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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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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