Brit. J. Psychiat. (1969), 115, 1227–8

Correspondence

ATTEMPTED SUICIDE

DEAR SIR,

The offer by Dr. Kreitman and his colleagues of 'parasuicide' as an alternative to 'attempted suicide' (*Journal*, June 1969, pp. 746–747) raises more problems than it solves. I think firstly that they are wrong in suggesting without qualification that 'the great majority of patients so designated are not in fact attempting suicide'. The acceptance by these patients of the risk of death is too definite to be dismissed in this way, even if the proportion at serious risk is possibly a minority. When Stengel and Cook showed that attempted suicide was not simply failed suicide and nothing else, they emphasized the complexity of motivations both in the suicide and the attempted suicide. Indeed, as Kreitman *et al.* rightly point out in rejecting the unfortunate term 'self-poisoning', there is a very real association between 'attempted suicide' and 'completed suicide'. The move to 'parasuicide' seems to jettison too much from this view.

Secondly, it would be misleading to regard attempted suicide as a simulation of suicide. If 'parasuicide' is meant to suggest an act of mimicry, it presumably implies simulation intended by the patient, and the total absence of serious self-damaging motivation. For how many cases can this be acceptably proved? Both the patient and the psychiatrist would have to agree the conclusion, and at least some psychiatrists find this situation relatively rare in their routine work with patients who have attempted suicide.

Thirdly, if we are to have categories both of attempted suicide and parasuicide I suspect this will lead to considerable uncertainty in clinical practice and meaningless results in epidemiology.

Lastly and least important, 'para' is of Greek etymology, and 'suicide' Latin. Some would object to mixing roots from different languages. I would not myself think that an important objection if the term helped in other respects, but it does not seem to do so. It may indeed secure about as much agreement as 'para-psychology'.

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COMMUNITY PSYCHIATRY

DEAR SIR,

I am stimulated by the proud note struck in Dr. Maurice Silverman's letter (*Journal*, July 1969, p. 863) to reflect on the controversy which has persisted over the past decade regarding the number of beds required to provide an adequate psychiatric service for any given population. The trend, like that of the female hemline, is clearly towards the creation of the mini-unit. In the absence of major therapeutic advances or of improved manpower during this time, such reductions often have to be achieved through the ingenuity of the psychiatrist, by substituting chairs for beds in his day hospital, redefining the specialty within narrower limits, or restricting the demand by educating the community to tolerate higher thresholds of misery within their midst.

With appropriate acknowledgement, may I offer for your readers' consideration the formulation of a new law which states that bed-space contracts so as to decrease the patients available to fill it. Perhaps while waiting for a biochemical breakthrough we have discovered the final solution to the problem of psychiatric illness.

I am led to the conclusion that there are other factors influencing the organization of medical care besides the needs of the patient. If some of these are the needs of the doctor it would be interesting to investigate what these are, and why in the psychiatrist's case there should be such a powerful drive to reduce the number of beds under his care.

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TRAINING OF PSYCHIATRISTS

DEAR SIR,

Dr. Fraser (*Journal*, August 1969, p. 979) would have a good point in favour of some subnormals being the concern of psychiatrists if, in fact, they were only referred for 'deviant behaviour or abnormal psychological development' and were discharged as soon as these had been corrected. In practice,