5. Streiner DL. Breaking up is hard to do: The heartbreak of dichotomizing continuous data. Can J Psychiatry 2002;47:262-6.
6. Andrade C. Categorizing continuous variables. Can J Psychiatry 2002;47:35-6.

Authors’ Responses to the Comments on “Leisure Time Physical Activity and Risk of Developing Depression among the Youth of Kangra District, Himachal Pradesh, India”

Sir,

We thank Suhas et al.[1] for their interest in our article.[2] The authors of the letter have used the term “prospective study,” which does not seem appropriate to us. Although the characteristic or exposure (leisure time physical activity) is being studied at the time of the study, it becomes a cross-sectional study.

Their critical comment on using less number of confounders is valid. However, it is important to note that the setting where the study participants were approached was in itself a limitation because of which the socio-demographic details of the family cannot be elicited. We agree that the study breaks no new grounds in the field of studies on physical activity and mental health, but the majority of studies have been conducted in a socio-cultural environment different from India, especially this part of the country (sub-Himalayan region). Factors affecting mental health differ in different settings. Hence, to proceed with any intervention, we needed a ground work on the same in this region. Therefore, to that extent, this study is a useful addition to the medical literature.

We also agree that the scale has not been validated for our country and that different cut-offs have varying sensitivity and specificity. The shorter version (10-item scale) is generally used for late-life depression.[3] We intentionally used the original scale to introduce all the items to the study participants. The primary reason for doing this was that this study would serve as a base for further validating the scale in our settings.

According to the authors of the letter, the participants with depression should not have been excluded from the study. We, however, differ from this statement as the chronic morbidity and mental illness of any type will skew our data toward depression, giving a false result in favor of increased depression. Our objective was to study an apparently healthy population. The categorization of physical activity and depression scores was done to compare the results with other studies. However, we presented the mean scores of depression scale score in our results. We do agree that categorization of continuous variables may increase the possibility of type two error.

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Conflicts of interest
There are no conflicts of interest.

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REFERENCES

1. Suhas S, Chakravarty RK, Ransing R, Vadlamani N, Andrade C. Comments on “Leisure time physical activity and risk of developing depression among the youth of Kangra district, Himachal Pradesh, India”. Indian J Psychol Med 2019;41:93-4.
2. Singh M, Sharma P, Raj D, Sharma S, Kaushal A, Raina SK. Leisure time physical activity and risk of developing depression among the youth of Kangra district, Himachal Pradesh, India. Indian J Psychol Med 2018;40:426-32.
3. Smarr KL, Keefer AL. Measures of depression and depressive symptoms: Beck Depression Inventory-II (BDI-II), Center for Epidemiologic Studies Depression Scale (CES-D), Geriatric Depression Scale (GDS), Hospital Anxiety and Depression Scale (HADS), and Patient Health Questionnaire-9 (PHQ-9). Arthritis Care Res. 2011;63:454-66.

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Comments on “Prevalence and Predictors of Abuse in Elderly Patients with Depression at a Tertiary Care Centre in Saurashtra, India”

Sir,
This correspondence is made in reference to the original article, “Prevalence and predictors of abuse in elderly patients with depression at a tertiary care centre in Saurashtra, India” by Patel et al. The paper explored the prevalence of abuse in elderly patients, including its various socio-demographic variables that could predict its possibility.

The study is an important contribution to the limited data available regarding the abuse of elderly population in India. As this study has been done on a specific group of elderly people, those suffering from major depressive disorder (MDD) with exclusion of those with sensory or cognitive impairment, it would have been better if the study mentioned the need or significance of studying the problem of abuse in this group compared to the rest of the elderly patients. Moreover, excluding all patients with cognitive impairment will exclude not only patients with dementia but also those with depression whose cognitive impairment is not because of dementia but due to pseudo-dementia, a temporary condition, a part of depression itself.

We could not find in the study how many elderly depressed patients were excluded because of their score being <25 in Mini-Mental State Examination (MMSE), the tool used in this study to rule out patients with cognitive impairment. There are a few concerns about the use of MMSE and its score of 25 as the cut-off to detect and exclude patients with cognitive impairment among the elderly Indian population. MMSE cannot reliably differentiate cognitive deficits which are a part of depression from those due to dementia. In the study, a quarter of the sample belonged to either old-old (70–79 years) or the oldest-old subgroups (80 years and above), 22% and 4%, respectively, and an almost similar proportion (23%) had no formal education and was classified as illiterate. The cut-off score of 25 in MMSE may be too high for these elderly subjects who are illiterate or have a lower level of education. A recent study using receiver operating characteristic (ROC) curve analysis to find out a reliable cut-off score of MMSE to detect dementia found that cut-off scores should be different according to the level of education as follows: 22 for the low education group (sensitivity = 87%, specificity = 82%), 23 for the middle education group (sensitivity =...