undertaking tasks which can be performed just as competently by other professionals whose training is shorter and less costly. The content of psychiatric training ought to be assessed with this in mind. We need to determine what other aspects of psychiatric practice can be carried out by non-medical professionals and which tasks require a medical degree. The results would almost certainly lead to a diminished role for psychiatrists but the specialty might be healthier and more viable as a result.

If the nurse's responsibilities are to expand, some lessons can be learned from the United States where the career role of nurse clinician is well established. One area which is of particular significance for psychiatry concerns the detection and management of emotional complications in the physically ill, a facet of what has come to be known as liaison psychiatry.

The liaison nurse clinician undertakes special training, leading to a master's degree, after a basic nursing course and the scope of nursing in this field has recently been described (Bilodeau and O'Connor, 1978; Beraducci *et al*, 1979). Such an expansion of the nurse's sphere of influence offers the prospect of improved psychological care for the physically ill. Indeed, if the psychological needs of patients in general hospital wards are to be met it might be more realistic to establish a career structure for liaison nurse clinicians rather than to expect an increase in the numbers of psychiatrists available for liaison work. However, if this is done the particular contributions of nurses and psychiatrists will have to be defined, within certain limits, so that unnecessary overlap is avoided.

This is another area where the specially-trained nurse could extend the traditional boundaries of nursing responsibility. The establishment of a career structure for the liaison nurse should be given serious consideration by nursing and medical authorities in the United Kingdom.

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References

Beraducci, M., Blandford, K. & Garant, C. A. (1979) The psychiatric liaison nurse in the general hospital. *General Hospital Psychiatry*, **1**, 66–72.

Bilodeau, C. B. & O'Connor, S. O. (1978) Role of nurse clinicians in liaison psychiatry. In *Handbook of General Hospital Psychiatry*, (eds. T. P. Hackett and N. H. Cassem). St Louis: Mosby.

Dear Sir,

Professor Marks and his colleagues are to be congratulated upon their most recent paper (*Journal*, October 1979, **135**, 321–9) on nurse therapists in psychiatry, and also upon the careful planning and evaluation evident in this project. They make a number of important points. It may seem churlish then to express irritation at their implicit but persistent suggestion that the nurse's clinical role is extendable only in the direction of behaviour therapy. I have written elsewhere of this matter and of my different experience at the Ross Day Hospital (Morrice, 1974, etc.). Here let me make but two points.

(1) To insist, as the authors do, that the expanded role and greater autonomy of the nurse are 'new' and 'unusual' is to deny the practice over many years of well-known therapeutic communities like Henderson Hospital, the Cassel, Dingleton, and Fort Logan. In such settings the multidisciplinary team has demonstrated its basic purpose in enabling paramedical staff to broaden their clinical roles and responsibilities in an atmosphere which seeks to encourage new learning for all. So it happens that the performance of the nurse in therapy with groups, couples, and families is seen to match that of more prestigious professionals.

(2) Fostering a nursing elite, trained and confined to behaviour therapy (with all its undoubted advantages), may lead to neglect of the urgent need for many more nurses to be trained, led, and supervised in a broad psychodynamic treatment approach. My belief is that, if even a small percentage of nurses, in and out of hospital, were to make more conscious and skilful use of the opportunities presented in their day-by-day relationships with patients, a transformation would occur in many situations that are still too often bleak, inactive, and merely custodial.

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References

Morrice, J. K. W. (1974) Life crisis, social diagnosis and social therapy. *British Journal of Psychiatry*, **125**, 411–13.

—— (1975) The psychotherapeutic role of the nurse. *Nursing Times*, Oct. 9, 1634–5.

—— (1978) Extending the role of the clinical nurse. *British Medical Journal*, Dec. 2, 1570.

THE VALIDITY OF NATIONAL SUICIDE RATES

Dear Sir,

Douglas (1967) argued that official suicide rates were inaccurate since different coroners and medical examiners have different criteria for categorising deaths. In support of this, Brooke (1974) presented

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coroners from different nations with the same set of documented deaths and found wide variation in the number categorised as suicide by the coroners from different nations.

On the other hand, Sainsbury and Barraclough (1968) correlated the suicide rates in eleven industrialized nations with the suicide rates of immigrants to the United States from these eleven countries. The correlation was 0.87, indicating that nations with high official suicide rates have emigrants who continue to have high suicide rates after they have emigrated to the United States, even though the criteria used by coroners in the United States may be different from those in the home nations. Sainsbury and Barraclough concluded that official suicide rates for different nations may be relatively comparable.

Some recent data lend support to the conclusions of Sainsbury and Barraclough. Kramer *et al* (1972) have reported suicide rates by sex for immigrant groups to the United States. The Spearman rank correlation coefficients between the suicide rate of the immigrants and the suicide rate of the home nations were 0.89 ($n = 12$) for the total population, 0.92 ($n = 12$) for males, and 0.75 ($n = 12$) for females. Thus, the relative comparability of official suicide rates may be reasonably accurate for the suicide rates of each sex.

This conclusion is confirmed by analysis of data from immigrants to Australia. Whitlock (1971) reported suicide rates by sex of immigrants from 16 nations to Australia for 1965 to 1967 and Burvill *et al* (1973) for immigrants from 12 nations for 1962 to 1966. The Spearman rank correlation coefficients between the suicide rates for the immigrant groups and the suicide rates of the home nations are again quite high: for males 0.79 ($n = 16$) and 0.91 ($n = 12$) and for females 0.79 ($n = 16$) and 0.84 ($n = 12$).

Finally, Dublin (1963) reported suicide rates by sex and age for immigrant groups to the United States in 1959. He noted that many of the rates were based on less than twenty cases and so not very reliable. Nevertheless, the suicide rates by age and sex of these immigrant groups were correlated with the suicide rates by age and sex for the home nations for 1962 (WHO, 1965). The data are shown in the Table, from which it can be seen that 16 of the 18 correlation coefficients are positive and all nine of the statistically significant correlations are positive. In addition, the correlations that are low tend to be for those groups in which the suicide rate is lowest (namely the younger groups and females).

Although doubts have been raised about the validity of official suicide rates reported by nations, the stability of the rankings of the suicide rates of these nations and immigrants from these nations to the United States and Australia suggests that national suicide rates may be comparable. It should be noted that these data are based on immigrants from industrialized nations. Data from other nations of the world may not be as reliable.

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Table I

Correlations between the suicide rates by age and sex in ten nations with the suicide rates of immigrants from those nations to the USA

Age	Both sexes	Males	Females
15–24	0.53	0.15	0.15
25–34	0.33	0.52	0.02
35–44	−0.28	0.07	−0.05
45–54	0.84*	0.79*	0.59*
55–64	0.48	0.77*	0.52
65–74	0.90*	0.94*	0.57*
75+	0.84*	0.85*	0.38
All ages	0.92*	0.95*	0.71*

* Statistically significant at (at least) the 5 per cent level.

References

Brooke, E. (1974) *Suicide and Attempted Suicide*. Geneva: World Health Organization.

Burvill, P., McCall, M., Stenhorse, N. & Reid, T. (1973) Deaths from suicide, motor vehicle accidents and all forms of violent deaths among migrants in Australia. *Acta Psychiatrica Scandinavica*, **49**, 28–50.

Douglas, J. (1967) *The Social Meanings of Suicide*. New Jersey: Princeton University Press.

Dublin, L. (1963) *Suicide*. New York: Ronald.

Kramer, M., Pollack, E., Redick, R. & Locke, B. (1972) *Mental Disorders/Suicide*. Cambridge: Harvard University Press.

Sainsbury, P. & Barraclough, B. (1968) Differences between suicide rates. *Nature*, **220**, 1252.

Whitlock, F. (1971) Migration and suicide. *Medical Journal of Australia*, **2**, 840–8.

World Health Statistics Annual 1962. Geneva: World Health Organization, 1965.

CORRECTION

In Dr Kenyon's review of **Bisexuality: A Study** by Charlotte Wolff (*Journal*, October 1979, **135**, 378) line 8 'bio-physical' should be 'bio-psychical'.

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