

Correspondence

EDITED BY LOUISE HOWARD

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Suicide attempts in rural southern Spain

Sir: The results from the 15 research centres included in the recent WHO–EURO Multicentre Study on Parasuicide (Bille-Brahe *et al*, 1996) varied substantially. Therefore, the data from the centres grouped together as a single sample appear unrepresentative; different sociocultural features may be associated with suicide attempts in different regions of Europe.

As part of a broader study on suicide attempts in a rural area in southern Spain (Osuna, Seville) we sought to establish the annual prevalence of parasuicide per 100 000 inhabitants, and to evaluate any gender- and age-related differences in risk factors. The same definition of suicide attempt as that used by Bille-Brahe *et al* (1996) was used. The sample was taken from attenders at the Emergency Department of Osuna Hospital – the point of contact for medical or surgical treatment of any such attempt (whether within the public or private health care systems) within the region of interest.

In 1997 the annual prevalence of parasuicide attempts (resulting in attendance at the Emergency Department of Osuna Hospital) was 101.8/100 000 (112 attempts/110 056 inhabitants). (If repeat attempts are excluded, this figure falls to 85.4/100 000 (94 individuals/110 056 inhabitants).) This figure is above those found in the southern European centres included in the WHO–EURO Multicentre Study (i.e. Emilia-Romagna, Padua and Guipúzcoa) (Bille-Brahe *et al*, 1996). Despite the fact that it has traditionally been considered that the highest rates of suicide and parasuicide occur in urban areas (González *et al*, 1997), some studies have found rates in rural areas equal to or even greater than those seen in urban areas (Gabriel *et al*, 1993 (Greece); Obafunwa & Busuttill, 1994 (Scotland)). Explanations postulated for these elevated rates of suicide and parasuicide in rural areas have included agricultural decline,

technological development and consequent socio-economic changes, and the imitation by young people of urban models of behaviour. The prevalence rate reported here is greater than that obtained recently for Madrid (Gutierrez *et al*, 1997) and, therefore, adds to the evidence bringing into question the traditional association between suicide attempts and urban areas.

The female to male ratio in the present series was 1.28:1, in accordance with the progressive increase in male parasuicide rates observed internationally. Male gender was significantly associated ($P < 0.01$ by χ^2 and analysis of variance) with less possibility of rescue, less self-criticism after the attempt, reduced frequency of personality or adjustment or neurotic disorders and increased frequency of schizophrenia and psychoactive substance-related disorders, and greater use of non-pharmacological (i.e. violent) methods. These gender differences increased with increasing age of the subject; indeed, there was greater overall severity with increasing age. Thus, in our area, age and gender were simple and reliable markers for severity.

Given the sociocultural variation attending parasuicidal acts, it would be of interest to investigate the modulating effects of these socio-demographic variables in other Mediterranean areas and in other European countries, as well as the differences in prevalence rates between urban and rural areas.

Bille-Brahe, U., Anderson, K., Wasserman, D., et al (1996) The WHO–EURO Multicentre Study: risk of parasuicide and the comparability of the areas under study. *Crisis*, 17, 32–42.

Gabriel, J., Paschalis, C. H. & Beratis, S. (1993) Suicide in urban and rural southern Greece. *European Journal of Psychiatry*, 7, 103–111.

González García-Portilla, M. P., Sáiz-Martínez, P. A., Bobes, J., et al (1997) Factores sociodemográficos. In *Prevención de las Conductas Suicidas y Parasuicidas* (eds J. Bobes, J. C. González-Seijó & P. A. Sáiz-Martínez), pp. 46–53. Barcelona: Masson.

Gutierrez, E., Gamo, E., Guindeo, J., et al (1997) Estudio epidemiológico de las tentativas de suicidio atendidas en la urgencia hospitalaria. *Actas Luso-*

Españolas de Neurología, Psiquiatría y Ciencias Afines, 25, 172–181.

Obafunwa, J. O. & Busuttill, A. (1994) A review of completed suicides in the Lothian and Borders region of Scotland (1987–1991). *Social Psychiatry and Psychiatric Epidemiology*, 29, 100–106.

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Prevalence of depression in old age

Sir: If I understand him correctly, Blazer (1999) believes that reports concerning the prevalence of major depression in old age are not very meaningful – he used the words “not that interesting”. He referred to “the role of comorbidity . . . which is common among the elderly, yet not considered in the operationalised criteria for major depression”. He stated that the question “what is the true prevalence of depression in late life?” cannot be answered because researchers have used differing methodologies in their population studies. Surely the major problem is that researchers vary in their definitions of depression.

Reifler (1994) stated that “when geriatric psychiatrists talk about depression in elderly persons, they are usually referring to major depression”. Copeland (1999) commented that European psychiatrists fling the net wider and “seem to identify depression at treatable level wherever it is found, taking together . . . major depression, dysthymia, adjustment disorder and the more severe forms of bereavement”. He added that method should be determined by purpose, and the Europeans seem to prefer the wider concept when it comes to intervention. It is unsurprising that researchers who define depression differently have different answers concerning the prevalence of depression in late life.

Discussions about these differences become rather tedious, as Dr Blazer implies. However, I submit that those advocating for optimal care for elderly people should remain interested in the question of prevalence.

First, if doctors believe that depression is less common in old age, they may be less likely to look for it. Second, administrators may be influenced by prevalence figures when considering allocation of resources.

The latter can be illustrated by an Australian example. A recent, expensive survey of 10 000 adult Australians (McLennan, 1998) repeated various of the mistakes noted in earlier studies and added some of its own (Snowdon

et al, 1998). The prevalence of affective disorders (major depression, dysthymia, mania, hypomania and bipolar disorder) was reported as only 1.7% among those aged 65 years and over, while it was 5.8% among the total adult population. Because mental disorders were reported in this survey to have a much higher prevalence among young people (over 20% at age 18–44 years, compared with 6.1% after age 65 years), the Minister for Health emphasised the need for a national focus on mental health services for young people. The New South Wales Department of Health referred to the same survey and commented on the lower mental health morbidity of older people, in a document describing plans for the distribution of resources.

Survey reports can be misinterpreted. Clinicians and administrators may need to be reminded that treatment for depression may be of benefit to far more older people than just those with a diagnosis of major depression. In this context, I agree that some prevalence studies should be recognised (at least by budget-holders) as “not that interesting”.

Blazer, D. (1999) EURODEP Consortium and late-life depression. *British Journal of Psychiatry*, **174**, 284–285.

Copeland, J. R. M. (1999) Depression of older age. Origins of the study. *British Journal of Psychiatry*, **174**, 304–306.

McLennan, W. (1998) *Mental Health and Wellbeing: Profile of Adults, Australia 1997*. Canberra: Australian Bureau of Statistics.

Reifler, B. V. (1994) Depression: diagnosis and comorbidity. In *Diagnosis and Treatment of Depression in Late Life* (eds L. S. Schneider, O. F. Reynolds, B. D. Lebowitz, et al), pp. 55–59. Washington, DC: American Psychiatric Press.

Snowdon, J., Draper, B., Chiu, E., et al (1998) Surveys of mental health and wellbeing: critical comments. *Australasian Psychiatry*, **6**, 246–247.

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Stereotypes of ageing

Sir: Copeland *et al* (1999) concluded that depressive symptoms in older people do not uphold the stereotypes of old age. However, the study itself seems to preconceive the stereotype that ‘older people are asexual’. This is contrary to the evidence that sex continues to play an important part in the lives of both men and women, at least until the mid-seventies, with little if any decline in enjoyment and satisfaction (Kinsey *et al*, 1953; Kellett, 1996). Sexual dysfunction

is well recognised as a symptom of depression in the ICD–10 and in the DSM–IV as well as in community studies of the depressed elderly (Kivela & Pakkala, 1988). We regret to note that the new EURO–D scale (Prince *et al*, 1999) also accepts this stereotype by ignoring sexual dysfunction as a symptom of depression in the elderly.

Copeland, J. R. M., Beekman, A. T. F., Dewey, M. E., et al (1999) Cross-cultural comparison of depressive symptoms in Europe does not support stereotypes of ageing. *British Journal of Psychiatry*, **174**, 322–329.

Kellett, J. M. (1996) Sex and the elderly male. *Sexual and Marital Therapy*, **11**, 281–288.

Kinsey, A. C., Pomeroy, W. B., Martin, C. E., et al (1953) *Sexual Behaviour in the Human Female*. Philadelphia, PA: W. B. Saunders.

Kivela, S. I. & Pakkala, K. (1988) Clinician-rated symptoms and signs of depression in aged Finns. *International Journal of Social Psychiatry*, **4**, 274–284.

Prince, M. J., Reischies, F., Beekman, A. T. F., et al (1999) Development of the EURO–D scale – a European Union initiative to compare symptoms of depression in 14 European centres. *British Journal of Psychiatry*, **174**, 330–338.

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Author’s reply: I will start by trying to answer the last point raised by Drs Praseedom, Tube, Vourdas, Rafnar and Woodfield. The purpose of the EURO–D Scale is to harmonise some existing scales of depression. Rightly or wrongly, such scales for older people tend not to include a question about sexual activity, which is why EURO–D itself could not include it. Similarly, the fact that sexual activity was not discussed in the article should not be interpreted to mean that the authors do not regard it as important in older people. The items discussed were limited to those which had been recorded by sufficient centres to make comparison possible. Sexual activity was not one of these. In a longitudinal study in which it is proposed to burden the respondent with later interviews, the great fear of research workers is that of refusal to proceed after the first interview. Questions on sexual activity were removed from the community versions of the Geriatric Mental State when it was found to upset a small proportion of respondents. They can be included if wished. Also, although intrinsically interesting, it is not a symptom essential for diagnosis.

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Old age forensic psychiatry

Sir: The editorial by Yorston (1999), while thought-provoking in that it highlights the potential creation of a sub-speciality, is not backed by robust arguments. Simply quoting that crime is rarely associated with the elderly is not an argument in favour of creating a sub-speciality within forensic psychiatry. In our experience, there is enough evidence to support the view that resources, if available, should be concentrated on other subgroups of patients (i.e. young offenders, women) among whom there is a well-established lack of resources to meet an increasing demand.

The author seeks to create an impression of a distinct lack of inter-speciality collaboration in respect of forensic psychiatry issues pertaining to the elderly. This surprises us as it has not been our experience, certainly at local level. When appropriate, there is close and open communication between the old age and regional forensic psychiatry services. This inter-speciality collaboration helps to identify potential problems and allows for little delay when intervention is required to respond and manage such cases as they present, particularly in the community. This has, in the past, allowed for ease of passage through the medium secure unit.

One might consider that medium secure units are not ideal environments to meet the needs of the elderly, but to extend this, as the author suggests, to a declaration of unmet needs is too sweeping a statement.

From a training viewpoint, we would expect those in higher forensic training to have appropriate experience, in both assessing and treating elderly offenders. Current higher training programmes in forensic psychiatry should offer experience in sub-specialities such as child and adolescent, learning disability, drug and alcohol, prison, and old age psychiatry.

To conclude, the notion that elderly offenders are missing out in terms of specialist assessment and treatment does not, we believe, hold true.

Yorston, G. (1999) Aged and dangerous. Old age forensic psychiatry. *British Journal of Psychiatry*, **174**, 193–195.

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Cytosolic phospholipase A₂ gene in schizophrenia

Sir: Walker *et al* (1999) present an excellent, and much needed, overview of altered lipid