influence on the prevalence rate of postpartum depression.

It is regrettable that Longhurst and Weiss should take the liberty of misinforming your readership with these false allegations. Readers may draw their own conclusions from the evidence in print.

Ghubash, R., Hamdi, E. & Bebbington, P. E. (1992) The Dubai Community Psychiatric Survey: prevalence and sociodemographic correlates. *Social Psychiatry and Psychiatric Epidemiology*, **27**, 53–61.

__, Abou-Saleh, M. T. & Daradkeh, T. K. (1997) The validity of the Arabic Edinburgh Postnatal Depression Scale. *Social Psychiatry and Psychiatric Epidemiology*, **32**, 474–476.

O'Hara, M. W. & Swain, A. M. Rates and risk of postpartum depression – a meta-analysis. *International Review of Psychiatry*, **8**, 37–54.

M. T. Abou-Saleh, R. Ghubash Department of Psychiatry & Behavioural Sciences, Faculty of Medicine & Health Sciences, United Arab Emirates University, Al Ain, United Arab Emirates

Editorial comment: Copies of the two articles referred to in the preceding correspondence were sent to four senior editors of the *British Journal of Psychiatry*, all of whom found substantial similarity between the two papers. Those concerned by this matter might also like to look at a third paper by the same authors (Ghubash *et al*, 1997).

Authors submitting papers to the *British Journal of Psychiatry* (serially or otherwise) with a common theme or using data derived from the same sample (or a subset thereof) must send details of all relevant previous publications, simultaneous submissions, and papers in preparation. Failure to do so may arouse criticism and censure.

A paragraph to this effect will be added to our Instructions to Authors with immediate effect.

Ghubash, R., Abou-Saleh, M. T. & Daradkeh, T. K. (1997) The validity of the Arabic Edinburgh Postnatal Depression Scale. *Social Psychiatry and Psychiatric Epidemiology*, **32**, 474–476

Greg Wilkinson Editor, British Journal of Psychiatry, 17 Belgrave Square, London SWIX 8PG

Ethnicity in psychiatric epidemiology

Sir: Singh's (1997) editorial on race, ethnicity and culture was timely and welcome. If there is any field in which these issues need to be aired, it is psychiatry. I had hoped that the *British Medical Journal*'s guidelines would be an impetus for other journals to follow suit and develop their own editorial policies on research into ethnicity, culture and race (Anonymous, 1996). In this light, I am happy that Singh's five guiding principles so closely echo my own work (McKenzie & Crowcroft, 1996) and that of Senior & Bhopal (1994).

There are some points, however, which may need further discussion. It should be stated explicitly that epidemiology alone may not be a sensitive enough tool for cross-cultural research. Dr Singh emphasises the need for large-scale studies so that confounders can be measured, but measuring confounders does not necessarily produce valid categories.

The epidemiological approach often sacrifices validity and detail for measurability (Pope & Mays, 1995). This can cause problems in the field of culture and ethnicity, where validity is important. The simple rule of thumb that 1 multiplied by 0=0 and 100 multiplied by 0=0 should be kept in mind. If you measure something badly, larger numbers will not help you.

A lot of groundwork needs to be carried out before large epidemiological studies are performed, in order to avoid problems of misclassification. The two main problems of misclassification – bias, leading to false and misleading findings (always difficult to ignore from large epidemiological studies), and non-differential classification, leading to a failure to detect important differences between groups – need to be avoided through good study design and are difficult or impossible to correct at a later stage by any statistical trickery.

Poor understanding of the nature of ethnicity and culture underpins its poor measurement and the poverty of coherent testable hypotheses. Qualitative methods such as ethnography, which often use small sample groups, can be more powerful tools for understanding culture and ethnicity and can help in hypothesis generation. Qualitative and quantitative investigation are not mutually exclusive; qualitative methods can be used to set the hypotheses for large-scale epidemiological studies and to make sense of the results gained from epidemiological studies.

The need to 'unpack' cultural and ethnic variables is also stated by Singh as important. However, it is not always desirable or even possible to 'unpack' culture or ethnicity. Ethnicity and culture are social and psychological constructs that are context driven. They are complex entities made up of interrelated factors. It is difficult to know how each factor affects the whole. Controlling for one factor may weaken the validity of the whole construct. Reductionism can lead to circular arguments. For instance, it is common to control for socio-economic status when looking at ethnic differences. However, it may be that these socio-economic differences are mediated by institutional racism, and the experience of them in the context of racism are catalysts and perpetuating factors for psychological and social changes which produce identity, differences in disease incidence and service use.

Despite this caveat, unpacking could be of great importance if it is used to produce multi-dimensional instead of categorical representations of culture and ethnicity.

Research into the validity and use of race, ethnicity and culture needs to be ongoing. It was one of the nine points proffered for improving measurement of ethnicity by Senior & Bhopal (1994) and it is as true today as it was in 1994.

Anonymous (1996) Style matters. Ethnicity, race and culture: guidelines for research, audit and publication. *British Medical Journal*, **312**, 1094.

McKenzie & Crowcroft, N. S. (1996) Describing race ethnicity and culture in medical research. *British Medical Journal*, **312**, 1054.

Pope, C. & Mays, N. (1995) Reaching the parts that other methods cannot reach: an introduction to qualitative methods in health and health services research. *British Medical Journal*, **311**, 42–45.

Senior, P. A. & Bhopal, R. (1994) Ethnicity as a variable in epidemiological research. *British Medical Journal*, **309**, 327–330.

Singh, S. P. (1997) Ethnicity in psychiatric epidemiology: need for precision. *British Journal of Psychiatry*, **171**, 305–308.

K. McKenzie Department of Social Medicine, Harvard Medical School, 641 Huntington Avenue, Boston, MA 02115, USA

Psychiatrists' attire revisited

Sir: The report by Gledhill *et al* (1997) highlights patients' views on psychiatrists' attire. Psychiatric patients preferred consultants to wear suits, though doctors in suits were perceived to be the least friendly, least easy to talk to and least understanding. The authors suggest that consultants exchange suits for less formal wear, offsetting a slight loss of perceived competence for better communication.

https://doi.org/10.1192/bjp.172.3.278b Published online by Cambridge University Press

These findings need to be interpreted with caution in view of the questionnaire used. The authors failed to ascertain whether the issue of doctors' dress was important to patients, prior to a specific choice of attire being made. Often, what doctors wear is not as big an issue for patients as we may believe and patients are reported to be less discriminating in their attitude towards physician appearance than physicians themselves (Dunn *et al*, 1987). Between 30 and 70% of patients in various studies are reported to have no preference regarding doctors' attire (Neinstein *et al*, 1985; Dunn *et al*, 1987; Friis & Tilles, 1988; Del Rey & Paul, 1995).

Patients should have first been asked whether their doctor's attire was of relevance to them, and those who felt it was could have gone on to choose one of the specified forms of dress. This study design would have provided a clearer picture of whether the issue of psychiatrists' dress was of significant concern to patients. If the majority felt that it was important, then the findings would have more relevance to clinical practice. To use an extreme example, consumers entering a fast food store may indicate a preference for one type of uniform over another when given two choices, but the majority may not really care as long as they get good service. While there are obvious differences between this situation and the issue of doctors' attire, the principle may well be the same.

Del Rey, J. A. G. & Paul, R. I. (1995) Preferences of parents for paediatric emergency physician's attire. *Paediatric Emergency Care*, **11**, 361–364.

Dunn, J. J., Lee, T. H., Percelay, J. M., *et al* (1987) Patient and house officer attitudes on physician attire and etiquette. *Journal of the American Medical Association*, **257**, 65–68.

Friis, R. & Tilles, J. (1988) Patients' preferences for resident physician dress style. *Family Practice Research Journal*, **8**, 24–31.

Gledhill, J. A., Warner, J. P. & King, M. (1997) Psychiatrists and their patients: views on forms of dress and address. *British Journal of Psychiatry*, **171**, 228–232.

Neinstein, L. S., Stewart, D. & Gordon, N. (1985) Effect of physician dress style on patient–physician relationship. *Journal of Adolescent Health Care*, **1**, 456–459.

M. Rajagopalan Ballarat Health Services, PO Box 577, Ballarat, Victoria 3350, Australia

Diagnostic criteria and functional psychosis

Sir: The correspondence between Ryan (1997) and Van Os *et al* (1997*b*) made interesting reading. Van Os *et al* make an important claim that 'pure' affective and schizophrenic states become rarer with time. Strangely enough, their claim is not borne out by the results of a previous study they published (Van Os *et al*, 1996). In that study, the same sample when diagnosed with DSM–III–R diagnostic criteria led to a diagnosis of only 12 cases of schizoaffective psychosis, with schizophrenia being more or less stable, and 43 cases of affective psychosis, compared with 17 in their present study (Van Os *et al*, 1997*a*).

This raises the following questions. First, are the research diagnostic criteria (RDC) unreliable at distinguishing 'pure' forms of affective and schizophrenic psychosis? Second, is it only affective disorder that presents with schizophrenic symptoms over a lifetime (theoretically, the lack of pure forms should affect both diagnoses)? Third, if this were true of the RDC, should they be avoided in favour of DSM–III–R or any other reliable criteria used to diagnose schizophrenia and affective disorder?

Ryan, A. (1997) Psychopathological syndromes and familial morbid risk of psychosis (letter). *British Journal of Psychiatry*, **171**, 289.

Van Os, J., Fahy, T. A., Jones, P., *et al* (1996) Psychopathological syndromes and the functional psychoses: associations with course and outcome. *Psychological Medicine*, **26**, 161–176.

—, Marcelis, M., Sham, P., *et al* (1997*a*) Psychopathological syndromes and familial morbid risk of psychosis. *British Journal of Psychiatry*, **170**, 241–246.

—, —, —, *et al* (1997*b*) Psychopathological syndromes and familial morbid risk of psychosis (letter). *British Journal of Psychiatry*, **171**, 289.

D. Kirby Department of Psychiatry, Charing Cross and Westminster Medical School, London W6 8RP

Authors' reply: What Dr Kirby notes, but may not realise, is that given a mixture of affective and psychotic symptoms, it is a lot more difficult to get a diagnosis of schizoaffective disorder using DSM criteria than it is using the RDC. The DSM requirement that there must have been delusions or hallucinations for at least two weeks in the absence of prominent mood symptoms is simply more restrictive. We recently examined 706 patients with functional psychosis and found the same relative diagnostic shift between the RDC and DSM systems, with ICD–10 being somewhere in between. Thus, more patients with affective and psychotic symptoms will be labelled as suffering with affective psychosis according to DSM and with schizoaffective psychosis according to RDC.

We fail to see what this relative shift has to do with our statement that patients with psychosis accumulate a variety of affective and non-affective psychopathologies as time progresses, which will affect the diagnostic distribution within a given diagnostic system accordingly. The only way to examine this *longitudinal* issue is to compare baseline with follow-up diagnoses within the *same* diagnostic system.

The choice of diagnostic system (and the ensuing diagnostic distribution) is arbitrary because there is no evidence that any system is more valid than the other. Thus, our response to Dr Kirby's first question ("are the RDC unreliable at distinguishing 'pure' forms of affective and schizophrenic psychosis?") is that, for the time being, all diagnostic systems remain equally (un)reliable. In our 1997 paper (Van Os *et al*, 1997) we chose the RDC to diagnose the patients because of its compatibility with the family history research diagnostic criteria method used to diagnose the relatives. In our earlier paper (Van Os *et al*, 1996) we examined a clinical issue and therefore used both DSM and ICD criteria, because these are most often used in clinical practice. The question following from Dr Kirby's observation is: if there is no agreement between diagnostic systems as to where to draw the line between basic categories in the functional psychosis, should we not, instead, concentrate more on overlapping psychopathological dimensions within the continuum of psychosis?

Van Os, J., Fahy, T. A., Jones, P., *et al* (1996) Psychopathological syndromes and the functional psychoses: associations with course and outcome. *Psychological Medicine*, **26**, 161–176.

—, Marcelis, M., Sham, P., *et al* (1997) Psychopathological syndromes and familial morbid risk of psychosis. *British Journal of Psychiatry*, **170**, 241–246.

J. Van Os, M. Marcelis, P. Sham, P. Jones, K. Gilvarry, R. Murray Psychiatric Epidemiology Program, University of Maastricht, PO Box 616, 6200 MD Maastricht, The Netherlands

Family involvement in the care of people with psychoses

Sir: Should communication between psychiatrist and non-professional carers be permitted without the patient's agreement? Szmukler & Bloch (1997) have confirmed my impression that the profession is at sea over this question. Community care of people with psychoses

https://doi.org/10.1192/bjp.172.3.278b Published online by Cambridge University Press