authors are obliged to explain all of our data and not just those bits which confirm our prejudices. Thus, while British psychiatrists seemed to expect more violence from Afro-Caribbean 'cases' – a view implying inferiority – they also saw the illness as likely to be of short duration requiring less medication – a view which is more difficult to classify along this dimension.

The notion of race-thinking introduced by sociologists who study this area is not a Bowdlerisation of racism but a variant of it, potentially more harmful since it is subtle and insidious. The generalisations that, for example, the Welsh are good at rugby and singing and the Jews have a flair for business, do not in themselves imply inferiority, but betray a willingness to describe people on the basis of supposed biological characteristics. People who hold these views can delude themselves that they are not being racist, unlike those who say the Welsh are stupid and the Jews avaricious. There is nothing comfortable about race-thinking since it tends to afflict most of us, including those eager to proclaim their liberal credentials. As Husband (1982) observed wryly: "The essential part of race-thinking is the common sense belief that 'race' is a self-evidently neutral fact, not to be confused with racism which is a special condition of a few disturbed bigots who abuse reality with their prejudice".

GLYN LEWIS
ANTHONY DAVID

*Institute of Psychiatry*
*De Crespigny Park*
*Denmark Hill*
*London SE5 8AF*

### Reference

HUSBAND, C. (1982) *'Race' in Britain: Continuity and Change*. London: Hutchison.

## The GHQ and the HAD

SIR: The study by Lewis & Wessely (*Journal*, December 1990, **157**, 860–864) provides example of the misuse of the Hospital Anxiety and Depression (HAD) scale. As they point out, there is no provision of score values for the sum of the two subscales. This is because the HAD was produced in order to distinguish between the constructs of depression and anxiety and *not* to provide an alternative to the General Health Questionnaire (GHQ) as a screening test for the presence of a 'global' psychiatric disorder. A major problem in psychiatric research is the nebulous nature of the constructs that psychiatrists use. It is surely time to stop presenting studies in such ill-defined terms.

May I take the opportunity to provide information about the obtainability of the HAD scale. Until recently it was made available, free of charge to applicants from the UK and Republic of Ireland, by the Medical Liaison Service of Upjohn. Upjohn regret that they have been unable to continue this service. Copies of the HAD with in-built scoring device and charts for recording scores have now been printed by the Leeds University Press and are available on application to me. A small charge is now necessary to cover costs and this information is also available.

R. P. SNAITH

*Clinical Sciences Building*
*St James's University Hospital*
*Leeds LS9 7TE*

## Ethnic minorities and the psychiatric system

SIR: Fahy & Dunn (*Journal*, December 1990, **157**, 933) mistake my point (*Journal*, September 1990, **157**, 451–452). Besides pointing out their mistakes of citation on the question of treatment, I was not advocating 'anthropological' studies as the proper alternative to descriptive quantitative research. My case vignette study which I cited (the paper on which is available to them) was as purely an empirical and statistical study as they could wish for.

The problem is that their own quantitative study did not support the conclusions which they claimed: that racial bias could not be attributed to psychiatrists. Hence my comment "not unuseful" – interesting data but faulty conclusions drawn from it. (A claim to be scientific is no guarantee that those making this claim are indeed so.) I am glad they now agree to a distinction between overt racism and other forms of racism: this was not apparent in their paper. Since my letter we have of course the paper by Lewis *et al* (*Journal*, 1990, **157**, 410–415) which demonstrates that psychiatrists do indeed make conscious associations between ethnicity and criminality.

Drs Fahy & Dunn now compound their technically incorrect citation with an error of interpretation: the position they are currently attributing to me in my original paper on the Mental Health Act (Littlewood, 1986) was one (concerning the *police*) of five general possibilities I listed there for useful consideration, and indeed the one which if it was to be taken as a general conclusion I myself called 'naive'. Not only that, but they then use this interpretation against my rather different criticism of their claim to demonstrate an association between the psychiatrists' diagnosis and treatment, rather than between ethnicity and treatment. They still have two different papers, two different arguments, mixed up.

To then applaud a study which demonstrates a high rate of diagnosed schizophrenia in black patients as having "brought transcultural psychiatry research to life" seems a little mysterious. Presumably this is a (covert?) way of arguing that the problems of intercultural psychiatry are simply problems to be located in the presumed psychopathology of the designated patient, and that the procedures of psychiatric practice, our underlying theoretical assumptions and their social context, are above any critique. If this is their message, then it is one I deplore.

ROLAND LITTLEWOOD
*University College and Middlesex School of Medicine*
*Wolfson Building*
*Middlesex Hospital*
*Riding House Street*
*London W1A 8AA*

### Reference

LITTLEWOOD, R. (1986) Ethnic minorities and Mental Health Act. *Bulletin of the Royal College of Psychiatrists*, **10**, 306–308.

## Professor Max Hamilton: an apology

SIR: During the recent CINP meeting in Japan a promotional item was distributed with a copy of the Hamilton Rating Scale for Depression, including the name of our drug, Tolvon. It was by no means our intention to indicate that the late Professor Hamilton had endorsed this drug or that he had been associated with it. We are sorry to learn that close colleagues and the immediate family of the late Professor Hamilton have been disturbed by this publication, particularly in view of the fact that, in helping with drug trials, Professor Hamilton was always impartial and insisted that his name should not be used to sway a decision one way or another.

If we have inadvertently given any other impression we should like to state that this was certainly not our intention.

PIETER A. VAN KEEP
*Organon International bv*
*PO Box 20*
*S340 BH Oss*
*The Netherlands*

## Suicide in Indian women

SIR: We want to put forward our views about some of the aspects related to suicide in Indian women, described by Raleigh *et al* and Veluri & Greene in two recent issues of the *Journal* (January 1990, **156**, 46–50, and July 1990, **157**, 149–150).

Burning is not the only method commonly chosen by Indian women to commit suicide. In a recent Indian study (Shukla *et al*, 1990) carried out in Jhansi, a small city in North India, burning, drowning, poisoning and hanging were the methods used by women for committing suicide in 36%, 23%, 27% and 16% of cases respectively.

There does not appear to be any relationship between the phenomenon of *Sati* ('Suttee') and suicidal burning in the current context as mentioned by Raleigh *et al* and Veluri & Greene. *Sati* is a custom, which was practised by Hindu women after the death of their husbands, in which they used to burn themselves on the husband's pyre. It was accepted as a devotion to the husband by society rather than suicide as would be described in terms of recent thinking. The practice (malpractice) of *Sati* was quite prevalent in India, until the first few decades of this century, although it started in the medieval period. Sporadic cases are still reported, especially from the rural areas and the state of Rajasthan, where it still has social acceptance. In some cases of *Sati* it is a forced burning rather than a voluntary suicide.

The comment of Veluri & Greene regarding overdosage of drugs as a method for committing suicide does not appear valid in our opinion. It is not due to ignorance on the part of the suicidee, but due to the difficulty in procurement and expense involved, that Indian women chose other methods for committing suicide. Drowning is another method used by women from rural India. A common method of drowning is by jumping into the village well.

We feel that the availability and accessibility of a particular method to Indian women determines the way of committing suicide.

R. K. CHADDA
S. SHOME
M. S. BHATIA
*Department of Psychiatry*
*University College of Medical Sciences*
*and GTB Hospital*
*Delhi-95*
*India*

### Reference

SHUKLA, G. D., VERMA, B. L. & MISRA, D. N. (1990) Suicide in Jhansi city. *Indian Journal of Psychiatry*, **32**, 44–51.

## Carbamazepine and NMS

SIR: Dalkin & Lee (*Journal*, 1990, **157**, 437–438) report a case of probable neuroleptic malignant syndrome (NMS) without fever following an overdose of trifluoperazine and carbamazepine. The authors suggest that carbamazepine may modify NMS,