
Correspondence

Assessment of suicide risk

Sir: Appleby (*Psychiatric Bulletin*, April 1997, **21**, 193–194) recognises the absence of convincing evidence for the effectiveness of clinical services in reducing suicide. He goes on to support the need to promote risk assessment. The case for this emphasis on risk assessment is often based on the finding that a significant proportion of patients who commit suicide communicate in some way the possibility that this may occur. However, I believe the much larger group of patients, who communicate such ideas for whom suicide is not the outcome, may suffer as a result of the unquestioning acceptance of some features of conventional methods of assessing risk.

Thoughts of self-harm or suicide do not exist in isolation. By focusing our questions on these cognitions we fail to acknowledge the complex and varied aetiology of such thoughts and to a certain degree ignore other cognitive manifestations of emotions. In addition we develop a specific vocabulary in which emotional distress is replaced by terms purported to reflect risk. Patients recognise our disproportionate interest in this aspect of their 'complaints' and in an attempt to convey their distress soon 'learn' this vocabulary. This then obscures the nature of the actual distress which has obvious implications for any interventions. In the extreme a patient may be criticised for using this language which they have been coerced into so doing.

Laing (1960) argues that psychiatrists apply a diagnosis merely on the basis of a breakdown of communication between the psychiatrist and the patient. On the other hand, however, where communication is enhanced due to the development of a common language (on the doctor's terms), the psychiatrist teleologically also identifies morbidity. While no significant impact has been made on the rate of suicide, despite repeated fine-tuning to the risk assessment procedure, I feel we should question the effects (both the absence of a positive effect and the possible presence of a negative effect) of this aspect of the current approach. Similarly, we should be alert to the consequences of the development of such forms of communication within all therapeutic relationships.

LAING, R. D. (1960) *The Divided Self: A Study of Sanity and Madness*. London: Tavistock.

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Sir: As Director of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, Louis Appleby begins his editorial (*Psychiatric Bulletin*, April 1997, **21**, 193–194) by correctly asserting that the main causes of suicide are social and that there is no evidence that psychiatrists can do anything to exert a meaningful influence upon suicide rates. However, he appears to retain the assumption that doctors could still do better if they tried harder. In describing a study by his own group (Dennehy *et al*, 1996), he notes that half of the patients who went on to suicide did not express suicidal ideas to medical attendants "suggesting that some people indicate their risk in less direct ways". It is possible that many people will not indicate the risk in any way and that doctors, being neither omniscient nor omnipotent, are very frequently incapable of doing anything at all.

Despite the lack of any evidence to support the view, I believe that what psychiatrists can do to prevent suicide is little better than rearranging the deckchairs on the *Titanic*. At least while the country is steered on a course, from which the profession has little power to deflect it, towards the icebergs of growing social inequalities, youth unemployment and underfunded health and community care, perhaps the best we can hope for is to help some of our suicidal patients to clamber into the lifeboats. Given the present evidence, we delude ourselves and we risk a dangerous and counterproductive collusion with the captains of the ship, if we suggest that we can do more.

DENNEHY, J. A., APPLEBY, L., THOMAS, C. S., *et al* (1996) Case-control study of suicide by discharged psychiatric patients. *British Medical Journal*. **312**, 1580.

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Description of primary delusions: confusion in standard texts and among clinicians

Sir: McAllister-Williams highlights the confusion that exists in the definition of the term "primary delusion" (*Psychiatric Bulletin*, June 1997, **21**, 346–349). The second version of the Schedules for the Clinical Assessment in