sample the frequency of deaths is higher in men (162/702 v. 136/1006 in women). A power calculation for anxiety disorder shows that we could have detected an unadjusted relative risk of 1.65 in women and 1.71 in men, with an alpha risk of 0.05 and a power of 0.80. The analysis in men is thus not underpowered and if an association with mortality exists in men, it is less strong than in women.

With ageing, people face multiple adverse events including physical multimorbidity and loss of capacities. Personal resources, such as self-efficacy, sense of mastery or control beliefs, and psychological resilience are important in the process of coping with a chronic disease. On the other hand, anxiety disorder, irrespective of the aetiology, could clearly contribute to a worse outcome. This underlines the importance of developing interventions for older persons aimed at maintaining or improving psychological coping resources when health declines. Up to now, very few well-designed studies have been performed with such a large population sample, capable of controlling for main confounders and using a validated anxiety diagnosis including anxiety subtypes. Although future research is needed to confirm our results and the gender-specific association, our study also stresses the importance of including anxiety diagnostic tools in population-based cohorts to improve the understanding of the consequences of anxiety in late life.

Although we agree that QoL measures represent a potentially highly useful clinical tool, we cannot accept that Boyer et al’s study provides evidence for this claim in any way.

We felt that the most salient finding from the trial was in fact the far lower satisfaction in the control group of patients who had their QoL assessed but had the results ignored. If we offer an assessment or intervention, we should be careful to follow-up our intentions or the result may actually be detrimental overall.


**Authors’ reply:** We are in agreement with Langford & Badenoch’s general comment on the need for holistic assessment in psychiatry. It is currently established that patients’ views, and especially quality of life (QoL) measures, should supplement the usual indicators of quality in healthcare. However, we are doubtful about the relevance of their criticisms.

Langford & Badenoch denounced the following sentence: ‘Global satisfaction was significantly higher in the QoL feedback group […]’ compared with the standard psychiatric assessment […] and QoL assessment groups.’ This assumption was derived, however, directly from our results (i.e. the proportions of very satisfied patients were 73% in the QoL feedback group, 45% in the QoL assessment group and 68% in the standard group). The comparison performed using a chi-squared test was statistically significant (P = 0.025), allowing us to state that global satisfaction significantly differed between the three groups. As we have written in our Discussion, this finding did not prohibit us from suggesting that integrating QoL assessment and feedback with standard psychiatric assessment seemed relevant or that priority should be given to strategies that implement QoL measurements in routine practice.

Moreover, this assumption was in agreement with our study design (i.e. three arms) and the sample size calculation performed for this design. However, we recognise that multiple treatment arms in randomised controlled trials (RCTs) are sources of misunderstanding, especially because there are several possible comparisons. Langford & Badenoch re-wrote our primary outcome for a two-arm RCT as follows: ‘level of patient satisfaction in the QoL feedback group compared with standard psychiatric assessment’, implying pairwise chi-squared tests. However, our primary outcome and analysis were defined in accordance with the primary objective integrating the three-arm design. The objective was to globally determine the ‘positions’ of QoL feedback, QoL without feedback and the control group with respect to their relationships to satisfaction; we did not aim to question the relevance of using the QoL measure (which is already recognised in the literature) in 2 x 2 comparisons between the different arms. The primary criterion was thus analysed using a global chi-squared test, determined a priori; it was not analysed using pairwise chi-squared tests (as recommended by Langford & Badenoch), which were not planned and for which the alpha error risk was not controlled. It is also widely recognised that bias may be introduced if decisions regarding data analysis are driven by the data.

Langford & Badenoch also claim that ‘The conclusions drawn by the authors, that their findings “provide strong support […]”

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