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SIR: The problem of dose and diagnosis were reconsidered on many occasions during our patient's long psychiatric contact. The hierarchical system of classification that Dr Malizia supports was quite inadequate for our patient. Although at times a primary diagnosis of depressive episode was justified, at others she had no depressive symptoms at all and attempts to force her into a depressive diagnostic category would have been Procrustean nonsense. During the ten years in which we have had personal contact with the patient, the most persistent symptom has been severe generalised anxiety, but obsessional rituals dominated her symptoms for nearly a year and at other times her agoraphobia made her almost housebound. Rather than bend all these symptoms into the status of secondary depressive ones, it is much more appropriate to allow the co-existence and changing dominance of different symptoms at different times. This patient is an exemplar of the general neurotic syndrome, a relatively severe neurotic disorder in which the depression, anxiety and other neurotic symptoms are associated with dependent or anankastic personality characteristics (Tyrer, 1985, 1989; Andrews *et al*, 1990).

Dr Malizia's comments about dosage are important and have been reinforced by others (Bridges, 1983; Quitkin, 1985). Our patient had been treated with up to a maximum of 175 mg daily of amitriptyline, but in higher dosage she was extremely handicapped by unwanted effects and on one occasion went into urinary retention. Unusually, these anticholinergic effects persisted even after prolonged dosage. Although it is possible to argue that the efficacy of combined antidepressnt therapy could be achieved by merely increasing the dose of a single antidepressant (bearing in mind that both groups of drugs increase the availability of central monoamines), we feel that this would not be sufficient explanation for the improvement shown in our patient, not least because she responded at relatively low dosage. More particularly, she regarded the improvement that she achieved on combined antidepressant therapy as qualitatively different from all previous treatments, and this had given a new dimension to her life. Although it would have been reasonable at first to regard this as a non-specific effect, the fact that it was still maintained after many years of treatment and that she relapsed during the placebo substitution described in our paper suggests that there are specific effects of combined antidepressant therapy that are not achieved by single drugs.

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Jewish depressives

SIR: I was very interested to read the study on Jewish depressives by Ball & Clare (*Journal*, March 1990, **156**, 379–383); however, I was disappointed, as the conclusions that the authors reach are not justifiable.

The sample population is a highly selected group, and there is no evidence that the Jewish depressives in the study were representative of the depressed members of the whole Jewish population of Hackney, or indeed of the rest of the country. Little information is given of the selection procedure for the study, which may be a main source of bias.

Forty per cent of the Jewish sample were widowed, compared with 19% of the non-Jewish sample. I performed the χ^2 test on this data myself, and the difference between the two groups approached statistical significance. It was remiss of the authors not to mention this fact, as widowed status has a bearing on the nature and course of depression (Parkes, 1965).

Furthermore, we know nothing about the social status, racial mix or types of religion of the non-Jewish sample, nor indeed about their 'religiousness' scores in comparison with the Jewish sample. There is also no indication as to whether this control group is representative of any population, be it Hackney or England in general. Such data would be essential to ascertain any effect that the Jewish religion has on symptoms.

Most of the Jewish sample experienced antisemitic persecution in the 1930s. It might be that this single factor has more bearing on the nature of subsequent depressive episodes than any vague cultural or religious issues centred around being Jewish. But

sadly the opportunity to look into this has been missed in this study.

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SIR: Hypotheses based on false or inadequate data are always invalid. The paper by Ball & Clare (*Journal*, March 1990, **156**, 379–383) gives an example of this.

The authors ask us to believe that the saying of the mourners' prayer might be responsible for the lower scores of guilt in Jewish depressives. Jewish women, they also tell us, have even lower guilt scores. Since women do not say the Kaddish (mourners' prayer), the authors are asking us to believe that the 60% who do not say the Kaddish benefit most!

This remarkable conclusion is a tribute to inadequate research before publication. Ex nihilo, nihilo fit.

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SIR: Dr Samuel's point concerning the saying of the Kaddish is noted. The suggestion quoted in my paper (Kidorf, 1963) concerned Jewish rituals as a whole. It was proposed that these practices allowed a formal opportunity to express grief and provided a good setting for 'grief work', facilitating a healthy resolution of grief rather than denial or incomplete grieving which possibly contributes to guilt and depression. Men and women have different roles in respect to these rituals but could be expected to share common attitudes and benefits. Women, indeed, are central to the transmission of values and attitudes within the Jewish family and society (Green, 1984).

Concerning sample selection and Dr Routh's other points; the sample were consecutive referrals to the local catchment area psychiatric services diagnosed as suffering from depression and giving their religion as Jewish during the 20 months of the study. Controls were consecutive white non-Jewish patients fulfilling similar criteria. All patients were residents of Hackney and over the age of 45 years for reasons described. During the final six months of the study only men ($n = 2$) were recruited to the control group as the required number of non-Jews had been collected and the shortfall of control men compared with the Jewish group was already apparent. It is possible that cultural factors operating at the level of general practitioner referral could bias the sample of depressives seen in hospital. A community or general practice survey would be required to investigate this. It is of note however that both groups were referred from a large number of practices. The possibility of similar factors affecting hospital admission and influencing results was minimised by collecting out-patients in addition to in-patients.

The Jewish residents of Hackney have a similar demographic profile in terms of age, immigrant status, socioeconomic group and housing to the white indigenous non-Jewish population. In keeping with other inner London Boroughs, there is a relative excess of older age and lower income groups and fewer young married couples who tend to move to outer London Boroughs. Thus our sample was representative of the white population of Hackney but not of the country as a whole, since this borough distinguishes itself in many measures of deprivation and social disadvantage (Harrison, 1983). The control group were white and born in England. On social measures they were remarkably similar to the Jewish group. Two of the patients gave their religion as Roman Catholic and both of these attended church weekly. The remainder gave their religion as Church of England or none, four of these attended church once or twice a year, the remainder not at all. Church attendance has been considered an adequate estimate of religious belief in Christians (Argyle, 1958) but Synagogue attendance is not in Jews. This was a factor leading to the development of the scale used in this study (Fernando, 1973).

As stated, there was an excess of widowed individuals in the Jewish group and single people in the control group. We found neither sex nor marital status were related to scores for tension, guilt or hypochondriasis. The differences between the Jewish and control groups for these symptoms were highly significant.

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