agree with the opinions expressed. It is suggested by your anonymous contributor that the mass media misleadingly stress the significance of familial factors in mental illness. It is claimed (i) that the case for the familial aetiology of mental illness is presented in a one-sided and superficial manner, (ii) that this engenders guilt in the members of the families of psychiatric patients, and (iii) that it deters potential patients from seeking help. In my opinion the presentation of mental illness in terms of family dynamics is usually carefully and thoughtfully done by the mass media. The recent programme in the 'Spaces Between Words' series illustrating Esterson's version of family therapy is a case in point. It is perhaps not before time that members of patients' families were made to feel in some measure responsible for the predicament in which patients find themselves, for in many cases they are. Finally, far from discouraging patients from seeking psychiatric help, it is highly probable that presenting so called mental illness in a manner which reveals it as the outcome of intrafamilial conflicts is likely to make it more comprehensible and to reassure people that we in the psychiatric profession are not blind to those factors which seem all too obvious to the sensitive layman.

I should like to propose that the practice of expressing such anonymous opinions in *News and Notes* should cease. Discussion of topics of current interest is highly desirable, but we, like the mass media, should invite experts to present each side of the case fairly and comprehensively.

JOHN BIRTCHNELL.

MRC Clinical Psychiatry Unit,
Graylingwell Hospital,
Chichester, Sussex.

DOCTORS, SAMARITANS AND SUICIDE

DEAR SIR,

My attention has been drawn to an article by Dr. Brian Barraclough in the April 1972 issue of *News and Notes* (1), which is critical of a study in which I investigated the effectiveness of Samaritans. This study (2) indicated that the introduction of Samaritan schemes was followed by a significant reduction in suicide rates, in comparison with demographically matched control towns in which such schemes did not operate.

Barraclough's first criticism concerns his feelings about whether some of the towns (experimental and control) are well-matched, and he suggests that some pairs of towns are unrealistically compared with one another. He is unsure, for example, of the wisdom of matching Hull and Merthyr Tydfil. Barraclough's objections to the matching are based purely on intuition, and since the basis of this intuition is not made clear I fear that it cannot be taken in any way seriously. The controls in the original study were drawn from the results (3) of a principal components analysis of 57 census-derived social and demographic variables for all towns in England and Wales. The control town was the most similar town (without Samaritans) to the experimental Samaritan town as indicated by the simultaneous plotting of four axes, representing the four major components of the data. A second set of controls was taken, this time matched with the experimental (Samaritan) towns on three demographic variables which are known to vary with suicide rates, namely age, sex and class structure. Using this fresh set of controls, the differences in suicide rate in the Samaritan and the control towns remained significant.

Recently the original study of Moser and Scott from which I drew controls has been criticized on technical grounds. Andrews (4) has proposed an alternative kind of analysis of Moser and Scott's original data, namely a cluster analysis rather than principal components analysis. This re-analysis identifies fourteen distinct clusters in a taxonomy which is significantly different from that presented by Moser and Scott. It appears that six of our original experimental towns could have more adequate controls than those chosen in the original study. The new controls are (Samaritan town first: control town second), Liverpool : Newcastle; Derby : Sheffield; Manchester : Oldham; Birmingham : Leeds; Swansea : Newport; Bradford : Dewsbury. Merthyr remains an adequate control for Hull! I have recalculated differences in suicide rates in the relevant periods, and the difference in favour of the Samaritan towns remains significant, at the 5 per cent level.

The second point which Barraclough makes is that there may be an intervening sociological variable, which caused both the decline in suicide rate and also enabled sufficient people to come forward and staff a Samaritan branch. But what can this mysterious sociological variable be? It could conceivably be an increase in social cohesion, which Durkheim has shown to be inversely correlated with suicide rates. But why should there have been an increase in social cohesion in Liverpool and not in Newcastle, and in Derby and not in Sheffield, for example? The reasons for this emergence of social cohesion are very obscure. It seems to me to be far more plausible that Samaritans were organized in a particular town because of situational factors, such as the existence of an enthusiastic priest (like Chad Varah) who possessed sufficient energy and influence to get a branch going.

The kind of sociological phenomenon which can influence suicide rates is well illustrated by Lyon's

https://doi.org/10.1192/S0007125072301662 Published online by Cambridge University Press

study (5) of depression and suicide in Belfast. Deductions from sociological and psychological theory about suicide suggest that there may be an inverse relation between the incidence of depressive illness (and of suicide) and the opportunity to externalize aggressive behaviour. The riot situation in Belfast during 1969–1970 provided an opportunity to study this hypothesis. The incidences of depressive illness in the city and a neighbouring peaceful rural county were compared; there was a significant *decrease* in depressive illness in Belfast in both sexes and in all age groups, in comparison with the rural area.

The decrease was even more significant in riot areas. The suicide rate fell by almost 50 per cent and there was a noticeable increase in the rates of homicide and crimes of violence. In contrast, the rural county showed a sharp increase in male depressives. The social changes which have led to a reduction of the incidence of both depression and suicide in Belfast have been profound. It is sociological phenomena of this order, I suggest, which can be responsible for changes in the suicide rate, and not some 'invisible' social change which has affected a number of British towns in which Samaritans have been established.

Though Samaritans may have some influence on the incidence of suicide in Britain (which is falling steadily) they appear to have little influence on the rate of attempted suicide (which is rising rapidly). Suicide and attempted suicide appear to be phenomenologically different behaviours. This is illustrated by another recent Belfast study. O'Malley (6) found that admissions to the Mater Hospital, Belfast rose from 66 in 1967 to 167 in 1971. This increase is similar to that observed in other parts of Britain, and the factors underlying attempted suicide are clearly of a different order to those underlying completed suicide. The completed suicides tend to be older, to be suffering from clinical depression, and to use much more potentially lethal methods like gas, hanging or drowning. The attempted suicides, by contrast are younger, much less likely (as in O'Malley's Belfast study) to be suffering from depression, and to have used less potentially lethal methods, such as poisoning with various substances. The older, depressed individuals do appear in the attempted suicide population, but it is the younger males, socially and personally maladjusted, and often with a history of drug-taking or alcohol abuse, who are contributing to the increase in the attempted suicide population (7).

Barraclough suggests that medical services, rather than Samaritans are more important as suicide prevention agencies. On Barraclough's own evidence general practitioners are in fact particularly inefficient in this respect, since a high proportion (85 per cent) of completed suicides have presented complaints of mental distress to their general practitioner in the month before committing suicide (8). Barraclough argues that since Samaritans see roughly 3 per cent of suicides, while doctors see 85 per cent, doctors are in a much stronger position to prevent suicide. But further interpretation of these figures could be that the very success of the Samaritans means that only a small proportion of their clients go on to commit suicide. Samaritans are in the peculiar position that (apart from broad statistical investigations of the kind I have outlined above) they can be measured only in terms of failure (the number of clients who later kill themselves). That the client goes on living is not a direct criterion of success.

There is some evidence that conventional psychiatric treatment can be successful in the treatment of some patients who have attempted suicide (9). In a controlled trial of psychiatric treatment in patients admitted to King's College Hospital following a suicide attempt, 33 patients were given no treatment; 60 patients were given brief treatment; and 79 patients given prolonged treatment. After one year 48·5 per cent of untreated patients had made a further attempt, compared with 28 per cent of those briefly treated, and 19 per cent of those intensively treated. The correlation between treatment and favourable outcome remained significant when other social and clinical factors were controlled (10).

CHRISTOPHER BAGLEY.

Centre for Social Research,
The University of Sussex,
Falmer,
Brighton, BN1 9QN,
Sussex.

REFERENCES

1. BARRACLOUGH, B. (1972). 'Doctors, Samaritans and suicide.' *British Journal of Psychiatry*, April, Supplement, 8–9.
2. BAGLEY, C. (1968). 'The evaluation of a suicide prevention scheme by an ecological method.' *Social Science and Medicine*, **2**, 1–14.
3. MOSER, C., and SCOTT, W. (1961). *British Towns*. Edinburgh: Oliver and Boyd.
4. ANDREWS, H. (1971). 'A cluster analysis of British towns.' *Urban Studies*, **7**, 271–81.
5. LYONS, H. (1972). 'Depressive illness and aggression in Belfast.' *British Medical Journal*, **1**, 342–4.
6. O'MALLEY, P. (1972). *Journal of the Irish Medical Association*, **65**, 109–13.
7. BAGLEY, C. (1971). 'An evaluation of suicide prevention agencies.' *Life-Threatening Behaviour*, **1**, 245–59.
8. BARRACLOUGH, B., BUNCH, J., NELSON, B., and SAINSBURY, P. (1969). 'The diagnostic classification and psychiatric treatment of 100 suicides.' *Proceedings of the Fifth International Conference for Suicide Prevention*, 129–32.

https://doi.org/10.1192/S0007125072301662 Published online by Cambridge University Press

9. GREER, S., and BAGLEY, C. (1971). 'The effect of psychiatric intervention in attempted suicide: a controlled study.' *British Medical Journal*, **1**, 310–12.

10. GREER, S., and BAGLEY, C. (1971). 'Clinical and social predictors of repeated attempted suicide.' *British Journal of Psychiatry*, **119**, 515–22.

UNIVERSITY AND TEACHING HOSPITAL DEPARTMENTS

The London Hospital Medical College

The following are the research topics recently completed, current or projected within the Department:

1. Review of the literature on psychiatric aspects of lower bowel disorders.
2. A psychological study of relationships in normal adolescence.
3. A study of psychiatric symptoms in pre-school children.
4. A study of fantasies of suicide in adolescence.
5. Attitudes to therapy among disturbed adolescents.
6. An inquiry into the roles of the services for maladjusted children.
7. An ethological study of behaviour in young children.
8. Personality and rheumatoid arthritis.
9. The psychology of disorder of voice.
10. The psychiatric picture in Cushing's syndrome.
11. The delineation and measurement of study difficulties.
12. Life events and glaucoma.
13. A psychological study of attention dysfunction in schizophrenic patients.
14. A survey of psychiatric illness diagnosed within the general hospital.
15. An investigation of meanings of illness.
16. Hypnosis for intractable diplopia.

University of Bristol

Research activities in which the Department of Mental Health is involved are as follows:

1. Dwarfism.
2. The determinants of aggressive behaviour amongst patients in sub-normality hospitals.
3. Some aspects of parental deprivation and sub-normality.
4. Life events and abdominal symptoms in general hospital out-patients.
5. Human behaviour in disaster.
6. Psychiatric problems in surgical practice.
7. Fatigue in off-shore sailing.
8. Processes of middle age in relation to family structure and mental health.
9. The evaluation of attempts to modify anti-social behaviour in 10–12 year old boys by means of group techniques.
10. Re-housing stress and environmental design. (In association with the Department of Architecture and the Department of Psychology).
11. Experimental social work to modify patterns of stress following re-housing. (In association with the Department of Architecture and the Department of Psychology).
12. Changes in attitude amongst medical students towards mental illness.
13. Communication between depressed patients and their spouses.
14. Association between diabetes and mental illness.
15. Anorexia nervosa: Follow-up study and behaviour analysis during weight increase.
16. Self-injuries: Assessment of services and prognosis.
17. The incidence and nature of psychiatric problems among Bristol University undergraduates.
18. Aspects of behaviour of brain-damaged, epileptic and intellectually retarded children in a sub-normality hospital.
19. Aspects of the labelling, identification and management of pre-school problems of children in the community.
20. Patient interaction and therapeutic processes in psychiatric wards.
21. Psychiatric aspects of fatigue: accident proneness.
22. Processes of institutionalization: labelling procedure in relation to psychiatric population.
23. Occupational mental health.

University of Edinburgh

Research work in the Department during the past year has included the following:

1. Psychopathology of Bronchial Asthma: Study of phenomenology of 80 patients is now complete. Treatment of 40 patients with behaviour therapy is now almost complete.
2. Flying Phobia: Phenomenology and treatment study of 20 patients is now complete except for the examination of controls.
3. Films, Feelings and Physiology: Various studies of the effect of stressful films have been undertaken, some of which are now complete.
4. Measurement of Mood: Various studies are under way on the use of Visual Analogue Scale comparing it with existing methods.
5. Phenomenology of hyperthyroidism: a study of 20 patients is complete.
6. Investigations in progress at the Western General Hospital include joint studies of anorexia nervosa and of the treatment of obesity; an investigation of psychiatric morbidity in general hospital patients is continuing.
7. Study of the role of psychological factors in the precipitation, course and prognosis of acute coronary thrombosis.
8. Evaluation of a Night Hospital.
9. Prevalence and perception of psychiatric symptoms in three South Indian Communities.

https://doi.org/10.1192/S0007125072301662 Published online by Cambridge University Press