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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Diagnosis of personality disorder

SIR: I do not agree with the statement by Casey & Tyrer (*Journal*, February 1990, **156**, 261–265) that a long-standing clinical attitude towards personality disorder and mental illness is that the patient is presumed to have either one or the other. The ICD–9 (World Health Organization, 1978) allows more than one diagnosis to be made so that an illness and personality label can both be given to a patient if required. Also, with axis I and II of DSM–III (American Psychiatric Association, 1980), it is possible to make a diagnosis of psychiatric illness or personality disorder alone, or to make both diagnoses in the same patient.

It is not surprising that distinguishing between neurotic disorder and personality disorder in the presence of chronic neurotic traits is extremely complicated. The ICD–9 does not give guidance on how to distinguish personality disorder from neurosis or from normal personality. In the light of such ambiguities, I found the final suggestion that general practitioners, when referring, should convey their personality assessments concisely and precisely, although laudable, rather naïve.

The main finding, that of the unexpectedly higher occurrence of personality disorder in general practice patients with conspicuous psychiatric morbidity, is alarming. However, I wonder if this could be because of the instrument used. The Personality Assessment Schedule (PAS) differs from all other instruments for assessing personality disorder in deriving the classification primarily from a computer program and adopting a dimensional approach rather than a categorical one for diagnosis. Its hierarchical structure may have lost information important in the general practice setting of the study, and its dimensional approach makes the question of caseness difficult.

Finally, the authors argue that their figure of 28% of all patients having a diagnosis of personality disorder is a true finding, since there was significantly greater social dysfunction in these patients. The PAS only refers to social adjustment. If their patients' sense of subjective distress had been noted, would they all still have qualified for the diagnosis of personality disorder or would they have been included in the less damning category of personality traits of psychiatric significance?

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SIR: Dr Travers fails to appreciate the gap between the ideal and the real world of clinical psychiatry. We agree that ICD–9 and DSM–III do allow for more than one diagnosis but this is rarely adhered to in practice. Even case registers, the bastions of epidemiological information, only cater for single diagnoses and the Department of Health has adhered to this approach also in national statistics.

In pointing to our naïve belief that general practitioners (GPs) should be encouraged to provide information on the patient's personality, Dr Travers is succumbing to clinical nihilism. If the family practitioner is not in a position to give details of the patient's pre-morbid traits and functioning, then who is? To suggest otherwise is to undermine the collaboration suggested as necessary by the World Health Organization (1973) between GPs and psychiatrists. Personality assessment is less of a sophisticated academic exercise than a skill that can be taught, and is grounded in the recognition of the separation between mental-state diagnosis and personality status (axis I and axis II).

Dr Travers' more substantive worries about the PAS have already been covered in the original paper. The suggestion that the cut-off for deciding on personality disorder in this population is too high and allows both categorical and dimensional diagnoses, is erroneous. The PAS adopts the approach used in clinical practice (i.e. that of diagnosing personality disorder only when it impinges on others). Within the PAS it is possible to measure personal distress, but to make a diagnosis of abnormal personality at this level would be over-inclusive and probably most people would meet these broad criteria. Setting it at the level used in our study has found constructive and predictive validity – those with personality disorder are significantly more socially dysfunctional (Casey *et al*, 1985), and have more frequent contact with