British Journal of Psychiatry (1994), **164**, 271–272

Reading About . . .

Suicide (Update 1988)

A clinician who wants to read about suicide faces a problem which besets the whole of psychiatry: how to encompass the many perspectives, each with its own discipline, all of which have to be included in any comprehensive and complete explanation of the problem. Face-to-face contact with suicidal people is central to our own clinical experience, but if we are to build up any credible theory about causation and prevention then these have to withstand a vigorous challenge from others, for example community doctors who seek proof by controlled trials, or social scientists who accord paramount importance to social events in the causation of suicide. Careful selection of papers and reviews in our reading is rendered all the more important at the present time when suicide prevention finds itself centre-stage as a result of the *Health of the Nation* targets for suicide prevention (Department of Health, 1992).

It is of course essential to keep in touch with epidemiological issues which, among other things, inform us about trends in suicide rates among various age-specific groups of the population. Much current concern focuses on the increasing rates of suicide in young men: two useful recent papers analyse the possible causes of these changes (Charlton *et al*, 1993*a*,*b*).

The international scene reminds us that suicide rates vary greatly from one country to another, and the Proceedings of the First European Symposium on Empirical Research into Suicidal Behaviour brings together a panoramic view of the European scene. Platt's contribution provides an invaluable update source of data on suicide trends in the various countries (Moller *et al*, 1988).

As clinicians we need to scrutinise how we assess and manage suicide risk, particularly at a time of massive change in the way services are organised. The dilemma of how to use clinical risk factors to inform our clinical decisions remains as much a problem as ever. Hawton's paper on the assessment of risk summarises the issues well, and others have also attempted to identify good clinical practice (Hawton, 1987; Morgan & Owen, 1990). We are beginning to realise that traditional risk factors need to be widened in scope if we are to improve our clinical effectiveness in recognising and managing suicide risk: the predictive value of severe anxiety and panic attacks, as well as alienation from others are two examples which have received attention recently (Fawcett, 1992; Watts & Morgan, 1994).

A sensitive understanding of the suicidal state of mind is one of our major responsibilities as clinicians, and we need to ensure that we inform the wider debate appropriately: in particular the importance of impulse and ambivalence is not widely appreciated by others who may argue with total conviction that it is never possible to abort a suicidal crisis. A recent account of Schneidman's engaging and informal approach is well worth reading in order to encompass the clinical complexity of the suicidal mental state (Schneidman, 1993).

The role of availability of agent is closely related to impulsivity and is well illustrated by Kreitman's consideration of the 1960s' coal/gas story in the UK (Kreitman, 1976) as well as Lester's work on the availability of firearms in the USA (Lester, 1990).

Our attention must also focus on the several crucial components of any clinical service which aims to be effective in suicide prevention. The potential role of general practitioners in suicide prevention has been highlighted in certain recent papers which set out to evaluate the effectiveness of specific educational programmes concerning the management of depression and suicide risk. These deserve to be read in the original (Michelle & Valach, 1992; Rutz *et al*, 1992).

The disturbing increase in numbers of suicide in prisoners, especially young persons on remand, also demands our attention, and Dooley's review sets out the main points well (Dooley, 1990).

Our reading would also remain incomplete if we did not include something on adolescence and here we would find much value in the paper by Shaffer *et al* (1988). Nor should we forget the needs of survivors: Alison Wertheimer describes this well in her recent book (Wertheimer, 1991).

It is only too easy to become totally preoccupied with our own local scene and it remains as important as ever to retain a much wider perspective if we are to be effective in suicide prevention. Looking back helps

in many ways. Anderson's book on Victorian suicide helps us to maintain a balanced judgement on our present day attitudes to our clinical work, particularly in the way it considers the role of medical men in suicide prevention (Anderson, 1987).

Those who wish to extend their reading further would also find it useful to browse through a recent collection of essays written in honour of that distinguished American practitioner, Edwin Schneidman, on the occasion of his reaching his 75th birthday (Leenaars, 1993). Valuable too is a recent English translation of Nils Retterstol's book, *Suicide: a European Perspective* (Retterstol, 1993). This is a rewarding combination of statistical reviews, clinical material, as well as personal anecdote, and is a welcome record of Retterstol's long and distinguished contribution to the cause of suicide prevention this side of the Atlantic.

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