

pathology' since they obtained their results on a group of outpatient depressives, yet they press on us their general conclusion that the Zung scale 'is a valid and sensitive measure of clinical severity in depressed patients'. This conclusion is much more general than their data really allow, since their study begins only in the middle range of severity and works downwards from there. All that their results really show is that depressed outpatients can generally recognize when they are feeling somewhat better and a lot better than at the beginning of treatment, and that their self-rating judgments generally agree with two kinds of physician ratings (Hamilton rating and global rating). I don't personally think that is enough to justify their strongly worded conclusion about the continued use of the Zung scale as a research instrument. It would depend very much on what the research question happened to be.

In their discussion of our critical report on the Zung scale, the authors have been, to say the least, less than gracious. In our earlier report (1973) we did not say 'that the ZSDS was not a valid research instrument'. What we said, in effect, was that the Zung scale 'is not recommended for use in research studies' and we were quite specific about the sort of studies we had in mind—those which call for matched groups of depressed patients, such as antidepressant drug trials. We also questioned its empirical utility in psychiatric clinics and suicide prevention centres, since our own results indicated that the Zung scale cannot discriminate mildly depressed outpatients from severely depressed inpatients. The figure in the paper by Dr Biggs and associates indicates exactly the same thing—a Zung score of about 52 can be associated with a Hamilton score of anywhere between 9 and about 32! Dr Biggs and his associates may be encouraged by such results, but I am not.

The authors also make much of the point that the correlations between various depression scales are strongly related to the range of severity studied. They have failed to recognize that we had precisely this point in mind in studying a wider range of clinical severity in our own report, and they neglect to mention that in our paper we specifically discussed the common finding that correlations are always better looking when the scores are toward the low range.

Before we proceed to the statistical analysis of the concurrent validity of the Zung scale, it seems to me that we should first settle the question of its face validity. As we said five years ago, 'the least that can be asked of a rating scale is that it should distinguish mildly depressed individuals from those with an illness of psychotic proportions'. Our own results indicated that the Zung scale cannot do this, and in

the absence of evidence to the contrary I will continue to recommend that the Zung scale should not be used in research studies.

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SUICIDE IN SUDAN

DEAR SIR,

We wish to report a study of 100 cases of suicide and attempted suicide in Khartoum Province, Sudan, during the period 1 June 1971 to 31 May 1975. It included all cases reported to the police of this Province. The reports were screened for age, sex, social status (including marital and economic position) and mental illness, including alcoholism and socio-economic stresses.

Ten were consummated suicides (5 men, 5 women). Ninety made serious but non-fatal attempts (50 women). The calculated incidence rates for the population of 1.2 million are: 1 in 500,000 for consummated suicide and 1 in 50,000 for attempted suicide.

The commonest age group for both attempted and committed suicide was 10–29 and about half were married. Forty-eight were unemployed, 42 employed and 10 students. Ninety-two were Moslems and 8 non-Moslems. Socio-economic stresses and family problems seemed the commonest causes. Mental illness including alcoholism was less important. The commonest method for suicide was burning.

TABLE
Methods used in suicide

Method	Attempted suicide n = 90	Committed suicide n = 10
Burning	46%	60%
Drugs	19%	10%
Sharp instruments	14%	—
Drowning	9%	10%
Kerosene ingestion	4%	—
Iodine	—	10%
Alcohol	—	10%
Hanging	4%	—
Jumping from high places	3%	—
Under cars	1%	—

The findings in this study differ in certain respects from those published abroad. The sample was small, study retrospective, and suicide is an offence under the Sudan penal code, so that reporting may have been distorted and this may explain the seemingly low incidence. However, certain comments may be justified: suicide was high among Sudanese women, perhaps because our women lead a very closed indoor family life, their mobility is restricted, and they are basically unemployed. Suicide was relatively high in the young age group. In the closely-knit nature of our society the elderly find every support; social, moral and financial, and their prestige increases with age, they are never isolated and not sent to special homes. They may therefore have less reason for suicide. Suicide among the married may be partly explained by the fact that the majority of these marriages are imposed on the marital partners, usually to satisfy tribal dignities. No consideration is given to the suitability of ages, interest and wishes of the couples.

Suicide by burning is an indicator of the seriousness of the attempt, but may also be due to the fact that drugs are not widely known and available in Sudan, as in developed countries.

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EXPERIENCE AND NATIONALITY IN ASSESSMENT OF PARASUICIDE

DEAR SIR,

Most papers on parasuicide have concentrated on epidemiology and relatively few on the influence of help offered (Walk, 1967; Choudhury, 1973; Morgan *et al.*, 1976). Greer and Bagley (1971) compared parasuicide patients who did not see a psychiatrist with those who did, and found the latter had a better prognosis, although the assignment to each group was not random. Gibbons (1977) studied 400 parasuicides who were randomly assigned to GP follow-up, OP follow-up or intensive social work, and found no difference in repetition after one year; and Gardner (1977) recently showed no difference between physicians and psychiatrists, in terms of assessment and outcome of cases of parasuicide. We thought it interesting to look at whether length of psychiatric experience or the nationality of the psychiatrist would in fact affect assessment or outcome after one year.

We followed up 544 consecutive cases of parasuicide in Sheffield (aged 15 and over) for one year, by means of hospital records, coroners' courts, social services and probation officers. In terms of experience we divided the psychiatrists into two groups at the senior registrar/registrar boundary, such that the average experience of the two groups was nine and two years respectively. For nationality we divided into British (12) and foreign (5) graduates.

It was shown that junior psychiatrists ($n = 8$) suggested significantly more people should have no follow-up care ($P < .01$) and this appears to have been chiefly due to the foreign graduate portion of the junior psychiatrists (5 per cent significance), whereas the senior psychiatrists ($n = 9$) referred significantly more people to in-patient care ($P < .01$) or GP follow-up ($P < .05$). There was no significant difference in the referral rates to social services, outpatients, day hospitals or other agencies between the four groups.

There was no difference in outcome at one year (suicide or further parasuicide) in the patients seen by the different groups of psychiatrists, a finding at variance with the expectation of Blake and Mitchell (1978), but reassuring in view of the fact that most parasuicides are seen by junior psychiatrists in Britain, of whom a large percentage are foreign graduates.

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