

Reason for childhood referral

	Melbourne*			St. Louis†			
		Behaviour problems	Other reasons		Antisocial behaviour	Other reasons	
<i>Adult diagnosis</i>							
Schizophrenia	(26)	42%	58%	Schizophrenia	(25)	64%	36%
Personality disorder	(47)	45	55	Sociopathy	(94)	95	5
Neurosis	(24)	21	79	Neurosis	(84)	52	48

* Recalculated from Table VI.

† Recalculated from Table 6.1.

to those dropped by Dr. Mellsoop because they occurred in fewer than 20 cases, and controls.

The table shows that once these efforts to obtain comparable data sets were made, the disagreement Dr. Mellsoop pointed to has disappeared. The St. Louis study shows as much association between childhood neurosis and adult neurosis as his study does. (Of course, the overall rate of referrals for antisocial behaviour in St. Louis is higher, reflecting the fact that the children were older at referral, since we defined childhood as under 18 and Dr. Mellsoop defined it as under 14, and that the St. Louis clinic served as a facility for the juvenile court. But this should not affect comparisons between diagnostic groups.)

The important point is not that Dr. Mellsoop's data and ours agree, but rather that the data he used to show that 'neuroses in childhood were prominent precursors of adult neuroses' are similar to data which constituted a part of the results from which we drew quite different conclusions. Was our interpretation wrong? I don't think so. Indeed, I believe the cases we had to discard to make our data set comparable to Dr. Mellsoop's are essential to deciding the role of childhood neurosis in adult neurosis. When one is limited to subjects who are sick both as children and adults, the most one can say is that neuroses in childhood are more prominent in adult neuroses (and schizophrenia) than they are in adult personality disorders. But to say that childhood neuroses play a prominent part in adult neuroses in general, one needs the ex-patients we had to discard to obtain a match with the Melbourne cases, i.e. the healthy adults and those with other diagnoses, as well as the controls who were normal children. It was especially our failure to find a difference in rates of neurosis between ex-patients and controls that convinced us that childhood neurotic symptoms were not important precursors of adult neurosis.

Actually, Dr. Mellsoop has only 13 cases of neurotic adults for whom childhood records of neurosis were found. Certainly these 13 cases do not constitute a prominent part of however many neurotics aged 25

to 29 there may be among the more than 100,000 names he found in the central patient registry.

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SELF-POISONING IN ADOLESCENTS

DEAR SIR,

I was interested in Dr. White's article (*Journal*, January 1974, 24-35), because over the past four years I have been collecting details of Bradford school children admitted to hospital following self-poisoning. The age group of the children is largely 10-15, that is just preceding the age group studied by Dr. White. Nevertheless, many of his observations seem to apply to this younger group of children. Although he states that most patients had the drug immediately available, he does not indicate how this came to be so. In my group the majority of children took sleeping tablets or tranquillizers that had been prescribed for a parent. In two cases, the parents actually threw the bottle of tablets at the child with the advice to take the 'bloody lot'. It might be that in other cases a similar suggestion was made in a more subtle way. This suggests that we are dealing with a pre-selected group of children and certainly strengthens the observations already made as to the importance of parental tone.

Dr. White's observations about Jamaican children are confirmed by our experience in Bradford, and we now regard this situation as the 'Jamaican Syndrome'. Like him, I feel that the plight of these children calls for a more responsible attitude on the part of the Jamaican Government.

It is difficult to describe clinically the conditions that these children present after self-poisoning, and I doubt whether our conventional diagnostic terminology is appropriate. In the Bradford group few children were seriously ill. Many were quite cheerful and anxious to return home, as if the experience in itself had had a cathartic effect. Many had no wish to die, either before or after the event, and did not appear to appreciate the irreversibility of death. Complaints of being 'fed up' and an attitude of petulance and resentment were also common in this group. Some of the children were miserable, unhappy and desperate. As in Dr. White's group, their life history revealed vicissitudes which made me wonder if I was listening to fiction and not fact. These children, mainly girls, had to be admitted to an adult female ward and obviously found great comfort from the nursing staff and sympathetic patients. They genuinely appreciated my efforts to understand their problem and eagerly accepted the help I offered, even though in many cases there was precious little I could do.

Self-poisoning in older children and adolescents is probably increasing, and I do not believe we understand the reason for this. I sometimes wonder if it is a desperate attempt to find a happier environment and therefore paradoxically represents a will to live rather than a wish to die.

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THE MANAGEMENT OF RESISTANT DEPRESSION

DEAR SIR,

The recent letters by Drs. Shaw and Hewland (1) and by Dr. Davidson (2) raise the question just who is resistant, the patient or the doctor?

When one reads that the suggested line of treatment is to obliterate the depression by various combinations of drugs, electric shocks, putting the patient to sleep and performing leucotomies, one is left wondering whether it is not the doctor who is unable to accept the depression. Neurophysiological and biochemical factors in the functioning of the C.N.S. are important no doubt, but surely the content of the patient's mind is also relevant.

A patient may find his own thoughts painful and unacceptable and hence wish to get rid of them. A doctor could feel the same way and therefore collude with the patient. Perhaps this explains the dogmatic textbook statement that 'in true endogenous depression any attempt at systematic psychotherapy is contraindicated as it often leads to deepening of the patient's sense of worthlessness' (3). If a depression was accepted rather than shut out, one

might expect the patient to feel worse initially. However, in the long term less resistant doctors might result in less resistant depressions.

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A SURVEY OF THE MEDICATION IN A HOSPITAL FOR THE MENTALLY HANDICAPPED

DEAR SIR,

On a day in February 1974 a census was made of the medicines being given to 585 long-stay mentally handicapped in-patients at Meanwood Park Hospital, Leeds.

There were 301 patients (51% of the total) receiving medication. Of 150 (25% of the total, who were recorded as suffering from epilepsy, 135 (24%) were taking anticonvulsant medicines, and 63 of these patients were on two or more anticonvulsant preparations. Tranquillizers were being given to 130 patients (22%), and 42 of them were also having anticonvulsants.

The most frequently prescribed medicines were:

	Male	Female	Total
<i>Anticonvulsants</i>			
Phenobarbitone..	60	46	104
Phenytoin ..	38	16	52
Primidone ..	9	1	10
Sulthiame ..	11	4	15
Carbamazepine..	5	6	11
<i>Tranquillizers</i>			
Haloperidol ..	40	24	64
Chlorpromazine	23	30	56
Thioridazine ..	14	8	22

This survey shows that in this particular hospital a quite narrow range of well-established drugs was favoured. Most of the patients are being given thrice daily dosages, and hence every day in the hospital nearly 1,000 doses of medicines are administered to patients by nursing staff. This presents the nurses and the pharmacy with a not inconsiderable workload and responsibility.