in schizophrenia as well\(^5\). Therefore, the claim of identifying BDI as a valid instrument for picking up depressive symptoms in chronic schizophrenia needs to be qualified. If the implication is that it is more valid than HDS, then this paper does not answer such a question. As mentioned above, different scores on two different scales do not imply greater or lesser validity. The authors base this claim on the assumption that BDI and HDS pick up different kind of phenomena. It should be emphasized that the difference in BDI and HDS is not so much in the phenomena (both pick up affective, cognitive and somatic components of depression) but in the way it is administered.

5. The possibility of the study being underpowered has not been alluded to. For instance in a study with three groups at the significance criteria (\(\alpha\)) of 0.5, and a medium effect size (which seems reasonable), a sample size of 52 patients per group would be required\(^8\). While this may not be possible given the constraints of the study design, I believe that the conclusions drawn should have acknowledged this limitation.

**Authors’ response**

Following is our response to the queries raised by Dr Singh\(^1\):

1. The participants were consecutive attendees at our Community Mental Health Centre in Salford, UK. The criteria for inclusion in the Depression in Acute Schizophrenia (DepASch) and Depression in Chronic Schizophrenia (DepChrSch) groups were based on screening of individuals with known schizophrenia. The Depression (Dep) group was a control group who had previously been diagnosed to have clinical depression on the basis of DSM-IV criteria, American Psychiatric Association, 1994\(^2\). In each group depressive symptoms had been present for at least 14 days prior to assessment. The threshold for inclusion from each group was a score greater than 16 on the Hamilton Depression Scale (HDS).

2. In each group depressive symptoms had been present for at least 14 days prior to assessment. The threshold for inclusion from each group was a score greater than 16 on the HDS.

3. We accept the point made by Dr Singh\(^1\). However we respectfully point out that the BDI and HDS are commonly used in the everyday clinical setting for evaluating and following depression in people with schizophrenia. Hence we feel that their use in this study is justified.

4. We were not trying to make any position statement concerning the sensitivity of the Beck vs. Hamilton scales, rather to make the point that the nature of depressive symptoms in stable chronic schizophrenia is predominantly subjective whereas in acute schizophrenia the symptom profile includes the classical biological symptoms of depression as rated by the Hamilton Depression Scale. In reality, both rating scales should be administered. We just wanted readers to be aware that the Beck scale sometimes detects depression in chronic long-term schizophrenia when this would be missed by the Hamilton scale.

5. We accept this limitation. However, we feel that our conclusion that the BDI be used to identify depressive symptoms in chronic schizophrenia so that early intervention can be targeted appropriately is a valid one, given the

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**Shubh Mohan Singh**  
Department of Psychiatry  
Gyan Sagar Medical College & Hospital  
Banur 140 601, Punjab, India  
shubhmohan@gmail.com

**References**


robustness of the statistical analysis performed by Soni.  

A. Heald, J. Morris & S.M. Soni
Salford Royal Hospitals University Trust
Hope Hospital, Salford
Greater Manchester M6 8HD, UK
*For correspondence:
adrian.heald@manchester.ac.uk

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