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Definition of Suicide

SIR: Farmer (*Journal*, July 1988, **153**, 16–20) need not be distressed at not possessing or discovering an ideal definition of suicide – that is to say, one that is both theoretically cogent and robust in practice. No-one has. The reason, I suggest, for this imperfect state of affairs is that while motivation is certainly central to the designation of a death as suicidal, yet for all our concern as psychiatrists about why people do the things they do, we do not possess any clear theory of motivation. There is no generally accepted view as to what types of motivation people have, of how to deal with non-conscious determinants of action (i.e. whether intent and motivation are synonymous), of how clearly to distinguish immediate from ultimate goals, of how to think about hierarchies of motivation, or of how to operationalise our definitions, such as they are. The problem is a very general one and not specific to suicide, and as usual we have to be content with approximations and the risk of misclassification in borderline instances. Progress is nevertheless possible.

Professor Farmer rightly concerns himself with how suicide is defined and investigated by various agencies, especially those that generate official statistics. No-one doubts the need for caution in using (any) official data, but it is worth commenting that differences in definition are eminently researchable. Investigators can – indeed have – contrast legal decisions with those reached by psychiatrists, have organised the exchange of death records between different jurisdictions to determine if doing so results in significant differences in verdicts, have examined the local effects on suicide rates of a change in coroner, have compared suicide rates of immigrant groups with those of their nation of origin, and so forth. The results suggest that on the whole, suicide statistics remain serviceable within certain defined limits. To put the matter metaphorically, it is consensually agreed that the bath contains a baby as well as the bath water.

But my main concern is Professor Farmer's veteran campaign concerning the relation between parasuicide and completed suicide. He hints that the distinction is largely artefactual, given that young women metabolise drugs more effectively than men. It would be instructive to see a properly calculated analysis along these lines, using the extensive data now available. Beyond this, Professor Farmer belabours the issue of the dichotomous versus the unitary view of the parasuicide/suicide relationship. As I understand it, the work of Stengel, Kessel, and others shows that the two groups of patients differ on a large number of characteristics, including their basic epidemiology; on other variables they resemble each other, such as being involved in acts of self-damage. Moreover, there may be an overlap in the sense that a small proportion of parasuicides can be construed as 'failed' suicides. Could I be enlightened as to whether I hold a dichotomous or unitary theory, and what is gained by the distinction?

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Postpartum Mania

SIR: The recent paper on puerperal psychoses by Platz & Kendall (*Journal*, July 1988, **153**, 90–94) was of considerable interest to us, because the method which they used was similar to the one which we published several years ago (Kadrmas *et al*, 1979). However, some findings were different. In their study, unlike ours, there was no significant increase