

We agree that depression following myocardial infarction predicts long-term quality of life and we recently showed that this effect persists after controlling for cardiac condition and quality of life at 3 months post-myocardial infarction (de Jonge *et al*, 2006). However, it is unclear whether and how detection and treatment of depression can counter these effects. In the SADHART study Glassman *et al* (2002) found that the effects of sertraline were modest and appeared to be restricted to depression with an onset before the infarction, but Dickens *et al* found that depression and anxiety which were present before myocardial infarction did not predict quality of life. In the ENRICHD trial (Berkman *et al*, 2003), cognitive-behavioural therapy had modest effects on depressive symptoms at 6 months post-infarction in patients with depression and social isolation, but these effects diminished over time. In the EXIT trial (Appels *et al*, 2005), where the focus of treatment was explicitly on vital exhaustion, only some intervention effects were observed and these were modified by the presence of a previous cardiac history.

We agree with Dickens *et al* that there is a need for improved detection and treatment of depression and anxiety following myocardial infarction but several questions need to be addressed. These include 'can the effects of depression and anxiety be linked to specific subgroups of emotional disorders based on symptoms and/or onset?'; 'can interventions that were developed in general psychiatry be applied to depression post-myocardial infarction or should they be adapted?'; and 'how can psychiatric interventions be integrated into regular cardiac aftercare?'

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Authors' reply: We agree that although observational studies have shown that depression is associated with subsequent impairment in health-related quality of life in coronary heart disease, intervention studies have failed to provide convincing proof that treating depression improves this outcome. Previous intervention studies have not addressed this question satisfactorily because the SADHART study (Glassman *et al*, 2002) was not sufficiently powered to demonstrate the efficacy of antidepressants in coronary heart disease and the ENRICHD study (Berkman *et al*, 2003) did not anticipate very high rates of spontaneous remission of depression or unplanned prescription of antidepressants in the control group. The results of these trials, however, together with our own results are valuable for planning future treatment trials.

We also agree that there are many unanswered questions relating to the nature of the association between depression and negative outcomes in coronary disease. As mentioned by de Jonge & Ormel, the timing of the onset of depression (Dickens *et al*, 2004a), the specific aspects of depression or anxiety that are associated with poor outcome and the possibility of vulnerable sub-populations of patients (such as those without social support) (Dickens *et al*, 2004b) require further investigation. Furthermore, whether the association between depression and negative outcomes in coronary disease is the result of residual confounding by severity of heart disease (Dickens *et al*, 2005) remains unsolved. Further research is required to address these questions, although it is likely that most will only be convincingly resolved through intervention studies.

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High female suicide rates: ecological fallacy or sad reality?

Yip & Liu (2006) present a demographic perspective of female suicide in China, the only country in which the suicide rate is higher among women than men. However, this reversed gender representation also exists in certain communities in other countries. In the Indian subcontinent suicide rates are higher in men than in women but the difference is lower than in most countries: the male:female suicide ratio in India is 1.3:1 (Cheng & Lee, 2000). Suicide among immigrants from the Indian subcontinent to Britain was higher among young married women than men (Soni Raleigh *et al*, 1990). Tadros & Salib (2006) also reported that significantly more Asian women than Asian men killed themselves in Birmingham and Solihull, a clearly reversed gender ratio compared with suicide in the White population and in other ethnic groups in Birmingham and the UK as a whole.

Suicide terrorism is not an egoistic suicide but none the less is a form of fatal self-harm in the legal and human sense and has a distinct underlying political, individual and social logic. The support of and acceptance by the attackers' own communities ensure an endless supply of volunteers who seek 'voluntary violent death' in a bizarre act of so-called martyrdom, in order to promote what they firmly believe to be a just cause. Women carried out 15% (64) of such attacks over the past 25 years (Pope, 2005). Chechen women carried out 60% of all suicide bombings in Russia