trust that he will be similarly enlightened by our response.

NORMAN E. ROSENTHAL
STEVEN P. JAMES

Reference

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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