ATTEMPTED SUICIDE AS LANGUAGE

DEAR SIR,

Dr. Thompson is quite right to take us to task for using 'language' rather loosely in our paper on so-called attempted suicide (better termed 'parasuicides') as a form of communication (*Journal*, July 1970, pp. 121–2). Unfortunately we had no space in our paper in which to discuss distinctions between different kinds of communication, and a little inaccuracy often makes for both brevity and clarity.

Though we can scarcely develop the theme in a letter, we would suggest that it is useful to distinguish three main levels of communication:

1. The direct, uncoded expression of an affective (or similar) state, such as an angry blow or a cry of pain.

2. Non-verbal but culturally determined communication, such as a ceremonial bow or the raising of an eyebrow.

3. Verbal communication.

In our view parasuicide usually belongs to the second category. It is more than a simple expression of affect precisely because it is culturally defined or *coded*. It may thus be used by an individual to convey something other than itself, that is to say, it has one of the properties of symbolic communication. This means, of course, that the link between the act itself and that which it signifies is established by the subculture and is not an idiosyncratic association of the patient, in which case it would be meaningless. In this respect only does parasuicide have any of the characteristics of communication at the level of language. Dr. Thomson's own position on this point is not quite clear.

There is, incidentally, a wider issue here. It is often held by psychiatrists that much of the behaviour of most patients can be viewed as some kind of communication. Yet, in this country at least, very little research seems to have been carried out on how to define communication operationally and to study it objectively, let alone to distinguish its varieties. Unless this is rectified, the very concept of communication will go the way of 'dynamic', and for all practical purposes will cease to mean anything.

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GILLES DE LA TOURETTE'S SYNDROME

DEAR SIR,

Dr. N. Prabhakaran (*Journal*, May 1970, pp. 539–41), presents what he describes as the first case of Gilles de la Tourette's syndrome to be reported from India.

He further states that this syndrome has not been reported outside Europe and America. Dr. S. J. M. Fernando (*Journal*, June 1967, p. 614), too made a similar statement, in response to which Dr. A. Chakraborty (*Journal*, January 1968, p. 125) pointed out that two cases had already been reported in the *Indian Journal of Psychiatry*, one in 1962 and the other in 1966.

Within the last two and a half years, I have seen seven cases of this syndrome. I hope to report these in detail in the near future.

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DEAR SIR,

Dr. N. Prabhakaran's paper on the syndrome of Gilles de la Tourette states that this syndrome has not been reported outside Europe and America. Recently I have been preparing a report on a seventeen year old New Zealand boy with this syndrome, and while reviewing the literature have located two cases reported from India (Chakraborty, 1962, and Saroja Bai, 1966), and two cases recorded in Australia (Ellison 1964, and McKinnon, 1967).

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DEAR SIR,

I refer to Professor N. Prabhakaran's interesting report (3) of a case of Gilles de la Tourette's Disease in an Indian, which he states was described 'for the