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

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Reference

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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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