for depression in the medically ill. He claims that satisfactory screening for the symptoms of major depression demonstrates the usefulness of pencil and paper tests to non-psychiatrists. However, the validity of the concept of major depression and the indications for tricyclic drugs in the medically ill with depression have not been satisfactorily established.

Psychological symptoms are distributed continuously in the medical population with no clear separation between the psychiatrically ill and normal subjects. Proportionally more physically ill subjects have high numbers of psychological symptoms because the distribution curve is shifted to the right compared with the community population (House, 1988). A high number of medically ill patients will therefore be diagnosed as suffering from major depression. Since the latter concept was derived from observations of psychiatric patients, it cannot be assumed that a diagnosis of major depression implies the same need for antidepressant treatment in the medically ill. Most cases of significant depression occur because of the patient's awareness of the illness and its implications. Many of these episodes tend to be short-lived, resolve spontaneously (Lloyd & Cawley, 1983) or require psychosocial forms of treatment. Antidepressants are indicated in the medically ill when major depression precedes a significant medical illness, depressive symptoms are severe, or when they do not resolve after a few months. The role of antidepressants in the treatment of depression in the medically ill is otherwise unclear (Lloyd, 1991) and requires further research.

The specificity and sensitivity of pencil and paper tests for psychiatric disorders for medically ill patients should first be evaluated in terms of prognosis. Tests which identify patients with depression that does not resolve spontaneously after a few months would be extremely useful. Until then, paper and pencil tests for psychiatric disorders have a limited role in clinical practice for non-psychiatrists. There is now good evidence that the detection and management of psychiatric disorders by non-psychiatrists can be improved by a short course of interviewing training (Gask *et al*, 1987). This may be a better alternative for improving psychiatric detection and management in the general hospital.

GASK, L., MCGRATH, G., GOLDBERG, D. P., *et al* (1987) Improving the psychiatric skills of established general practitioners: evaluation of group training. *Medical Education*, **21**, 362–368.

HOUSE, A. (1988) Mood disorders in the physically ill: problems of definition and measurement. *Journal of Psychosomatic Research*, **32**, 345–353.

LLOYD, G. G. (1991) *Textbook of General Hospital Psychiatry*. Edinburgh: Churchill Livingstone.

LLOYD, G. G. & CAWLEY, R. H. (1983) Distress or illness? A study of psychological symptoms after myocardial infarction. *British Journal of Psychiatry*, **142**, 120–125.

RICHARD K. MORRISS

Department of Psychiatry
University Hospital of South Manchester
West Didsbury
Manchester M20 8LR

Systemic family therapy in adult psychiatry

SIR: I read with interest the paper by Bloch *et al* (*Journal*, September 1991, **159**, 357–364). We would agree that there is a need for increased systemic understanding in adult psychiatric practice.

We have had a Brief Therapy clinic in this hospital for three years. Unlike the Milan style favoured by Professor Bloch, we use work derived from the Mental Research Institute and the writings of Steve de Shazer (Fisch *et al*, 1982; de Shazer, 1988). We have found their approach to be of value in numerous cases. The clinic provides training in systemic work for hospital staff of various disciplines. An outcome study is in progress and early results are promising.

FISCH, R., WEAKLAND, J. H. & SEGAL, L. (1982) *The Tactics of Change: Doing Therapy Briefly*. San Francisco: Jossey-Bass.

DE SHAZER, S. (1988) *Clues: Investigating Solutions in Brief Therapy*. New York: Norton.

ALASDAIR J. MACDONALD

Crichton Royal Hospital
Dumfries DG1 4TG
Scotland

Service use by Indian immigrants

SIR: I read with great interest Sunjai Gupta's paper (*Journal*, August 1991, **159**, 222–225), which is thought-provoking. He does admit the need for further study about the genuine differences in the outcome determinants of psychosis in first-generation Asian immigrants.

I believe that any prospective study in future in relation to service utilisation and determinants of outcome in psychiatric disorders among Asians should take into consideration the 'pathway to psychiatric care for Asian patients'. My clinical impression, having worked with a large population of Asians in Leicester, is that almost 30–50% of my patients, both before and after contact with the psychiatric services, visit traditional healers, hakims, etc. These alternative pathways are pursued either in the UK or abroad. Psychiatric practice in India suggests one-third of patients had treatment with faith healers before the first consultation (Trivedi & Settu, 1980).