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JOHN M. EAGLES

Ross Clinic
Royal Cornhill Hospital
Cornhill Road
Aberdeen AB9 2ZF

AUTHORS' REPLY: Dr Eagles raises two very interesting questions. In our paper we hypothesise that the decreasing first admission rates of schizophrenia in Denmark could be explained partly by a parallel decrease in available psychiatric beds. The reduction in capacity was about 50% during the study period. Dr Eagles suggests that the bed reduction "has been largely of long-stay beds, that is, not the type of beds which would be occupied by first admission schizophrenic patients", and therefore could not be responsible for the decrease in schizophrenia first admission rates.

Unfortunately, the Danish registration system does not distinguish between beds for acute admissions and beds for long-stay treatment. But the fact that we, in the period 1980–1989, found a reduction in long-stay patients admitted for more than five years from 1820 to 320, a decrease of 1500 patients (census figures), might illustrate the situation. In the same period bed numbers were reduced by 2630.

Of course, we should not reject the possibility of a genuine decrease in schizophrenia rates in the population. However, as we discuss in our paper, there are still some possible nosocomial explanations to be tested.

Dr Eagles also points to the gender disparity in our material: 5314 newly diagnosed male schizophrenics compared with only 3254 females. He underlines the hypothesis that narrowly defined schizophrenia may be less common among females than among males which "could constitute an important clue in the search for the causes of the disorder". We fully agree with that. The Institute of Psychiatric Demography, Aarhus, Denmark is a World Health Organisation (WHO) Collaborating Centre and over the past few years has been investigating this in conjunction with the WHO Collaborating Centre, Mannheim, Germany.

POVL MUNK-JØRGENSEN
PREBEN BO MORTENSEN

Psychiatric Hospital
Skovagervej 2
DK-8240 Riskov
Denmark

Origins of Delusions

SIR: I read with interest Dr Roberts' review article on the origins of delusions (*Journal*, September 1992, **161**, 298–308). However, in an otherwise comprehensive review, in the section on psychodynamics, there is an omission of more recent psychoanalytic views on delusions. There is no mention of the concept of pathological projective identification, as formulated by Bion.

Based on detailed analytic work with schizophrenics, Bion described the genesis of hallucinations and their link with the formation of delusions. He differentiated the abnormal thinking process in the so-called psychotic part of the personality from the working of the non-psychotic personality. His views are not just of theoretical interest, but are, as I have attempted to illustrate elsewhere with clinical examples, of central importance in understanding psychotic patients' communications in general psychiatric practice (Lucas, 1991).

Dr Roberts comments that psychodynamic formulations on delusions are now giving way to cognitive psychology models. I believe the situation should not be regarded as a competitive one, but that each approach needs to be fully explored and appreciated in its own right. Bion has left us a rich legacy to explore further within general psychiatric practice.

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RICHARD LUCAS

Claybury Hospital
Woodford Bridge
Woodford Green
Essex IG8 8BY

AUTHOR'S REPLY: I am grateful to Dr Lucas for drawing attention to the contribution of Bion. Since submitting the paper I have also been reminded of Jung's many ideas about the psychogenesis of delusions and the meaning of symptoms. My concern in constructing the review was to bring order into chaos and establish some means of navigating through a vast polyglot literature. In doing so I encountered what Roy Porter has called the "delicious danger of not knowing when to stop", and would welcome further correspondence with those able to point to any other significant omissions.

Dr Lucas also helpfully underlines the need for clinical work to be informed by wisdom wherever it may be found and the continuing value of psychodynamic insights to the daily practice of general psychiatry.

Holloway (1988) has emphasised that the care and treatment of patients suffering from long-term mental illness is ideally based on an "individualised

https://doi.org/10.1192/S0007125000180274 Published online by Cambridge University Press

assessment of need and a sensitive understanding of the person's inner world". However, it is by no means clear how this sensitive understanding is to be gained and contemporary training programmes may lack encouragement to pursue it (Yorke, 1988). This "defect in training" may in turn have serious consequences, for although Jaspers (1963) defined delusions as essentially un-understandable, he also stated that, "everything understandable has constituent potentiality of worth. In contrast we do not value the un-understandable". Josephs & Josephs (1986) have graphically described the lives of patients suffering from chronic schizophrenia as centering on "public institutions and poverty . . . chronic patients are to a lesser or greater degree homeless, familyless, jobless, penniless, and marginally employable. Their world is often one of insecurity, lack of privacy, prejudice, impersonality and occasional violence". It is the recent history of psychiatric services that chronic psychotic patients, as some of the least understood, also run the risk of being the least valued and attracting the least investment of resources and services.

The ascendancy of cognitive psychological perspectives I take to be as much due to their accessibility and the attraction of quantification as any demonstrable benefits as yet derived from these theories, although there is hope that in due course there will be clear and effective protocols for the psychological treatment of drug-resistant delusions and hallucinations. Integrationists such as Dr Lucas and myself may wish to explore a number of models simultaneously, but there is considerable and inevitable competition between the theorists themselves. In wishing to emphasise the continued value of exploring psychodynamic perspectives alongside cognitive innovations, I have previously been accused of possessing an unwarranted nostalgia. However, I take the view that there is great merit in rekindling Bleuler's (Bleuler & Bleuler, 1986) original emphasis in inaugurating the schizophrenia concept, balancing phenomenological and epidemiological observations with a psychodynamic theory of symptom construction and meaning. For in seeking to understand as well as treat he was able to conclude that "the schizophrenic is not foreign to us, that he is not unintelligible and that we can develop empathy for him".

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GLENN ROBERTS

North Devon District Hospital
Raleigh Park
Barnstaple
Devon EX31 4JB

The 'myth' of suicide prevention

SIR: MacDonald (*Journal*, October 1992, **161**, 574) fails to prove his contention that "it must be time to demolish the myth that GPs can prevent suicide". He puts forward two arguments.

The first is that because suicide is rare, large numbers of patients would have to be seen in order to prevent a single suicide. This low yield would certainly be an argument against screening healthy individuals for suicide risk. The point is that most suicides consult their GP in the weeks before they kill themselves (Barraclough *et al*, 1974). Better detection and treatment of depressive disorders might prevent at least some of these suicides.

His second argument is that in order to demonstrate statistically significant differences in suicide rates "enormous sample sizes with huge numbers of GPs over long periods of time" would be required. This is not so. Rutz *et al* (1989) demonstrated statistically significant changes in the suicide rate on Gotland (population 56 000, 18 GPs) over a 12-year period using routinely collected mortality data. As the authors themselves conclude, this does not prove that their educational programme for GPs caused the decline in the suicide rate; other factors may have contributed, and similar studies should be carried out to corroborate their findings.

The case for suicide prevention by GPs remains 'not proven', but there are good grounds for carrying out further trials. It is wrong to dismiss suicide prevention by GPs as a "myth".

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ELAINE MCCABE

Department of Public Health Medicine
Forth Valley Health Board
33 Spittal Street
Stirling FK8 1DX
Scotland

https://doi.org/10.1192/S0007125000180274 Published online by Cambridge University Press