

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.

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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