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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References

1. Shaw, D. M. & Hewland, R. (1973) The management of resistant depression. *British Journal of Psychiatry*, **123**, 489–90.
2. Davidson, J. (1974) The management of resistant depression. *British Journal of Psychiatry*, **124**, 219–20.
3. Slater, E. & Roth, M. (1969) *Clinical Psychiatry*. Ballière, Tindall and Cassell.

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
Anticonvulsants			
Phenobarbitone..	60	46	104
Phenytoin ..	38	16	52
Primidone ..	9	1	10
Sulthiame ..	11	4	15
Carbamazepine..	5	6	11
Tranquillizers			
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.

In a ward for disturbed women 25 of 26 patients were taking medication, and in a ward for disturbed men 28 of 38 patients were on treatment. Only 3 of 31 patients were prescribed drugs in a ward for non-disturbed cases. The patients in the hospital are long-stay, and the pattern of medication for a majority of them remains unchanged for long periods.

The value of such a survey is that it encourages the doctors to think about their prescribing habits, and the nurses and the pharmacy to consider their dispensing arrangements. The information gained is also of use for comparative purposes with similar hospitals.

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BRITISH ACADEMY OF PSYCHOPHARMACOLOGY

DEAR SIR,

For many years the United Kingdom has lagged behind other countries in having no specific organization dedicated to psychopharmacology. A number of other countries have established their own national organizations, which are affiliated to the Collegium Internationale Neuro-Psychopharmacologicum (C.I.N.P.), one of the best known of these being the American College of Neuro-Psychopharmacology.

In view of the considerable contributions made by our country to psychopharmacology, it appears to us that the present situation is anomalous and that the time has come to establish a national organization in this country. To avoid confusion with the Royal Colleges, we propose that this organization be called 'The British Academy of Psychopharmacology'.

We believe that there is a particular need to focus attention on the importance of drug treatment in psychiatry, in the eyes of both the young clinician and the research scientist. The objects of the Academy will therefore be to further research in psychopharmacology, both clinical and experimental, and to improve the quality and standards of psychotropic drug evaluation. This can be accomplished by means of the spoken and written word, through the media of meetings, study groups and publications.

We propose to call a meeting in the near future of all members of the profession who may have an active interest in psychopharmacology, for the purpose of determining the constitution of the Academy, to elect officers, and to consider the Academy's policy, particularly in relation to the pharmaceutical industry. To this end we have drafted some suggestions, and we would be pleased to forward these to any interested member of the profession. We would also like to receive suggestions and comments concerning the establishment of the Academy, and invite those interested to communicate with any one of the undersigned.

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