non-culpable? Any psychiatrist giving evidence in the criminal court should check their prejudice, as the saying goes: and it goes both ways. Just as it may be unsafe to assume a woman is mad because she has killed someone, it may be unsafe to assume a man is bad because he is violent, especially when it comes to domestic homicide.

Gwen Adshead Ravenswood House, Mayles Lane, Fareham PO17 5NA, UK. Email: gwen.adshead@southernhealth.nhs.uk

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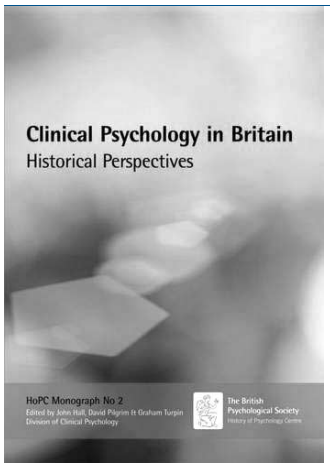

Clinical Psychology in Britain: Historical Perspectives

Edited by John Hall, David Pilgrim & Graham Turpin.
British Psychological Society. 2015.
£21.99 (pb). 395 pp.
ISBN 97819854337313

This book is the place to look for an account of the history of clinical psychology, as it presents the first historical account of the discipline in Britain. It provides an understanding of the developments in the field which reflect the professions of the contributors to the book. These include historians, academic sociologists and academic psychologists, although the vast majority of authors are clinical psychologists who have played a significant role in the development of the profession over the past 30 years.

Edited volumes in the history of science often receive criticism for being somewhat inconsistent, in terms of the information presented in each chapter and the styles in which they are written. This stems from the variety of different contributors and, as the editors have alluded to in the closing pages, the tendency for authors who actively practise the profession to slip into uncritical 'Whiggish' narratives on how the profession has progressed. However, the lack of interest in clinical psychology by professional historians has effectively left its vibrant and often fascinating history to those who practise it. One slight criticism of this work is that there is often a tendency to overlook other professions on which psychologists undoubtedly relied as the field developed since the Second World War. For instance, John Hall's chapter is the only section which briefly touches upon the fact that clinical psychologists often rely on the help of psychiatrists, occupational therapists, social workers and mental health nurses, on whom there is a relative wealth of literature, and whose professions have, similar to clinical psychology, rapidly developed since the introduction of the British welfare state in the late 1940s (see for example McCrae & Nolan's 2016 book *The Story of Nursing in British Mental Hospitals: Echoes from the Corridors*).

However, the relatively eclectic nature of this book does reveal some fascinating aspects of the profession, especially on how it emerged from the eugenicist ideas of the late-19th and early 20th centuries and how the National Health Service was essential for the rapid development of clinical psychology in Britain. This work successfully highlights important individuals to the profession who have otherwise been overlooked, a prime example being William McDougall (1871–1938), who was one of the 'most celebrated' psychologists in the first half of the 20th century but has now been largely forgotten by professionals in the field. This book should become a central resource for anyone wishing to take forward the history of clinical psychology.

Edwin D. Rose History and Philosophy of Science, Churchill College, University of Cambridge; **John Rose** School of Psychology, University of Birmingham, Edgbaston, Birmingham B15 2TT, UK. Email: j.l.rose@bham.ac.uk

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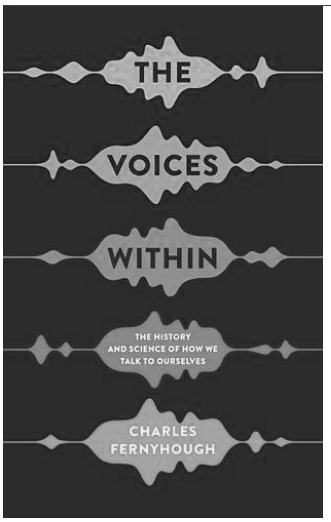

The Voices Within: The History and Science of How We Talk to Ourselves

By Charles Fernyhough
Profile Books. 2016.
£16.99 (hb). 352 pp.
ISBN 9781781252796

This is a truly exceptional book for its scope, richness of detail and originality. It is about inner speech, a subject that is central to our understanding of the nature, phenomenology and origins of auditory verbal hallucinations. Fernyhough says of his goal: 'I want to ask what it is like to have this sort of thing going on in your head [inner speech]. I want to investigate how it feels to be caught up in the flow of impressions, ideas and internal utterances that make up our stream of consciousness'. And he does just that. Furthermore, he persuades us (if we ever needed persuading) that 'Talking to ourselves is a part of human experience which, although by no means universal, seems to play many different roles in our mental lives'.

I was surprised to discover that less than a quarter of us engage in inner speech. But, it was not much of a surprise that the four distinct categories of inner speech are the faithful friend, the ambivalent parent, the proud rival and the calm optimist. The function of inner speech at the very least includes the regulation of action and the capacity to take different perspectives. There appears to be a developmental dimension to the role of inner speech in regulating behaviour. Fernyhough relies on Vygotksy's theory on the transition of social speech to private speech (that is speech that acts as a tool to assist a child in performing particular tasks), and ultimately into inner speech. Accompanying this transition is a significant transformation in the form of utterances such that they become abbreviated, even truncated, but yet retaining a dialogic aspect.

Fernyhough is at his very best when dealing with inner speech. The interest from a psychiatrist's point of view lies in the fact that auditory verbal hallucinations are currently conceived of as inner

speech in which there is a misattribution error leading the person to locate the experience as deriving from external space. In this sense, a science of inner speech will demonstrably shed light on the nature and origins of auditory verbal hallucinations. Fernyhough's implicit approach is to normalise auditory verbal hallucinations by drawing continuities with self-talk in sportsmen, the nature of silent reading, and verbal hallucinatory experiences of writers. The problem is that there is not enough recognition that analogy, the correspondence in certain respects between things, is not evidence of identity. It is like arguing that normative blinking and blinking tics are on a continuum or that arm gestures and hemiballismus are continuous entities on account of superficial family resemblance.

This is a book that informs as well as provoking thought and reflection. It could say more about the phenomenology of auditory verbal hallucinations. Although it ignores the continuities between such experiences as thought echo, thought broadcasting and auditory verbal hallucinations, it addresses the potential neurology of auditory verbal hallucinations. It is quite simply a remarkable book.

Femi Oyebode Professor of Psychiatry, National Centre for Mental Health, 25 Vincent Drive, Edgbaston, Birmingham B25 2FG, UK. Correspondence c/o: bjp@rcpsych.ac.uk

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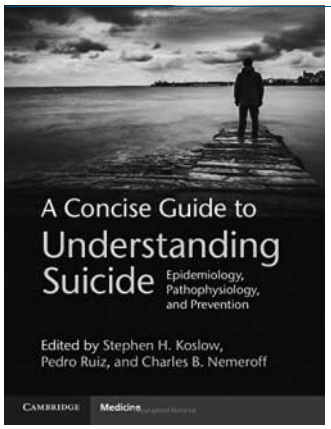

A Concise Guide to Understanding Suicide: Epidemiology, Pathophysiology, and Prevention

Edited by Stephen H. Koslow, Pedro Ruiz & Charles B. Nemeroff. Cambridge University Press. 2014. £67.50 (hb). 408 pp. ISBN 9781107033238

Suicide is a worldwide challenge; it represents a major public health problem, and suicide mortality across the globe accounts for almost one million deaths annually, leaving behind families, friends and colleagues struggling to recover from such a tragedy. Researchers have seen some significant progress in understanding suicide and interesting research is emerging.

The textbook contains 41 chapters, written by 88 internationally renowned researchers. The book is presented in six sections organised around common themes such as understanding suicide; special risk populations; treatment; and ending with suicide prevention. In recent years there have been a number of textbooks published on suicide, which usually present either public health or mental health perspectives. What I found most interesting in this book is the variety of perspectives with regard to the suicidal process. The different chapters examine aspects such as risk assessment, cognitive processes, and psychotherapy, as well as psychiatric, neuropsychobiological, pharmacological, and metabolic syndromes of suicide. Most of the chapters are concise, and adopt a multidimensional perspective on each specific theme. Many chapters offer graphics, tables and figures, all helpful, which allow the reader to identify specific areas of interest within the book. Each chapter is developed to explore one aspect of suicide behaviour and gives sufficient, state of the art information to the reader.

This book offers a wide perspective on suicide research, but there is an important focus on the detection of suicide potential. Of course, detection, evaluation and prediction of suicidal behaviours are important issues. In chapter 29, Davidson, Olson-Madden, Betz & Allan describe the steps to emergency department identification, assessment and management of suicidal patients. The chapter raises the question of who should be systematically screened for suicide risk in an emergency department setting, what type of clinical assessment and care should be offered for those patients presenting with low imminent risk of self-harm and what type of care is needed for some higher level of risk. This chapter offers a definition of different subgroups of suicidal behaviours, identifies major proximal and distal risk factors and proposes different risk levels, each accompanied by treatment recommendations. The authors suggest that a safety plan may be required for some patients before discharge. Stanley, Biggs & Brown present the safety planning to prevent suicidal behaviour in more detail in chapter 39. Safety planning is a strategy developed with the patient allowing identification of ways in which they could keep themselves safe during a suicidal crisis by recognising warning signs, employing different level of coping strategies during a suicidal crisis and, finally, restricting access to lethal means of suicide.

The safety plan differs from a no-suicide contract, which was used regularly in clinical settings for a long period. Reflecting on the advantages and iatrogenic effects of such no-suicide contracts in chapter 40, Miller highlights the historical use of these contracts, how and why the no-suicide contracts were used and the unintended negative consequences of these contracts. As an alternative to the use of no-suicide contracts, Miller suggests that clinicians encourage patients to communicate in detail about their suicidal thoughts, impulses, ideas and plans, and make a judgement about the state of the therapeutic alliance. Of course, the assessment of suicidal risk requires valid answers from patients, who may be ambivalent about their suicidal thoughts or afraid to disclose completely their suicidal plans or access to means. Therefore, the question of suicide assessment is of great importance. In chapter 4, Berman & Silverman take the reader step-by-step in the sensitive process of exploring the presence or absence of suicidal ideation, motivation, intent, planning and behaviour. The authors discuss the benefits and limitations of screening tools, and the importance of adding a face-to-face clinical interview in the process of making a clinical judgment based on sound systematic models of conducting a suicide risk assessment and a suicide risk formulation rather than intuition. The suicide risk formulation is based on the understanding of how multiple and different risk factors may interact in the life of one individual and play out differently for another person. The authors conclude by saying that 'clinical judgement will always be necessary to the suicide risk formulation as purely actuarial models will never attain the level of specificity and sensitivity desired'.

There are a number of other chapters addressing suicide risk assessment, suicide treatment, especially pharmacological treatment, and the identification of mediators and moderators of biological markers. The editors suggest that research on suicide should focus on: the development of algorithms predicting suicide risk; biological markers; mapping neural circuitry and biological mechanisms; the development of effective pharmacological and psychotherapeutic treatments; and standardised assessment of