Methods: The authors used a questionnaire derived by them from the Hamilton Rating Scale for Depression (HRSD) which they describe as the "most appropriate in community studies in the elderly". They cite Kearns *et al* (1982) in support of this, but in fact Kearns *et al* were at pains to point out that their observations on depression rating scales in in-patient samples could not be extended to out-patient or community settings. The HRSD is valid only as a measure of severity in established cases of depression; its usefulness with non-cases remains to be demonstrated, particularly in the elderly. There is much emphasis on somatisation and psychomotor symptoms in the HRSD, and positive responses to these items may well be related more to physical illness than to depressed mood in this age group.

The authors seem to have eschewed any sort of validation – they comment on the "confused" classification of depression in psychiatry, and assert that "depression and dementia here refer to categories defined according to . . . rating scales and not to clinical diagnoses". However, they quote "prevalence" figures, and seek to impress upon us the clinical relevance and "retrospective justification" of their factors and clusters; these might have been more convincing had they provided us with some initial validation of their cut-off criteria. I was particularly struck by their comment that "a score of 0–13 [on the HRSD] would include all normals but would not exclude all depressed patients – have they not heard of false positives? It is a pity that no psychiatrists were involved in their study.

Aims: The declared aims of Griffiths *et al* were to determine the association between depression, dementia, and disability, and to identify patients at risk in the community. The first aim has been thwarted by their inadequate sampling and methodology; the second seems to have been abandoned, since there is nothing in their paper that relates to it.

Good *et al* are particularly coy about the purpose of their study, and no underlying hypothesis is discernible. Implicit in their introduction is the potentially interesting notion that normal subjects and those with depression have a common structure to their symptoms, but they have not tested this useful null hypothesis with separate analyses of normal and depressed groups. Rather, all we are given is a description of the symptom structure in the group as a whole, quite unrelated to any clinical or operational diagnoses.

Had the authors clarified their aims at the outset they might have chosen their sample and methods more appropriately, and their fine display of multivariate techniques would have been to some purpose. As it is, their efforts merely demonstrate yet again that in epidemiological research at least you can't make a silk purse out of a sow's ear – not even with cubic polynomials.

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SIR: We were interested in the comments made by Lindesay, but consider that most of the points he raises would be answered by a more careful reading of our original papers. He reiterates reservations about the sample which we had been at pains to point out in our presentation. His criticisms underline the epidemiological problems we discussed.

We avoided arguing from the particular to the general – the subjects were 'elderly in the community', not "community elderly" as Lindesay alleges we asserted – there is a semantic difference. We emphasised that our sample was a 'good' group, described in terms of disability, and suitable for comparison with groups such as the housebound. Nowhere do we purport that the sample was random.

Our selection of the HRSD was based on a wide examination of the literature, and was not predicated on Kearns *et al* (1982) alone.

The identification of patients at risk is implicit in the final paragraphs of the discussion of Griffiths *et al* (*Journal*, April 1987, **150**, 482–493).

In Good *et al* (*Journal*, April 1987, **150**, 463–470) we stated that separate results were not presented for subsets of the sample, although the factor structure of the 'normal' subjects was similar to that of the whole sample; it would have been of little value to present a statistically non-significant analysis of the small depressed group.

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