suicidal behaviour is raised by 'pro-suicide' internet sites, as we lack all but the most preliminary studies in this area. Those studies that have been completed, in line with earlier research on 'pro-anorexia' sites, reported that 'pro-self-injury' boards relay mixed messages – clearly providing social support, coping methods and understanding, but also tending to minimise the significance of self-harming behaviour.[3] On the basis of current evidence, we might hypothesise that the use of such websites could equally be a protective factor or a risk factor.

The authors also mention internet addiction but seem unaware that the existing research is based on inconsistent criteria, is subject to widespread sample bias, relies almost entirely on correlative studies,[4] and that the concept itself lacks conceptual validity.[5] I challenge the authors to find any empirical studies to support their claim that in Asia 'cardiopulmonary-related deaths and even game-related murders in internet cafes are now regarded as serious public health issues'.

I wholeheartedly support the authors' contention that clinicians should consider the role of the internet in the lives of patients, but I would stress that this needs to be done with an understanding of the relevant research literature and a working knowledge of both the technology and culture of the medium.

We ask no less in other areas of clinical work and this is particularly important in a time when fears about the internet are amplified by the media with little regard to the evidence base.

1 Cooney GM, Morris J. Time to start taking an internet history? *Br J Psychiatry* 2009; **194**: 185.

2 Recupero PR, Harms SE, Noble JM. Googling suicide: surfing for suicide information on the Internet. *J Clin Psychiatry* 2008; **69**: 878–88.

3 Whitlock JL, Powers JL, Eckenrode J (2006) The virtual cutting edge: the internet and adolescent self-injury. *Dev Psychol* 2006; **42**: 407–17.

4 Byun S, Ruffini C, Mills JE, Douglas AC, Niang M, Stepchenkova S, et al (2008) Internet addiction: metasynthesis of 1996–2006 quantitative research. *Cyberpsychol Behav* 2008; Epub ahead of print.

5 Bell V. Online information, extreme communities and internet therapy: Is the internet good for our mental health? *J Ment Health* 2007; **16**: 445–57.

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Authors' reply: We welcome Dr Bell's interest in our letter and would be happy to debate the issue – but find ourselves entirely in agreement with him. He makes some crucial points which we too would emphasise. In particular, we all share the 'contention that clinicians should consider the role of the internet in the lives of patients'. We too 'would stress that this needs to be done with an understanding of the relevant research literature and a working knowledge of both the technology and culture of the medium.' Sadly, there is too little sound evidence to inform our attitudes.

Bell argues rightly that internet use could 'equally be a protective factor' and indeed one of us (J.M.) has participated in research exploiting the potential for delivering therapy via the web.

Bell is right in suggesting that until we have a better understanding of the complex and subtle influences which may be disseminated by the medium of the internet – and indeed by other communication media too – we and our colleagues are likely to fall into the trap of caricaturing both risks and benefits of internet use.

We are certainly aware that the term 'internet addiction' is itself a caricature of a diagnosis rather than a well-explored entity, but in the absence of empirical studies we are obliged to rely on anecdotal evidence. It has been as a result of some distressing clinical experiences, as well as concerns raised sensationally rather than scientifically in the media, that we have been moved to highlight the issue and to embark on our own preliminary studies.

Our letter does not aim to re-ignite a debate on whether the internet is helpful or harmful. As Dr Bell has observed, such a reductionist approach belies the complexity and variety of internet-based activities, any of which may have an influence in either direction.[1] We instead reflect that without empirical data to inform us, and where there is the possibility of either risk or benefit, careful and sensitive questioning of patients with high internet use may be a valuable component of a full psychiatric assessment.

The internet has taken a central place in modern culture particularly among younger people. Although we may not fully understand the complex interactions of the web and mental health, and while we await research to enlighten us, we are left with the choice to either ignore or engage with this phenomenon. Legislators, mental health advocates,[2] concerned parents and media journalists have all focused their efforts. It is time for scientists and clinicians to follow suit. In our view, this begins with the careful taking of an internet history.

1 Bell V. Online information, extreme communities and internet therapy: Is the internet good for our mental health? *J Ment Health* 2007; **16**: 445–57.

2 Papyrus: Prevention of Young Suicide. 2008 (http://www.papyrus-uk.org/news.html).

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Dementia: suicide by drowning

Purandare *et al*'s article on suicide in dementia is a valuable contribution to suicide research in the elderly, particularly in those with dementia.[1] The authors have already dealt with a number of methodological limitations quite succinctly. One important limitation in particular is the choice of controls. As the authors rightly stated, a control group of patients with dementia who had not died by suicide would have been more appropriate.

In the Method section, the authors referred to ICD–10 only and not ICD–9. As far as I am aware from my own experience dealing with the Office for National Statistics (ONS), ICD–10 has been used by ONS only since 2001. Prior to this date and for the first 5 years of Purandare *et al*'s study period (1996–2000), the ONS used ICD–9. If the authors applied the same criteria in their selection of suicide and open verdicts in cases reported between April 1996 and December 2000, then I assume they would have selected: ICD–9 E950–E959 for suicide and E980–989 excluding E988.8 for open verdicts respectively in a similar manner as they did with ICD–10 (p. 175). However, this very relevant fact does not appear to have been mentioned or explained by the authors, and was quite possibly omitted from the manuscript in error. However, this omission, which covers 5 years of a 9-year study, ought to be acknowledged and duly corrected.

I am grateful that the paper provides the opportunity to make one or two comments on some issues relating to drowning as a method of suicide in the elderly. Suicide by drowning accounted for 13.5% of total elderly suicide, being the third commonest cause of death in elderly suicide in England and Wales during 1979–2001 (16% for women as the second commonest cause of

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