

translation for the Chinese word *si*. Even *si* has no connotation of any emotional state at all in the Chinese language. Interestingly, Kaptchuk (1983) used the word 'pensiveness' for the word *si*, which does carry an emotional meaning of melancholy and sadness. How he came to use pensiveness to translate *si* is interesting indeed. In the *Dictionary of Traditional Chinese Medicine* (Beijing Medical College, 1984), *si* is translated into the word 'anxiety'. Furthermore, not all of the seven emotions were brought into clinical use.

Before the sinologists can translate the Chinese words correctly, and the lexicologists interpret the exact meaning of these words, we are just a group of armchair transcultural psychiatrists studying tautology, philology, analogy, and end up with pleonastic epistemology.

BEIJING MEDICAL COLLEGE (1984) *Dictionary of Traditional Chinese Medicine*. Hong Kong: The Commercial Press.

KAPTCHUK, T. J. (1983) *Chinese Medicine*, p. 129. London: Rider.

CHRISTOPH YUNG

Department of Psychiatry
Texas Tech University Health Sciences Center
3601 4th Street
Lubbock, Texas 79430, USA

The ethics of resource allocation

SIR: A point not mentioned by Dr Healy (*Journal*, January 1993, 162, 23–29) is the enormous savings made every time a long-stay patient is discharged subsequent to clozapine introduction. But there is another matter. Compared with the money spent on computer systems, and information technology departments to service them, the money spent on clozapine is chicken-feed. Has any attempt been made to evaluate the benefit to patients arising from the introduction of so much technology?

DAVID BUDDEN

Pharmacy Department
St Matthew's Hospital
Burntwood, Walsall
West Midlands WS7 9ES

Personality disorder and self-report questionnaire

SIR: Coid (*Journal*, February 1993, 162, 265) asserted that Dowson (*Journal*, September 1992, 161, 344–352) had provided evidence that the assessment of personality disorder by self-report instruments is invalid. We have tested a computerised version of Dowson's modified Personality Diagnostic Questionnaire (PDQ) on a group of 20 patients, and clinically assessed each of the positive responses

against the DSM–III–R criteria which they are intended to assess. Schizotypal and borderline personality disorders, and many traits in the other categories were significantly overdiagnosed.

A subsequent systematic comparison of the PDQ (modified) with the DSM–III–R criteria indicated, in disagreement with Dowson, that many of the items have poor face validity. Several items have confusing double negatives, and many produce false positive responses. However, the face validity of the clinician-administered Structured Clinical Interview Schedule (SCID-II) employed by Coid appears high, and this difference could explain the discrepancy. I would therefore question Coid's rather sweeping conclusions that self-report instruments "should not be employed in the future". We are improving the construct validity of our computerised version of the PDQ by rewording many of the items through a process of trial and error. As a self-report assessment instrument of personality, it is becoming clinically useful.

LEIGH NEAL

Department of Psychiatry
Princess Alexandra's Hospital
RAF Wroughton
Swindon, Wiltshire SN4 0QJ

Computerised assessment of depression in the medically ill

SIR: Meakin (*Journal*, February 1992, 160, 212–216) states that "the main rival of paper and pencil tests at present is the brief standardised interview", and "there are few other options available as screening tests". We would like to point out another available option overlooked: computer-administered assessment of depression. We recently developed a computer-administered version of the Hamilton Depression Rating Scale (Hamilton, 1960; Kobak *et al.*, 1990). Correlations with the clinician-administered version of the scale were high (0.96), and the mean score difference was not significant. The scale showed high internal consistency reliability (0.91). Using a cut-off score of 17, the computer correctly identified 94% of patients with major depression, and did not incorrectly identify any control subjects as having an affective disorder.

The need for identification and treatment of depression in medically ill, primary care patients is apparent. The National Institute of Mental Health multi-site Epidemiologic Catchment Area study found that while only 31% of patients identified with an affective disorder had sought help in the previous six months, 45% of these patients had sought treatment from their primary health care provider for a