 'after life'. Such beliefs can have a significant impact on the attitude of the recently bereaved person to the loss. Dr Kavanagh clearly identifies the possible conflicts between belief and actual experience: "A continuing problem for many people is the challenge that the death can pose to central attitudes by which we maintain goal-directed behaviour ... beliefs about the meaningfulness and fairness of existence ... belief in a divine being ... may also come under threat". However, Dr Kavanagh fails to incorporate an understanding of the benefits such beliefs may give to the sufferer. In the cognitive-behavioural interpretation that he suggests, "normative issues are discussed and irrational guilt is minimised".

Whose baseline is taken in deciding 'normative' and 'irrational'? A firmly held Christian belief in an afterlife of Heaven and Hell would be interpreted by many mental health workers as 'abnormal' and 'irrational'. Yet, to challenge and attempt to deny the sufferer's belief system would, I suggest, be to exacerbate their already significant and normal distress.

Any intervention for grief must make allowance for the philosophical or religious attitudes of the bereaved towards the meaning of life and death. This will help to achieve Dr Kavanagh's laudable aim "to maximise survivors' achievements and minimise the pain they suffer to gain them."

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SLE and multi-infarct dementia

SIR: Green (*Journal*, November 1989, **155**, 707–711) published the account of a 54-year-old woman with abnormal involuntary movements, who, over the years, had been given diagnoses of hysterical conversion syndrome and bipolar affective disorder. It transpired that a single diagnosis of systemic lupus erythematosus (SLE) could account for all these features, based on the evidence of selective micro-infarcts in the frontal and temporal lobes and serum autoantibodies to DNA.

We describe a second case of SLE presenting with protean psychiatric symptoms, again with discrete microinfarcts, this time in the frontal and temporal regions on nuclear magnetic resonance (NMR) imaging.

Case report: A 70-year-old Caucasian woman was transferred to Mossley Hill Hospital with a subcortical dementia-like picture. She had a deadpan expression, was uncommunicative and glided silently about the ward, occasionally with tears streaming down her face. Sometimes she would vary her behaviour by answering questions monosyllabically, or lying down on the floor or attacking other patients.

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