requiring our closest concern, and among other professional researchers (e.g. sociologists, anthropologists) with whom we have traditionally cooperated. Careful social and community research must now be the real priority in the issue of schizophrenia and Afro-Caribbeans.

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SIR: We read with interest the papers by Castle *et al* (*Journal*, December 1991, **159**, 790–794) and Wessely *et al* (*Journal*, December 1991, **159**, 795–801) and note their finding of higher rates of operationally defined schizophrenia among Afro-Caribbeans in the UK. In discussing possible explanations for these findings, Dr Wessely *et al* suggested that the prevalence of schizophrenia in this group could be increased either directly or indirectly by forms of social adversity such as unemployment, inadequate housing, low social class, the experience of racism and other forms of social deprivation.

The puzzling thing about these hypotheses to account for the higher rates of major mental illness is that the same factors are associated with an increased risk of non-psychotic disorders such as depression, anxiety, and functional somatic symptoms (Goldberg & Huxley, 1992). Yet the British evidence is that Afro-Caribbean patients are less likely to receive this diagnosis from general practitioners (GPs) than white British attenders. Gillam *et al* (1989), reviewing over 67 000 GP consultations in Brent, North London, found that GPs were less likely to diagnose psychosocial disorders in Afro-Caribbean attenders than in white British attenders. Similarly Johnson *et al* (1986) found from a community survey in the West Midlands that Afro-Caribbean respondents were much less likely than white British respondents to report having attended their GP with a psychological problem.

There are several possible interpretations of these apparently contradictory findings concerning schizophrenia and non-psychotic disorders. Firstly, the excess of schizophrenia might be due to biological not social factors, a consideration raised by Dr Wessely *et al*. Secondly, the excess of schizophrenia could be due to misdiagnosis, although the weight of evidence against this is increasing. Thirdly, the theories about the social precursors of schizophrenia might be correct yet operate differently with regard to non-psychotic disorders resulting in differing rates in the Afro-Caribbean population. Fourthly, Afro-Caribbean patients with non-psychotic disorders might not attend their GPs or the GP might not recognise these disorders. This could be due either to the mode of symptom presentation, or cultural differences in the nature of non-psychotic disorders (Helman, 1990). Lastly, it could be that Afro-Caribbean patients do not frame their distress in psychological terms because of the tremendous stigma attached to mental illness and the black community's discriminatory experiences of the mental health care system (Rack, 1982). Another aspect of discrimination which might impact upon the presentation and recognition of non-psychotic disorders is differential access to services and the unacceptability of having the stresses of living with discrimination redefined as neurotic illness (Rack, 1982).

Compared to the volume of work conducted into schizophrenia and the Afro-Caribbean community, relatively little work has been carried out in the UK on non-psychotic disorders such as anxiety, depression and somatic symptoms. If theories about the direct and indirect roles of social adversity in schizophrenia among Afro-Caribbeans in the UK are correct, then some explanation is required as to why it has been suggested that rates of non-psychotic disorders in primary care settings are lower, the opposite of what might be expected from work on vulnerability factors to non-psychotic disorders among the general population.

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SIR: Dr Eagles focuses interest on biological factors as possible causes of the excess of schizophrenia