

unmeaning as the loud laugh which succeeds them". (Haslam, 1809).

Haslam also refers to the frequency of auditory hallucinations among the insane, and elsewhere he devotes an entire book to the study of a patient admitted to Bethlem in 1797 with what appear to be classic symptoms of schizophrenic thought disorder (Haslam, 1810). What is important about all these descriptions of schizophrenia-like symptoms is that he writes of them as though they were nothing new: indeed, as though they were so common, obvious, and typical that it is scarcely surprising that most authors found them hardly worth mentioning, at a time before interest in phenomenology had developed, and when they had few opportunities for observation anyway.

The purpose of the evidence presented here is not to disprove the 'recency' hypothesis: our aim is rather to suggest that the historical reasoning it relies on is often dubious. The importance of Dr Hare's work is to raise issues which are important to modern psychiatry, while demonstrating how essential historical knowledge is to the debate. The history of psychiatry is too important to be left entirely to historians ignorant of clinical issues, or psychiatrists unqualified to evaluate historical evidence. As there can be few practitioners trained in both disciplines, we would plead for more active co-operation between the two.

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#### Repetition of parasuicide

SIR: We studied the repetition of parasuicide in Edinburgh in the period 1980–1981 (Wilkinson & Smeeton, 1987), and so read with interest the report by Kreitman & Casey (*Journal*, December 1988, 792–800). We are puzzled as to why the authors based

their categories of 'first-ever', 'minor repeaters' and 'grand repeaters' on the individual lifetime history of parasuicidal episodes. Given a stable pattern of parasuicide with respect to each cohort, more major repeaters are to be expected among older individuals, since they have been at longer risk of having an episode. This observation can be seen in Table II of their paper, up to the age of 34. Results for different age-groups would be made more comparable by assessing the patient on a recent fixed period of time (say two years), as in our recent study of parasuicide repetition (Smeeton & Wilkinson, 1988a).

Incidentally, the fact that there are relatively few major repeaters over 35 years of age seems to indicate that these individuals had episodes of parasuicide much less frequently in their youth than the present generation of young repeaters. In order to verify this trend one would have to check parasuicide records categorised by age over at least 30 years.

On the subject of prediction, we found that major repeaters (five or more episodes in 2 years) could be sub-divided into those with clustered and those with chronic patterns of parasuicides. Prediction should be much easier for those with a clustered pattern, since once one parasuicide is observed, a series will probably follow in the near future. In another type of clustering, episodes may occur around the same dates in consecutive years (Smeeton & Wilkinson, 1988b). It would be particularly interesting to see how clinical and social problems are related in time to clusters of episodes.

With the possibility of the clustering of episodes in mind, the lifetime history seems a rather crude measure of current needs. It may be that some patients with a large number of prior episodes (Drs Kreitman & Casey's major repeaters) are currently experiencing an untroubled period. Conversely, some of their minor repeaters may be commencing a period of frequent repetition and may be experiencing problems which are far from minor.

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