In family medicine we seek to build upon the strengths of families, whether urban or rural, disadvantaged or wealthy. Our emphasis is on inclusion: all of us are members of families and communities, with our own weaknesses and contributions to make to the public health. Understanding healthy and unhealthy family systems may lead to more effective family interventions and improved health outcomes for the entire community. □

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Defining Maternal Depletion Syndrome

We are writing in response to the May 1992 Journal article by Winkvist et al., "A New Definition of Maternal Depletion Syndrome."[1] We agree with the authors' decision to include economic and social factors in models for identifying causes of the maternal depletion syndrome. We have come to similar conclusions[2]: that socioeconomic conditions, including maternal work load and patterns of food consumption, must be considered in any assessment of maternal depletion. Efforts to identify causes of the syndrome emerge from a desire to produce conclusive quantitative data to affect government decision-making. However, as we mentioned in our article, the syndrome was not defined initially as a clinical one. Rather, it was a shorthand reference to the disastrous economic and social conditions in Third World settings that result in poor birth outcomes for women with closely spaced pregnancies.

Perhaps it is time to lay to rest the search for a clinical maternal depletion syndrome. Scarce research resources might be spent better on studies of illness prevention and of health promotion in those entire communities where families have inadequate or poor quality food and little or no health care, and where women have experienced increased work loads and decreased social and economic support.

Undoubtedly, women living in desperate poverty do have clinical problems that affect birth outcomes. But research into relationships between maternal and infant health within the broader context of the economy and society will uncover multiple interventions that can improve health for all mothers and their infants in such communities. □

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Winkvist and Colleagues Respond

We agree with Drs. Winikoff and Castle (who have made major contributions[1] to our perspective on maternal depletion syndrome) that research resources should be devoted to studies of illness prevention and health promotion in poor communities so as to improve the health of mothers and their children. We also concur that the search for a clinical syndrome can in all likelihood be ended. That is why we support the use of the term "maternal depletion" instead of "maternal depletion syndrome."[2]

Nevertheless, we think that, to develop the widest range of potentially effective interventions, we must understand both the biological and socioeconomic determinants of poor maternal health. This is particularly true for maternal nutrition, where our own research has shown that biological interventions are crucial at certain periods of the reproductive cycle to protect both maternal and infant health.[3,4] In addition, the biological significance of childbearing in women's health needs to be emphasized within larger studies of community health, because general development programs may not improve women's health most efficiently.

We believe that a better understanding of the biology of maternal malnutrition is in some circumstances essential for the development of effective policies and interventions. This understanding can provide a better focus on the remediable determinants of poor maternal and infant health. Our research, like that of Drs. Winikoff and Castle, is directed toward this end. □

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The Validity of Self-Reported Height and Weight in Perimenopausal Women

Most epidemiologic studies collect information on subjects' height and weight, and most investigations use interview or self-administered questionnaires. Measuring height and weight is not always feasible and sometimes may increase a study's costs substantially. Thus, concern may linger about the accuracy of self-report of height and weight; must they be measured objectively? A number of studies have examined this issue in a variety of populations,[1] but none of them has addressed this issue in perimenopausal women particularly. Because menopause involves many physiologic changes, and more and more studies are focusing on older women's health, we used data from a cross-sectional osteoporosis study to validate self-reported height and weight by measured height and weight among perimenopausal women.

The study recruited a volunteer sample of 352 White women aged 40 to 54 years from central North Carolina. De-