untreated. We do not claim to replace the therapeutic team but to strengthen it.

Those who give serious consideration to this important book will find much of interest and many ideas which, I hope, will become very widespread in British psychiatry, namely, goal definition, targeting of problem areas, therapeutic investment versus benefits achieved, and objective measurement at all stages throughout treatment.

In the unlikely event that the reviewer finds his own aeroplane hijacked by a lorry driver, I am sure he will be able to pursue a rewarding career in the literary field. I have no such pretensions. I would just like to be able to provide a demonstrably worthwhile service to the adult neurotic population.

MARTIN B. BROWN
Nurse Therapist

Pastures Hospital,
Mickleover,
Derby DE3 5DQ

DEAR SIR,

I am sorry that Miss Skellern should think my review was a joke, and I realize it will only make matters worse when I say that it was deadly serious. In the short space allowed me for my review I wished to make two points in as vivid a way as possible: first, to question what the basic educational requirements should be for a practitioner of behavioural therapy, and second to ask what the relationship should be between the nurse therapist and other professionals—notably clinical psychologists and doctors.

Although Miss Skellern may call me reactionary, it seems to me to be reasonable that practitioners of behavioural therapy should have qualifications in psychology, just as psychiatrists should have qualifications in medicine and airline pilots should know a little about general physics and engineering. At a time when our society is producing many graduates in psychology, it seems a pity that some of these could not be offered the sort of specialist training Dr Marks has described.

Mr Brown assures me that nurse therapists do not wish to 'fly the aeroplane', but this point is far from clear, since the course claims to provide an independent role for nurse therapists and the relationship of the nurse therapists to other members of the therapeutic team is left critically unclear. If the nurse therapists are to work alongside established clinical psychologists and under their general supervision let this be clearly stated: it has not been stated so far. Mr Brown goes on to say that nurse therapists will have an effect on British psychiatry: but again, the relationship between a nurse therapist and a psychiatrist is not made clear. If nurse therapists are to work on their own in the community, or if they are to work in a primary care setting, let it be made clear who is to pay them and to whom they are responsible. Mr Brown adds the image of the hijacker to my simile: I would only say that until these issues are resolved, it is the nurse therapist who will seem to others to have hi-jacked the aeroplane.

DAVID GOLDBERG

Department of Psychiatry,
The University Hospital of South Manchester,
West Didsbury,
Manchester M20 8LR

WHAT'S IN A NAME? ATTEMPTED SUICIDE

DEAR SIR,

Psychiatrists, aware of the growth in the number of patients who take overdoses of drugs, usually accept the view put forward by Stengel (1964) that those who kill themselves and those who do not succeed in killing themselves represent two different but overlapping populations. Those who survive the overdose and other methods of potential self-destruction provide many problems; a minor one is how to name the act carried out by such individuals.

There have been a number of suggestions concerning nomenclature. *Attempted suicide* is applicable only to a small percentage; undoubtedly there are a few who intended to kill themselves and fortuitous discovery has prevented death. For these, the term is appropriate. For the majority it is recognized that the intention to die is not in the forefront of the individual's motives. A number of alternative terms have been suggested for this behaviour. *Parasuicide* (Kreitman *et al*, 1969) is commonly used but it retains the connotation of a partial suicide—suicide related behaviour. *Pseudocide* (Lennard Jones and Asher, 1959) self-evidently and '*Self-poisoning*' (Kessel, 1965) have developed pejorative meanings with the implication of 'merely' an overdose and not an act of someone in distress. Ramon and his colleagues (1975) have drawn attention to the differing attitudes of nurses and doctors towards such individuals.

There is need to coin a new term which can be precisely defined without the disadvantages associated with the present names. I would like to propose the name *Propetia* which I introduced at the Annual Congress of the International Association of Suicide Prevention in 1975. The word derives from the Greek προπετεία meaning rashness, headlong haste and containing the idea of falling into something or rushing into it in a reckless manner without previous assessment of the risks. It is thus different from the

risks accepted for example by miners, mountain climbers and racing drivers; they take risks but recognize them and guard against them.

The word would label that behaviour in which an individual haphazardly took a number of tablets or physically injured himself without any real forethought concerning the implications of the act in terms of risk to life.

Thus treatment of the attempted suicide might well be psychiatric, but it is probable that the management of the propetic individual would be more likely to include social and environmental relief by various agencies, not excluding the family.

C. P. SEAGER

Whiteley Wood Clinic,
Woofindin Road,
Sheffield S10 3TL

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DEAR SIR,

Thank you for asking me to write in reply to Dr Seager's letter. I ventured the term 'self-poisoning' as preferable to 'attempted suicide' because it allowed those first coming into contact with the people concerned to pursue a course of action without needing to consider the patient's intention which is often, at the time of first intervention, still obscure. There still seems merit in this. Norman Kreitman with 'parasuicide' and now Phil Seager with 'propetia' wish to reintroduce concepts of motivation into the nomenclature. This is unhelpful in the Accident and Emergency Department or the general hospital ward where the circumstances surrounding the tablet taking may not yet have been established. Moreover, the psychiatrist must pursue his own inquiries without having had the issue pre-judged by terminology.

The nice nuances of Dr Seager's 'pejorative' were not lost on me, but the implication of 'merely an "overdose" ' cannot be drawn from my writings; and as to the implication of self-poisoning not being 'an act of someone in distress' may I perhaps quote from a paragraph headed 'Distress' from my article which Dr Seager himself cites: 'Is there a unifying basis to self-poisoning? Is there some feature that informs them all? The answer has already been hinted at. Distress drives people to self-poisoning acts: distress and despair, unhappiness and desperation.'

You will see that I still believe we should use a term that is independent of conclusions concerning motivation. Of course within psychiatric circles we ever need to discuss each of the multiple motivations for self-poisoning. Will new vocabulary help? I doubt it.

NEIL KESSEL

Department of Psychiatry,
The University Hospital of South Manchester,
West Didsbury,
Manchester M20 8LR

DEAR SIR,

Any honest parent entering his offspring for a baby show would have to admit that he brings a prejudiced eye to bear on the other competitors. It could well be that having proposed a term of our own to replace 'attempted suicide' my colleagues and I are biased against alternatives, but even with strenuous efforts to be impartial we have to conclude that Dr Seager's term 'propetia' will not do.

A distinction is proposed within the generality of self-poisoning and self-injury patients, but no definition is offered of the primary group to whom that differentiation is to apply. However, even if we allow this to pass, problems remain.

First, the distinction between the 'real' attempters and the rest is to be based on intention to die. The efforts of the last decade or so towards the use of criteria other than intent arose precisely because of the notorious difficulties of categorizing intentions with any degree of precision; those difficulties are no less now than formerly.

But it seems that to complicate things further, Dr Seager is also introducing an additional criterion based on notions such as recklessness, rashness, or impulsivity. This at once confounds the classification principle; what becomes of someone who resolves to die but makes up his mind briskly, or of the not-so-infrequent patient who plans quite carefully to take a non-lethal overdose?

Thirdly, while the characteristics to which Dr Seager points are certainly common, it can scarcely be claimed that they have been defined in his letter. What, for example, is the maximum time which a patient is allowed to take while thinking about his overdose and yet still be considered to be 'impulsive'? Just how 'reckless' must he be, and against what