is more complex than that. In search of making sense of symptoms by the health professionals, we believe that the first step is by understanding the symptoms and the distress experienced by the individuals themselves through their identification that something has gone wrong; then their search for a possible explanation for their distress will lead to identifying possible sources of help and then finding a way to seek relief. However, in this process of help-seeking there are numerous culturally determined barriers. Stigma will indeed be a potential barrier but it is also likely that other factors may help modify the idioms of distress. In an earlier study of middle-aged Punjabi women, we found that they were able to identify symptoms of depression, and life events causing it, but they also felt that these symptoms were part of life's ups and downs and not a medical condition; hence, they preferred to seek solace in religious places (Bhugra *et al*, 1997). They identified both psychic and somatic symptoms but were also clear in their discussion that sources of help were not medical. Similar observations were made in Dubai (Sulaiman *et al*, 2001). Our conjecture is that globalisation will influence the way individuals see their distress because media influences may affect their cognitive schema. Cognitive schema determine the meanings we impart to ongoing experience and give an expectation of the future (Strauss & Quinn, 1997). We do not hold the view that somatisation is enigmatic. It is a perfectly understandable representation of the distress which is a reflection of the explanatory models held by the individual.

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Disability and post-traumatic stress

Neal *et al* (2004) recently found no association between post-traumatic stress and judgement of disability. Therefore, they concluded that the clinical importance of post-traumatic stress disorder (PTSD) and its symptoms may be questionable. However, in our opinion their conclusions need additional consideration.

First, their multivariate analysis of variance compared the degree of disability of persons with PTSD with that of people with other mental health problems. From their results they could only conclude that PTSD caused no additional disability compared with other mental health problems. Moreover, from a statistical point of view, the sample size is not sufficiently large, especially when one tries to find differences between groups given the significance level used (P=0.01). In addition, the authors do not give insight in the multicollinearity between the independent variables of the multiple regression analysis; the expected high intercorrelations may have influenced the results.

Second, is it not strange to question disability in people with PTSD, major depressive disorder or alcohol dependence, while disability in social or professional functioning or in other important areas is a requirement for all DSM–IV diagnoses? Also, the authors took subjective judgement of disability as their main outcome measure and not objective measures of disability, such as the number of days not at work.

Third, previous studies found contrasting results. Brown *et al* (1996) and Lydiard (1991) report that major depressive disorder comorbid with anxiety disorders (i.e. PTSD) is more severe than major depressive disorder alone in terms of depressive symptoms, course of illness and treatment response. Finally, even if PTSD does not cause additional disability above major depression, the diagnosis is still relevant for the correct choice of treatment.

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Author's reply: The multivariate analysis of variance demonstrated no significant difference between the group with DSM–IV PTSD and the group without DSM–IV PTSD in terms of the severity of disability. This finding is unrelated to the other mental health problems measured in the study, as shown by the analysis of covariance. The power of the study was 0.85 (assuming a detectable difference of 3 out of 30 on the Sheehan Disability Scale and α=0.01). This is acceptable for limiting the chances of type II error. Multicollinearity is only of importance when trying to draw inferences about the relative contribution of more than one predictor variable to the success of the model. In this study the Beck Depression Inventory (BDI) (or its variant the M–BDI) was the only variable retained in the regression models and so multicollinearity is not an issue. Disability is not an absolute requirement in DSM–IV. The utility of objective measures of disability *v.* subjective measures was discussed in the paper. However, the subjective experience of the patient is probably of most value in clinical terms. Other studies have found contrasting results, as discussed in the paper's introduction. However, most have methodological limitations. The treatment of PTSD, as opposed to depression, may be relevant to the DSM–IV diagnostic criteria but may not be relevant to the patient.

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In defence of complainants

It is interesting that the complaints involved within the study by Lester *et al* (2004) were not subject to independent legal scrutiny. The reader therefore has no idea of their merits.

Anyone who has experienced the difficulties of authorities and courts will realise that bureaucracy and confusion pervade each institution. Anyone who has attended one of our supreme courts will know that the service is slow, correspondence often goes missing, checks are required to ensure that the correct folders and paperwork are presented, and often uncomfortable questions are ignored. These are characteristics

https://doi.org/10.1192/bjp.185.2.175 Published online by Cambridge University Press