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.


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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