studies. Furthermore, the discrepancy may be partially accounted for by difference in age distribution; in my series the majority of patients were over the age of 55 years. Although a few patients had been referred to psychiatrists in earlier years, none required this during the three year period except for M.E.F. (see Table above).

From these data there is no evidence that depression is a frequent precursor of neoplastic disease in men.

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ATTEMPTED SUICIDE: NOMENCLATURE

As a term, 'suicidal gesture', fails because it implies that the act was insincere or faked. 'Parasuicide' is preferable only because it has no precise meaning; but if it were adopted, it would soon assume the same connotation as 'suicidal gesture,' and other terms would have to be coined *ad infinitum.*

In dealing with suicidal patients there are two major pitfalls, viz.

(1) When it is considered acceptable for the patient to make a genuine attempted suicide, but not so if in retrospect the method used appears to have had no chance of success. (2) When the individual is assessed in terms of what the majority do.

It would be naïve to imagine that changing a diagnostic label would prevent mistakes. However, I agree with Dr. Kreitman and his associates that in this matter the nomenclature requires to be changed.

I suggest therefore that the term 'Threatened Suicide' be used for these cases. It would be used in the same way that obstetricians use the term threatened abortion, that is, in danger of aborting. Surely a patient in desperation, who, for example, falsely states that he has taken an overdose of pills, has threatened suicide. The following categories of suicidal behaviour would therefore be recognized:

(*A*) fatal outcome

(1) Accidental death from poisoning, injury etc., (not generally referred to as suicide).

(2) Suicide.
(intentional injury, poisoning etc.).

(3) Suicide following threatened suicide by injury, poisoning etc.,
(this implies that the doctor diagnosing is not sure if the patient really intended to kill himself, and implies the possibility of the patient having misjudged the harmful effect of the injury, poison etc.).

(*B*) survival

(4) Accidental injury, poisoning etc.,

(5) Attempted suicide (failed).

(6) Threatened suicide by poisoning, injury, drug overdose etc.

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ATTEMPTED SUICIDE AS LANGUAGE

Dear Sir,

In their paper (*Journal,* May 1970, pp. 465–73), Kreitman, Smith and Tan raise many interesting points, none of them related to language. They accept as a possibility the view that 'many so-called suicidal attempts function as a form of communication between the patient and the key figures in his environment, most often conveying an appeal for attention.' They hypothesise that 'the individual within the "attempted suicide subculture" can perform an act which carries a preformed meaning; all he requires to do is invoke it. The process is essentially similar to that whereby a person uses a word in spoken language, though certain important differences also exist (such as the relative lack of precision which often characterises behavioural as opposed to semantic communication.'

The hypothesis makes the all-too-easy assumption that communication is equivalent to language (though less precise along some undefined but presumably semantic dimension?) This is a low redefinition which denies language precisely its essential characteristic, i.e. that meaning is not performed but is generated by syntactic combinations, and confuses it with the pre-syntactic learning of a one to one link at the conceptual level of a meaningful sign or gesture.

Syntax is basic to language, and since non-verbal behaviour like self-poisoning is patently without it, attempted suicide as language is not a concept that empiricism could verify, any more than one could