Finally, it is our experience that women with strong views on the acceptability of taking medication during pregnancy and while breast-feeding. This may account for the fact that out of the 54 women in our study who went on to have a further pregnancy, only six took prophylactic medication in the puerperium (lithium or haloperidol). Although only two went on to have a recurrence of puerperal psychosis, the numbers are clearly too small to draw conclusions regarding the efficacy of prophylaxis.

This is an area, therefore, in which management decisions are not straightforward but the frequency and severity of post-partum episodes in women with bipolar disorder must weigh heavily in the risk–benefit analysis. What is needed, we can all agree, is further research to provide empirical data on which clinicians, women, and their families can base these difficult decisions.

We would, however, defend our contention that the decision to commence mood-stabilising (or indeed any) medication in women of child-bearing years should follow a ‘very careful weighing up of risks and benefits’. Any medication should be started assuming that the women may become pregnant and future pregnancy and contraception should be actively discussed at the earliest possible opportunity.

We would also argue that the evidence base for the use of prophylaxis in women with bipolar illness in the post-partum period is not as robust as would be ideal. As Dr O’Keane has outlined, the literature does support the use of lithium in this context, although the retrospective (and partially overlapping) studies differed in when lithium was commenced – important as there may be practical problems in achieving therapeutic levels quickly following delivery and the onset of puerperal psychosis is typically in the few days following delivery. In our series of 101 women with post-partum psychosis more than half had an onset on days 1–3 with over a fifth on the first post-partum day (further details available from the authors on request).

With regard to other mood stabilisers, there are few data in the literature. A recently published study demonstrated no efficacy for sodium valproate (Wisner et al, 2004) and, despite anecdotal reports of the benefit of typical or atypical antipsychotic medication as prophylaxis, there are no data regarding their use in this context.

Value of measuring suicide intent

The paper by Harriss et al (2005) addresses the very relevant issue of measuring suicide intent in the evaluation of future suicide risk. Measuring suicide intent is more useful than measuring the lethality of the attempts (i.e. the degree of danger to life resulting from self-injurious behaviour; Beck et al, 1975). Assessing the intent can be particularly useful in situations where there is no correlation between the expected and actual outcome of the method used as may happen in those with a low level of literacy. Accuracy of expectations about the likelihood of dying moderates the relationship between suicide intent and medical lethality (Brown et al, 2004).

Identifying a cut-off to differentiate between high-intent and low-intent attempts is very difficult. Median scores on the Suicide Intent Scale (SIS) were used by Harriss et al (2005) to categorise high-intent and low-intent attempts.


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Free will and volition

Although I agree with Professor Henderson (2005) that we should acknowledge that...