in'. I am not suggesting that hypotheses, speculation and interpretation should be proscribed, but they might well be relegated to footnotes.

J. E. Orme.

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Dear Sir,

It is not easy to see the point of Dr. Orme's comment on our paper on the EEG and personality. If we had not referred to his paper with McAdam then there would have been some justification for his drawing attention to its results and indeed for claiming a priority which we do not dispute. But, in fact, in our recent paper we have referred to this earlier work in the field and mentioned its results. It is true that we did not quote from it *in extenso*, nor did we further discuss its relevance to our findings since our paper dealt with normal subjects, whereas his subjects were chronic alcoholics. These are very different populations, and generalizations cannot readily be made between them except as the result of actual investigations of the kind that we have undertaken.

Moreover, as well as using per cent. time alpha, we also measured rate of change of potential (r.c.p.), alpha amplitude and alpha frequency. It is worth pointing out that since 1954 methods of EEG analysis have advanced considerably in accuracy and scope with improvements in electronics, recording and computing techniques. The nature of the EEG is better understood, and such experiments as ours, we hope, will lead to further understanding of its significance. Methods of assessment of personality have also developed beyond the controlled interview technique employed by Dr. Orme at that time.

However, it is when Dr. Orme discusses hypotheses and counter speculations that he becomes harder to follow. Does he really believe that scientists should present data unencumbered by reasons for collecting these data in the first place or interpretation of them once they have been gathered? To do so could be meaningless, confused and haphazard—in a word, useless. We wonder what Popper would make of his suggestion of the relegation of hypotheses to footnotes.

We fully support the plea for large fact-finding surveys, but also look eagerly for further theoretical syntheses, small scale experiments and replications of previous work. By a strictly quantitative investigation we have found in normal subjects an inverse relationship between extraversion and alpha prevalence and amplitude. That McAdam and Orme inferred from their investigation of chronic alcoholics a similar relationship strengthens both cases. It remains true, however, that contradictory findings have been published, and the complex area of personality correlates of the EEG still required both factual and theoretical clarification.

Finally, Dr. Orme feels that he 'is being taken on an essentially circular tour'. We suggest that his tour has an added dimension and corresponds to the spiral progress of science.

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PARASUICIDE

Dear Sir,

The problem of nomenclature in studies of so-called 'attempted suicide' has certain affinities with migraine: both are recurrent, are associated with headache, and induce difficulties of focusing clearly.

The only point on which everyone seems to be agreed is that the existing term 'attempted suicide' is highly unsatisfactory, for the excellent reason that the great majority of patients so designated are not in fact attempting suicide. Numerous alternative terms have been proposed; none has found general acceptance. Yet we feel that the problem remains as urgent as ever and requires another effort at solution. The case against misleading nomenclature in psychiatry and the havoc it causes, especially to non-psychiatrists, presumably does not have to be argued.

Of the various proposals, that recently advanced by Professor Kessel (1965) has attracted most interest; he suggests 'deliberate self-poisoning' and 'deliberate self-injury'. This suggestion seems to us to fail for several reasons.

1. The patient may be deliberately self-poisoned, yet outside the group generally regarded as 'attempted suicide', as with a patient on an LSD 'trip' or just plain drunk.

2. The patient may be free of all toxicological evidence of poisoning yet still be within the group of 'attempted suicides', as might arise with a patient on double-blind drug trial who takes a number of placebo tablets with the clear intention of poisoning himself. (This point is important as a reminder that the patients' intention may have to be taken into account in reaching a diagnosis.) To label patients as 'deliberately self-poisoned' who are not poisoned in the generally accepted pharmacological sense would seem to be heading for yet more confusion.

Both 1 and 2 above are in essence pointing to the ambiguity of the word 'poisoning'.

3. One claim for the 'deliberate self-poisoning' term is that it is based on objectively demonstrable behaviour and not on the inferential judgement of the psychiatrist, yet, as 2 above indicates, this claim is too sweeping and it is probably impossible to eliminate all assessment of motivation. Moreover, the deliberateness of the act also requires evaluation by the physician.

4. The terms proposed are long and clumsy, especially if one wishes to refer to the whole group of 'attempted suicides' (presumably as 'deliberate self-poisoning and self-injury').

5. The omission of all references to suicide, while historically understandable, neglects the very real association that exists between 'attempted suicide' and 'completed suicide'.

What, then, is our alternative? It appears that what is required is a term for an event in which the patient *simulates* or *mimics* suicide, in that he is the immediate agent of an act which is actually or potentially physically harmful to himself. Yet the 'attempted suicide' patient is not usually addressing himself to the task of self-destruction, and rarely can his behaviour be construed in any simple sense as oriented primarily towards death. To designate this act, which is like suicide yet is something other than suicide, we now propose the term 'parasuicide'. (The O.E.D. defines the prefix 'para' as 'by the side of' but also gives 'irregular, disordered and perverted' as additional meanings).

For clarity we must confirm that we are not proposing how parasuicide should be diagnosed, nor even offering at this point a full definition. We are also aware that other terminological difficulties in the field of suicide studies remain to be resolved, and that the adoption of our proposal would raise the question of whether 'attempted suicide' should serve for those patients to whom the phrase really applies or be dropped altogether.

All the same, 'parasuicide' seems to be an advance on existing terms. Before adopting it and possibly making a confused situation worse, however, we feel a duty to ascertain the views of our colleagues and trust that through the courtesy of your columns their opinions can be canvassed.

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AN UNUSUAL SEX CHROMOSOME MOSAICISM

DEAR SIR,

I wish to report a case of the unusual sex chromosome mosaicism 47XYY, 48XXYY, 49XXXYY in a subnormal man aged 22, who was discovered in a study of outstandingly tall in-patients in a hospital for the mentally subnormal.

A Caucasian, he was an illegitimate child and no details of his parents are obtainable. He walked at 2 years and talked at 3 years and he attended an ordinary school to the age of 7 and a special school until he was 15. He has a history of indecent behaviour and fire-raising, and intermittently he has shown evidence of delusions and hallucinations. On the Wechsler Adult Intelligence Scale his full scale intelligence quotient is 53. He is tall, height 182 cm., (73 inches), weight 60 kg. (132 lb.). His head appears small, with a cranial circumference of 52 cm. He is of asthenic physique, with small testes, gynaecomastia and scanty pubic and axillary hair. His skull X-ray shows a bulky mandible and prominent supra-orbital ridges. The pituitary fossa is normal. Electroencephalography shows no abnormality. His excretion of 17 ketosteroids is 1 mg./24 hours and excretion of 17 hydroxycorticosteroids less than 1 mg./24 hours (normal ranges, 17 ketosteroids 5–28 mg./24 hours, 17 hydroxycorticosteroids 5–21 mg./24 hours). Dermatoglyphs show axial triradii on both palms in a more proximal position than the normal, with narrow atd angles of 35°. His fingerprints are ulnar loops except for whorls on the left ring finger (IV) and on the right index (II), middle (III) and ring (IV) fingers.

Forty-two per cent. of cells in the buccal smear were chromatin positive. Seven drumsticks were counted amongst 300 neutrophils in the blood film. Peripheral blood culture revealed cell lines with 47 and 48 chromosomes and analyses showed complements of 47XYY and 48XXYY respectively. One cell had a chromosome count of 49, and analysis showed a sex chromosome complement XXXYY.

This man presents a combination of the mental and physical features of Klinefelter's syndrome and the XYY man.

I am indebted to Dr. M. K. Mason, M.D. (London), M.C. Path., Consultant Pathologist, and Miss Julie H. Eyles, B.Sc., Scientific Officer, of the Chromosome Reference Centre, St. James Hospital, Leeds, for the chromosomal investigation of this case.

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