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Authors' reply: Our rationale for investigating suicides in England & Wales jointly was twofold. First, although the male suicide rate has been somewhat higher in Wales than in England in recent years, the difference was not nearly as marked as that for Scotland *v.* England, as shown in Fig.1. The pattern of change in trends over the past two decades was also more similar for England *v.* Wales than when compared with Scotland. During the same period, there was little difference in the female suicide rate between England and Wales, while the female rate in Scotland was significantly higher than in the other two countries.

Our second reason was a technical one. At the beginning of our study, we sought advice from the General Register Office for Scotland and the Office for National Statistics about the comparability of their routinely reported suicide data. Because of differences in how suicide data were typically extracted by the two organisations, based on the usual residence and place of death of the deceased, it was concluded that using data from England & Wales combined would give us the best comparison with the Scottish data.

The cultural and ascertainment explanations of higher rates of suicide by drowning in Scotland proposed by Evans are interesting and plausible. An investigation of suicides in Scotland by Platt *et al* has reported that drowning as a method of suicide is more common in the Highlands and the Islands than other local areas in the country.¹ This method of suicide, however, would not have accounted for much of the overall differential between Scotland and England & Wales, for two reasons. First, it is a relatively rare method, accounting for 5% of all suicide cases in England & Wales, and 10% of those in Scotland, between 2000 and 2008,

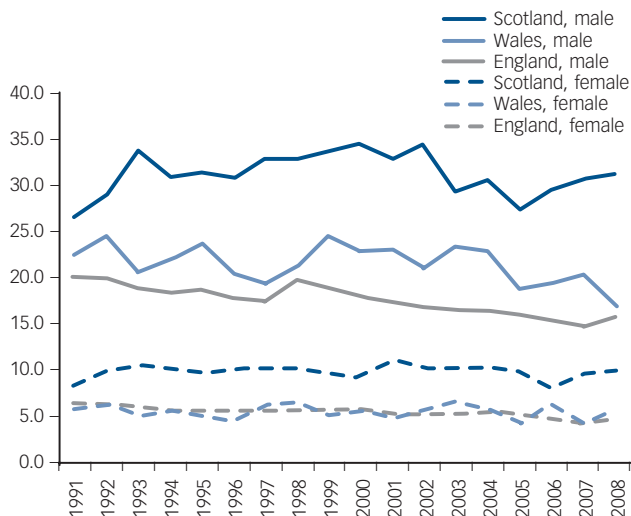


Fig. 1 Age standardised suicide rates by country, 1991–2008 (persons aged 15 and over). Data from General Register Office for Scotland and the Office for National Statistics.

and therefore would have made only a minor contribution to the overall between-country differential in risk. Second, although Scotland may contain the great bulk of all the standing water in Great Britain, most Scottish people who died by suicide lived in large urban areas located a considerable distance from the Highlands, where access to such a suicide method was unlikely to be any greater than was the case in England & Wales.

Declaration of interest

L.A. is the National Clinical Director for Health and Criminal Justice, and chairs the Suicide Prevention Advisory Group at the Department of Health. He was also the National Director for Mental Health in England between 2000 and 2010.

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Clinimetrics and psychometrics: never the twain shall meet?

Meta-analysis is upheld as a higher order analysis but it is not without fault as is evident in the conundrums raised by Hegeman *et al*'s article.¹ Although the methodology was rigorously applied, even the final list of 11 studies included in the meta-analysis were not entirely comparable, particularly in the area of medical comorbidity, a point highlighted by the authors. Our own clinical experience and findings (possibly shared by other psychiatrists) have been that the elderly do have significant medical comorbidity that affect clinical presentations. In one study, all but one elderly patient had a medical condition and 60% had two medical conditions.² The meta-analysis also does not take into account the significant role socioeconomic and cultural factors have in depressive symptom development and progression in the elderly. Socioeconomic issues play an important part given the changes in occupation, lifestyle and other roles in the elderly. This paper also serves to highlight the recently resurfaced distinction between clinimetrics and psychometrics.³ The relevance and applicability of psychometrically driven research is sometimes difficult to translate for the psychiatrist in clinical settings. Clinicians cannot rely entirely on rating instruments to arrive at a diagnosis and to devise management care plans. Clinicians will sieve through the history and presentations in detail and make global judgements on information presented, a process that goes beyond the one-dimensional nature of checklists and rating scales. Fava *et al* alluded to the 'sophisticated thinking that underlies clinical decisions' and that is a point that deserves consideration even as we review journal articles on research which is largely psychometrically driven to glean benefit for our clinical practice.

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Authors' reply: As highlighted by Mahendran, depression in late-life is often accompanied by medical comorbidity.¹ Owing to the lack of information on medical comorbidity in the studies included in our meta-analysis, we could not evaluate to what extent the differences found could be explained by an overlap in somatic symptoms of depression and medical comorbidity. Of the 11 included studies, only 4 reported on medical comorbidity. As the study sample of Koenig *et al* consisted of a medical in-patient population, medical comorbidity was present in both younger and older people with depression.² Moreover, age-related differences in the phenomenology of depression persisted after adjustment was made for medical comorbidity. In the studies of Brodaty *et al*, Gournellis *et al* and Tan *et al*, the levels of somatic comorbidity were indeed higher in older compared with younger people with depression.^{3–5} We did acknowledge that age-related somatic comorbidity may have caused some overlap with somatic symptoms of depression, explaining part of the age-related differences in the phenomenology of major depression. On the other hand, somatic comorbidity may also have an impact on the phenomenology of late-life depression, apart from the overlap of symptoms. Unfortunately, in our meta-analysis it was impossible to unravel potential mediating effects.

As noted in the introduction section, we agree with Mahendran that sociocultural and psychological factors related to ageing may influence the clinical presentation of depression in late life. In this meta-analysis, however, we aimed to investigate whether age-related differences in the phenomenology of depression exist at all. The question as to which of the biological, psychological or sociocultural factors may cause age-related differences, and how they might modify the phenomenology of depression in late life, needs further examination.

An important issue raised by Mahendran concerns the distinction between clinimetrics and psychometrics. Of course

clinicians cannot rely on existing psychometric rating scales alone when making clinical decisions. However, this distinction does not affect the overall results of our meta-analysis. Age-related differences in the clinical manifestation of major depression were investigated to start with. Going one step further, phenomenological differences corresponding to differences in prognosis, treatment and determinants, need to be investigated in future research, all of them important for clinical reasoning. Furthermore, this may not be so much an issue of clinimetrics as opposed to psychometrics, but a consequence of the inadequacy of the categorical DSM-IV classification system, leading to extensive comorbidity and diagnostic heterogeneity which impedes the search for determinants.⁶ As depression is a highly heterogeneous disorder, we focused on major depression to enable the search for age-related differences. Moreover, because no commonly used clinimetrically based model exists, we chose to use the most appropriate instrument currently available.

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