Authors' reply: As a general rule, it would seem prudent for one inclined to critique others for repeating points made elsewhere to double-check the originality of one's own complaints. Several of the points raised by Cohen & Lee have been made before – including in this journal (Edgerton & Cohen, 1994) – and have already been addressed by WHO-affiliated researchers (Sartorius, 1992; Jablensky & Sartorius *et al*, 1994).

More pertinently, Cohen & Lee misunderstand the nature of a 're-analysis' of existing data. They call for closer attention to methodological and cultural factors that might influence outcome measures. We concur, and said so in our article (Craig *et al*, 1997; p. 232), but the data at our disposal did not permit such an analysis. Instead, our intent was twofold. First, spurred by our own reading of the anthropological literature (Hopper, 1991), as well as by Edgerton & Cohen's earlier critique, we sought to determine whether the results of the short-term follow-up can suggest other ways of classifying settings than the developed *v.* developing classification. Second, we sought to apply a new methodological tool to see whether it would enable us to formulate better, more refined, questions. Our article reported results on both these counts. Our findings support the wisdom of seeking other ways of describing cultures in order to explain differential outcome in schizophrenia. They also indicate that new ways of analysing data can convey new and important insights. The empirically driven recursive partitioning method we used is quite different from traditional model-driven approaches. That results from the two methods exhibit a fair degree of concordance, we would argue, is a strength rather than a 'minor modification'. Moreover, our approach allows us to formulate much more specific attributions and interactive effects for predictive variables (p. 231), of precisely the sort Cohen & Lee call for.

Their most breathtaking complaint is that we fail to consider recent work demonstrating the possibility that a diagnostic grouping (non-affective recurring psychosis) may prevail in the developing countries. In the first place, this is not, to our knowledge, an accepted nosologic entity, or one that local clinicians were asked to identify in DOSMD at that time. Second, this specific diagnostic category is dependent upon a knowledge of course, and thus would have been hopelessly confounded with our dependent variable, and third, although an early paper used a clever bit of epidemiological sleuthing to argue for its potential applicability (Susser & Wanderling, 1994), Cohen & Lee appear to take us to task for the preternatural sin of failing to address an argument that appeared in the literature after our own was in press.

A final point that needs response concerns classification. To begin with, there is no sacred grove of permissible categories for cross-cultural research. Distinctions mark useful differences; their validity (utility) depends upon the task at hand. Specifically regarding gender, they first criticise us for presuming the cross-cultural validity of gender and then proceed two sentences later, to commit the same productive sin: they allege that the "demographic reality" of gender imbalances – "more men than women (sic)" in Northern India and Nigeria – ought to be integrated into the analysis, an argument that is difficult to make without assuming the reality of its component parts. Furthermore, they have asked why have we not examined the question "why should one expect better outcomes for women in Chandigarh?". The prediction tree displayed in Figure 1 clearly indicates that based on our analysis no such assertion can be made, and that better outcomes for women is predicted only for those women with non-insidious onset in the predominantly developed settings (that clearly exclude Chandigarh and Ibadan). They should also take note that our definition of 'good' and 'poor' outcome differs from that of their 1994 paper.

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Use of seclusion, restraint and emergency medication

Sir: Rangecroft *et al* (1997) report a significant decrease in seclusion and emergency medication during the course of a study which monitored these interventions. They also suggest that patients with a learning disability may respond quickly to the process of seclusion.

In a similar, large-scale study at St Andrew's Hospital, we have analysed 3071 incidents of emergency interventions over 18 months. We have found results which broadly support some of these findings and also present some interesting differences. As was found by Rangecroft *et al* there was a steady reduction in the use of seclusion when staff knew that management techniques were being monitored. There was a further dramatic reduction from an average of 69 to 30 seclusions per month following policy changes requiring medical attendance at seclusions. There appeared, however, to be some 'displacement' effect in that while seclusion figures reduced the recorded use of oral and intramuscular medication, in emergency intervention this increased. This finding is in contrast to Rangecroft *et al* who report a significant reduction in the use of emergency drugs given intramuscularly.

It is interesting that Rangecroft *et al* find a lower duration of seclusion in this learning disabled population compared with studies of non-learning disabled subjects. In contrast, we found a significantly higher duration of seclusion on learning disability wards compared with other wards. This supports the finding of Mason (1996) that patients with learning disabilities "tended not to respond as well to seclusion as those without a learning difficulty".

Some findings of Rangecroft *et al* have now been partially replicated in another sample; however, the contrasts pose questions which need to be addressed. These relate in particular to the effect of reducing one type of emergency intervention on the use of other types of intervention (a possible displacement effect) and the benefits of secluding patients with learning disabilities. These areas have been neglected in the past and warrant further exploration.

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