

trust that he will be similarly enlightened by our response.

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#### Depression: Distress or Disease?

DEAR SIR,

Professor Brown and his colleagues (*Journal*, December 1985, **147**, 612–622) are right to suggest that many of the affective disorders seen by psychiatrists are clearly related to psychosocial adversity. The other part of their argument, that ‘cases’ in the community do not differ greatly in severity from those seen by psychiatrists, is questionable. Symptoms are widely distributed in members of the general population; many people have a few symptoms but few have many. This distribution is curvilinear, without points of discontinuity. Wherever we decide to place the threshold for defining cases, provided an appreciable proportion of the population is so recognised, the severity distribution of cases is likely to reflect the underlying distribution of symptoms. In other words, most cases will be mild, a few severe. This has been noted in every community survey using the PSE-ID-CATEGO system that has provided such details, and is independent of the actual prevalence quoted.

Brown and his colleagues argue for similarity in severity between cases in the community and among patients. They do so on the basis of their findings in the Islington community and those reported by Sashidharan (1985) from his series of patients in Edinburgh. This would be justifiable only if the thresholds used in the two studies were the same. Both report results using the PSE-ID-CATEGO system, so the symptom ratings are combined in the same way to construct thresholds for case recognition. However, the criteria for recognising symptoms might well have been stricter in the Edinburgh study than in the Islington survey. Certainly the reported population prevalences in the Edinburgh survey are far lower (3.9% using the Bedford College case definition; Dean *et al.*, 1983) than those reported in Islington (17%) or by the same team in Camberwell (15%—Brown & Harris, 1978). Moreover, the criteria for symptom recognition among the patients who form the basis of Sashidharan’s paper (1985)

could well be even stricter, as these were based on interviews by psychiatrists, whereas the Edinburgh community survey was carried out by lay interviewers. It is known that psychiatrists tend to have stricter criteria (Wing *et al.*, 1977; Sturt *et al.*, 1981). An appropriate test of the hypothesis can be made if data are collected by the same interviewing team from a sample of the general population and from a comparison group of local psychiatric patients. There is such a study, although it is not mentioned by Brown and his colleagues (Wing *et al.*, 1981). Unlike that of Sashidharan (1985) this comparison was based on the full 140-item PSE, and demonstrated marked differences in severity between patients and cases in the Camberwell community, defined as ID5 and above (Wing *et al.*, 1978).

It is possible that we were rating symptoms more strictly than the Bedford College group, as our case prevalence based on Bedford College criteria was around 8.0%. Lowering our threshold for identifying symptoms would have increased the prevalence, but it would also have made the disorders in patients seem more severe.

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#### The Use of SRQ-20 in Primary Care Situations

DEAR SIR,

I was interested to read the article on the use of this instrument in Sao Paulo (*Journal*, January 1986, **148**, 23–26) as we have used it in an attempt to

establish the prevalence of psychiatric disorders in an urban Aboriginal population in Perth. With the assistance and co-operation of the local Aboriginal Medical Service, a pilot study was recently completed. Following discussion with Medical and Aboriginal Welfare Officers, brief training sessions were undertaken to familiarise officers with the SRQ and the questions involved. All patients attending the service during one week were asked to complete the questions and were assisted by an Aboriginal Social Work student who kindly volunteered her services for the week.

Thirty patients declined to co-operate because they were either too sick, could not read, were under the influence of alcohol or felt the questions were too personal. There were 109 completed SRQ's comprising 71 females and 35 males. Taking advice from previous reports, those with a cut-off score of 10 or more positive responses to questions were regarded as being psychiatric cases. Using this criterion, 34 (31%) of cases were identified. We were particularly interested in psychotic symptoms and found that 36 patients gave one psychotic response, 22 gave two, 4 gave three and another 4 gave four psychotic responses.

The results were discussed with those who are familiar with the difficulties and stresses of Aboriginals attempting to assimilate into white society. The opinion was expressed that it is inappropriate of Western psychiatrists to regard all these responses as necessarily being pathological. Such phenomena as premonitory dreams, telepathy, auditory hallucinations and awareness of ancestor spirits are all an intricate part of Aboriginal culture and belief systems.

The commonest psychotic response was an affirmative to the question, "Are you a much more important person than most people think?". The frequent "yes" answer to this question was thought to be an indication of what is perceived as resentment of the prevailing low opinion of Aboriginals held by white Australians. It is common knowledge that Aboriginal parents frequently reassure their children and adolescents that they are much more important than they think themselves to be.

In conclusion, we found that the SRQ was a suitable instrument for use in primary care situations but would advise caution in interpreting certain responses as indicating psychiatric pathology when they were in fact more likely to be a cultural response to anomie and demoralisation.

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#### Diagnostic Criteria for Dementia in DSM-III

DEAR SIR,

Jorm & Henderson (*Journal*, 1985, 147, 394-399) argue that the disorder of dementia is continuous with normal senescence because the Mini-Mental State (Folstein *et al.*, 1975) is distributed monotonically in community samples, neuropathological changes are found in both normal and demented people, and the disorder is usually described in terms of severity (pp. 394-395).

In the first of these arguments, Jorm & Henderson suggest that the failure to find a hump at the lower end of a distribution of cognitive test scores in the elderly population indicates the absence of a discrete disorder. Such evidence does not, however, rule out the possibility that the cognitive changes of dementia are qualitatively rather than quantitatively different from those of normal ageing because non-specific tests such as the Mini-Mental State may not measure the precise deficits which distinguish demented and elderly subjects. When more specialised tests are used, patients with dementia demonstrate serious specific impairments which suggest that they fail to use semantic information in memory encoding, and in this respect differ qualitatively from their peers (Weingartner *et al.*, 1981). Findings such as those by Weingartner *et al.* strongly suggest that quite different mechanisms (and hence causation) are involved in benign senescent forgetfulness and the memory deficits associated with Alzheimer type dementia.

In their second argument, Jorm & Henderson (1985) maintain that the neuropathological changes seen in Alzheimer patients 'merge' with those seen in normal elderly people, and such "merging" supports a dimensional relationship between Alzheimer's disease and normal ageing. Two issues need to be addressed here: first, whether pathological changes are similar in kind or degree in normal and demented groups, and secondly, what the significance of these neuropathological changes are for the continuity hypothesis. With respect to the first issue, contrary to Jorm & Henderson's position, some recent researchers (e.g., Keller, 1984) argue that the neuropathological changes in Alzheimer's disease differ in both location and in density from those observed in normal ageing (p. 41), suggesting a discontinuity, i.e. the superimposition of a disease process on senescence. Since intellectual performance appears to be relatively intact in brains which at postmortem show a certain degree of neuropathological change, a threshold effect is strongly indicated. Namely, once a certain level of neuropathology is reached, serious cognitive deficits appear. Presumably more research will clarify