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Author's reply: We accept that our findings require confirmation from further studies. However, human intuition has often been shown to be incorrect in the face of scientific research and perhaps ought not to be taken too seriously. A good example of this is the recent history of psychological debriefing to prevent PTSD (Rose *et al*, 2003).

The finding that the categorical measures of depression (according to DSM–IV) did not concur with the continuous measure of depression (according to the BDI), in terms of predicting disability, may be evidence for the unreliability of the way we categorise psychiatric disorder, in terms of individual functioning. This is a possible area for further investigation.

The study was a cross-sectional survey examining the within-subject variability and relationships between variables. It has not been explained how a control group would add anything to the findings. The origin of the subjects was not a variable in the study design and it has not been explained why the assessor should have been masked to this information. The SCID is the most widely used and the most thoroughly researched clinical interview format for PTSD (Wilson & Keane, 1997). The SPRINT is one of numerous other measures of PTSD. A search on the National Center for PTSD database showed 127 hits for the SCID and 3 hits for the SPRINT. The use of self-report questionnaires as continuous variables was integral to study design and was not an 'over-reliance'.

The study by Tucker *et al* (2001) does not tell us anything about the relative contribution of PTSD, depression or alcohol dependence to disability, which was central to our hypothesis. Paroxetine is effective in the treatment of depression as well as PTSD.

Employment by the Ministry of Defence does not introduce an obvious partisan interest in this study. On the one hand, the Ministry might benefit from showing that PTSD does not cause disability, but on the other hand, if PTSD has little relevance, then the need to employ military psychiatrists may be questionable. Either way, the employing organisation can hardly be said to have been concealed by the authors from Dr Green.

Declaration of interest

At the time of data collection, L.A.N. was employed by the UK Ministry of Defence. At the time of submission of the publication, he had no links with the Ministry.

Rose, S., Bisson, J. I. & Wessely, S. C. (2003) A systematic review of single-session psychological interventions ('debriefing') following trauma. *Psychotherapy and Psychosomatics*, **72**, 176–184.

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Analysis of psychiatric in-patient violence

There are two major problems with the study of Gudjonsson *et al* (2004) which render interpretation of the results problematic. First, violent incidents were identified from untoward incident reporting forms. Formally evaluated scales measuring violent behaviour were not used. It is well recognised that nursing staff may underreport violent behaviour on incident forms (Shah *et al*, 1991). Moreover, there is no mention of incident forms other than those for untoward incidents. In some hospitals there are different types of incident forms (including that for untoward incidents) depending how the incident is classified. Furthermore, no data are provided on the exact number of staff completing these forms and reliability between different raters in the reporting of violent incidents. The second concern is with the definition of ethnicity. The authors provide no information on how ethnicity was defined. It was simply ascertained from the record of ethnicity on the untoward incident form. There are many problems with the definition of ethnicity. Unless ethnicity is clearly defined and all those completing the incident forms use the same definition, this is likely to introduce bias in the findings. Again, no data are provided on how many staff completed the incident forms and the reliability in the reporting of ethnicity between different staff members. These issues are important because findings on psychiatric issues and ethnicity are often considered to be controversial and emotive to all sectors of society.

Gudjonsson, G. H., Rabe-Hesketh, S. & Szmukler, G. (2004) Management of psychiatric in-patient violence: patient ethnicity and use of medication, restraint and seclusion. *British Journal of Psychiatry*, **184**, 258–262.

Shah, A. K., Fineberg, N. A. & James, D. V. (1991) Violence among psychiatric inpatients. *Acta Psychiatrica Scandinavica*, **84**, 304–309.

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Authors' reply: The two main concerns of Dr Shah relate to the standard hospital incident form used in the study and lack of definition of ethnicity. We accept the potential methodological problems associated with the use and retrospective analyses of routine 'untoward' incident data.

However, we do have two specific comments on Dr Shah's letter. First, our study was a large-scale investigation involving 1515 'untoward' incidents on 14 general wards within our trust over a 3-year period. In view of the large number of incidents analysed we believe it is unlikely that unrecorded incidents or inaccurately recorded ethnic background of some patients would have significantly influenced the findings. In the statistical analyses the patients were only classified into two groups: 'White' and 'Black' (i.e. 'African–Caribbean' and 'African'). Second, the main findings were broadly similar to those of a previous large-scale study of 165 medium secure unit patients at the Bethlem Royal Hospital (Gudjonsson *et al*, 2000). In that study the ethnic background of the patients was obtained from the patient register rather than from the incident forms (Gudjonsson *et al*, 1999).

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