

SIR: Mr Smeeton and Dr Wilkinson ask why we categorised our patients on the basis of their lifetime history. The answer is that this method seemed to us the simplest, and to rest on no assumptions about patterns of repetition. Their proposal to classify patients solely by the number of episodes in the preceding two years implies that such clustering is a salient and consistent feature of repetition, and while there is some interesting evidence that this might be so, we do not think that at present it provides a secure basis for classification. Moreover, contrary to another of their suggestions, it turns out not to be true that the number of parasuicidal episodes increases linearly with age simply as a function of increased time at risk. The older patients in our series show a different pattern of parasuicide from younger subjects; they are predominantly first-ever admissions, and major repetition is distinctly rare. Our present view is that such patients are quite a different group from the younger ones, and probably reflect differences both in psychopathology and in social context.

Mr Smeeton and Dr Wilkinson raise the possibility of a birth cohort effect for parasuicide, much as proposed some years ago by Alderson (1974). They also indicate that formally testing such a model is scarcely feasible. But for what it is worth, we have found in our own data, which extend back to 1968, that the frequency of a prior episode in relation to age has constantly been much as reported in our recent paper. There is thus little support for a cohort effect. Alderson (1985) has come to the same conclusion for England and Wales.

Finally, they suggest the use of cluster patterns as a prognostic indicator among the major repeaters, referring to their own studies and work by others. This approach is eminently worth pursuing, but can only be applied to a small minority of all patients – less than 3% in their 1987 paper. Most repetitions will be generated by the much larger group of first-ever and ‘minor’ repeaters. Even for the major repeaters it would be unwise to base predictions solely on the past history of parasuicide and to ignore the many other aids to prognosis that are now available. Indeed, if we understand them correctly, Mr Smeeton and Dr Wilkinson themselves appear to recognise this point. At present there is no substitute for comprehensive psychiatric and social assessment in any attempt at prediction.

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Loss and theft

SIR: In Fishbairn's letter about shoplifting (*Journal*, June 1988, 152, 845–846), he wrote about risk-taking having an antidepressant effect and wondered if this was the mechanism behind shoplifting. In some 90 cases which I have studied, the event which always precipitated the risk-taking behaviour was a loss, or a threatened loss, of a significant other held in a symbiotic relationship with the self, which was experienced as a catastrophe and necessitated that they were caught in the act. This behaviour is similar to the all-or-nothing mode of the narcissistic personality, and ensures that someone cares when it was felt that nobody cared at all.

An illustration can be seen in the behaviour of a tertiary-educated woman who had been a compulsive shoplifter and had been seen for a year for twice-a-week psychotherapy, and had not shoplifted over that period. In a session it was suggested by the therapist that consideration could be entertained to work towards the ending of therapy. An hour later I was rung by the police to say that she had been caught shoplifting and that her mental state was such that they thought she needed hospitalisation.

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The use of propofol for anaesthesia during ECT

SIR: Rands (*Journal*, January 1989, 154, 125) is correct to draw attention to the adverse effect of propofol anaesthesia on seizure duration during electroconvulsive therapy (ECT). In a study involving 25 patients we observed that the use of methohexitone produced a median (QD) seizure duration of 33.0 (7.8) s, whereas the use of propofol significantly reduced this to 19.0 (9.0) s ($P < 0.01$) (Simpson *et al*, 1988). We concluded that propofol was not an appropriate agent for ECT anaesthesia, and that methohexitone should remain the standard agent. Since then, two other studies have shown that both observed seizures (Rouse, 1988) and cerebral electrical seizure activity (Dwyer *et al*, 1988) are attenuated by propofol.

In view of these findings we feel that the use of propofol anaesthesia for ECT should be