Stewart, D. E., Klompenhouwer, J. L., Kendell, R. E., *et al* (1991) Prophylactic lithium in puerperal psychosis. The experience of three centres. *British Journal of Psychiatry*, **158**, 393–397.

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Authors' reply: We agree with Dr O'Keane regarding the severity and potentially devastating consequences of post-partum psychosis in women with a history of bipolar disorder and assure her that any negative emphasis she detected in our brief comments regarding prophylactic treatment were indeed unintended. The brief report format did not allow us to discuss this aspect of management at length but we have taken up this issue more fully in our recent editorial (Jones & Craddock, 2005).

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.

Finally, it is our experience that women have 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.

Jones, I. & Craddock, N. (2005) Bipolar disorder and childbirth: the importance of recognising risk. *British Journal of Psychiatry*, **186**, 453–454.

Wisner, K. L., Hanusa, B. H., Peindl, K. S., *et al* (2004) Prevention of postpartum episodes in women with bipolar disorder. *Biological Psychiatry*, **56**, 592–596.

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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. Their results showed that women with high intent repeat suicide attempts whereas men with low intent tend to do so. Since there was a gender difference in the median values, the cut-off score used for males (10) was higher than that used for females (8). By virtue of using separate cut-off scores, men were classified as having low intent even if they had similar scores on the SIS to women in the high-intent group, possibly affecting the repetition rates. Quantifying and classifying suicide intent have been approached in different ways by various researchers. Baca-Garcia *et al* (2004) studied the characteristics which influence emergency psychiatrists in decisions to hospitalise after a suicide attempt, and found that a cut-off of 11 on the SIS correctly classified 72% of participants. However the authors clearly acknowledge the advantages of using an extensive clinical checklist over an instrument such as the SIS. Although the SIS was not originally designed to predict repetition of self-harm, it may be possible to identify similar cut-off points to predict the likelihood of repetition of suicide attempts when used with other known risk factors. For any risk assessment to be clinically meaningful it should be based on a composite index which takes into account various factors, including the level of suicide intent, the severity of depression, the degree of hopelessness, the impact of life events and the lethality of the attempt.

Baca-Garcia, E., Diaz-Sastre, C., Resa, E. G., *et al* (2004) Variables associated with hospitalization decisions by emergency psychiatrists after a patient's suicide attempt. *Psychiatric Services*, **55**, 792–797.

Beck, A. T., Beck, R. & Kovacs, M. (1975) Classification of suicidal behaviors: I. Quantifying intent and medical lethality. *American Journal of Psychiatry*, **132**, 285–287.

Brown, G. K., Henriques, G. R., Sosdjan, D., *et al* (2004) Suicide intent and accurate expectations of lethality: predictors of medical lethality of suicide attempts. *Journal of Consulting and Clinical Psychology*, **72**, 1170–1174.

Harriss, L., Hawton, K. & Zahl, D. (2005) Value of measuring suicidal intent in the assessment of people attending hospital following self-poisoning or self-injury. *British Journal of Psychiatry*, **186**, 60–66.

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Free will and volition

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

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