influence on outcome. We were able to compare the effect of personality estimated when ill and again on recovery and found that the former was the more important. This is in agreement with findings from cognitive psychology, where significant differences in dysfunctional attitudes between depressives and normal controls are found only in the presence of depressed mood. Thus it may be that self-ratings of personality are more valuable predictors when an individual is in a state of depression rather than on recovery, and that the changes produced by the depression are precisely those which offer most information for the future.

Our third point of difference concerns diagnosis. Professor Andrews *et al* claim to show that 'endogeneity' in depression has at most only a trivial effect on long-term outcome. However, this conclusion depends heavily on their definition of 'endogenous' depression – there are at least 18 different definitions and the degree of overlap between them is only partial. We have compared the prognostic value of several of these in our Maudsley series and have found (a) that differing definitions of 'endogenous' depression include different populations and (b) DSM–III melancholia emerges as the best predictor of poor long-term outcome (Duggan *et al*, 1991). Thus, it may be premature to dismiss the importance of the endogenous/nonendogenous distinction, as Professor Andrews *et al* have done.

Finally, the Sydney group continue to misrepresent our earlier papers. In London, 'endogenous' scores on Kendell's continuum predicted a much poorer outcome. Despite several appeals, it was the swift hare, not the slow tortoise, that lost Aesop's race.

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Urinary chromatographic profiles in psychiatric diseases

SIR: In 1980 Trygstad *et al* reported that patients with a variety of psychiatric diseases could be distinguished from each other and from normal controls by the pattern of peptides excreted in urine as studied by chromatography. Specifically, it was claimed that when urine was precipitated by ethanol saturated with benzoic acid, centrifuged at 4000 *g* for 10 minutes and the precipitate washed with ethanol, dissolved in ammonium bicarbonate and applied to a Sephadex G-25 column, the following distinctions in ultraviolet absorption profile could be made. Firstly, patients with unipolar and bipolar depression had patterns which differed from normal subjects and patients with neurotic depression, and these profiles were normalised by tricyclic antidepressant medication. Secondly, patients with hebephrenic or paranoid schizophrenia differed from normal subjects in demonstrating one or other of two chromatographic profiles characterised by an excess or deficit of peaks of absorption seen at elution volumes between 1200 ml to 1400 ml. Thirdly, patients with autism had excretion profiles which were similar to those seen in schizophrenia, but which could be distinguished from these latter on further (unspecified) fractionation steps. Fourthly, patients with hyperkinetic syndrome (minimal brain dysfunction) could be shown to have a distinct, but variable, pattern of urinary peptide excretion which returned to normal with amphetamine treatment.

These and related claims were made in a series of papers (e.g. Reichelt *et al*, 1981, 1985, 1986) by the same group of workers.

To assess these claims we have conducted an investigation of urine samples from five neuroleptic-free patients with schizophrenia (DSM–III criteria) and four age- and sex-matched normal subjects, using Sephadex G-25 and Biogel P-2 chromatography with techniques as described by the Norwegian group and a series of modifications (Gilroy *et al*, 1990). In the course of our investigation a number of difficulties with these techniques became apparent. In communication with the Norwegian workers, we have attempted to clarify the nature of the difficulties, and to further specify the precise procedures adopted. Details of these technical problems are given in our paper (Gilroy *et al*, 1990).

Our findings differ from those of the Norwegian group. We observe urinary chromatographic profiles which do not closely resemble those which they have reported. We found substantial differences in excretion profile between men and women on Sephadex G-25, but no significant differences (in our

small sample) between patients with schizophrenia and controls on either Sephadex G-25 or Biogel P-2. Our findings give no support to the view that the patients with schizophrenia can be readily distinguished from normal subjects by an analysis of the chromatographic profile of peptide excretion in urine.

Although we have not studied patients with unipolar and bipolar depression, autism or the hyperkinetic syndrome we consider that the uncertainties concerning the precise methods adopted by the Norwegian workers and the technical difficulties revealed in the course of our investigation cast their conclusions concerning the role of peptides in these conditions in doubt.

The methods used are complex, with many possible sources of variation, and we suggest that a more rigorous and quantitative approach than that so far adopted by this group of workers is required before these findings can be regarded as reflecting on the nature of the disease processes in question.

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Diazepam abreaction

SIR: Recently, Ellis (1990) made some interesting observations about the role of diazepam and other sedative drugs in abreaction interviews. However, this is not the first time such a practice has been adopted. In fact, this practice has been in routine use for more than 15 years in preference to 'amytal test' at the Department of Psychiatry, All India Institute of Medical Sciences, New Delhi, where some of us trained as psychiatrists in the early 1980s. In India, conversion hysteria is a very common clinical diagnosis not only in psychiatric out-patient clinics but in general practice and medical out-patients as well. Intravenous diazepam abreaction interview is generally much safer as compared with the 'amytal test' and can be useful in primary care settings where facilities for intubation and resuscitation are not very good. It is in this setting that a doctor in India encounters numerous cases of conversion hysteria. The use of diazepam abreaction is so common there that one does not consider it to be a rarity worth publishing. We have, incidentally, mentioned this clinical use of diazepam while discussing case histories of patients with multiple personality disorder (Adityanjee *et al*, 1989).

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Racial stereotypes

SIR: The paper by Lewis *et al* (*Journal*, September 1990, **157**, 410–415), is to be commended as an attempt to elucidate British racial stereotypes that may influence diagnostic practice. However, I do not think the study addresses the issue of racism in psychiatry – at least not very fully – and the title of the paper ("Are British psychiatricts racist?") is a misnomer.

In their report on the influence of racial stereotyping on diagnosis, the authors state that their findings refute the claim that British psychiatrists tend to overdiagnose schizophrenia among Afro-Caribbeans. I do not think that such a conclusion can be drawn from their study as reported. The use of case vignettes is a useful tool in this type of research in spite of the obvious drawback (referred to by the authors) that the