

course the more probable explanation of the latter is that the more disturbed patients had longer treatment because they remained disturbed at discharge.

As only 10 of the cases were off school for over a year, and many may have been towards the end of their normal schooling careers anyway, seeing that cases were included up to age 16, not much can be concluded from the data presented. The sweeping conclusion that prolonged time away from school has no long-term effect would need far more carefully gathered data than those presented.

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DEAR SIR,

We are gratified that such a distinguished adult psychiatrist has taken an interest in our paper and we welcome his comments.

The 'underlying conditions' are listed in Table II. In 57 of our 67 children there was a psychiatric diagnosis apart from phobia of school per se. These conditions needed more than purely behavioural therapy, and we continued treatment where necessary after the child had returned to school. Fourteen cases relapsed some time after completion of treatment and discharge and needed further treatment, but 11 of these 14 children had returned to school. The need for further treatment was not related to return to school.

In the group off school over a year 3 were over 14, and in the group off 7-12 months 3 were over 14. The solitary 16 year old was off school under 6 months and returned to school.

Details of the extensive data we collected on these children are available on request.

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TRANLYCYPROMINE ADDICTION

DEAR SIR,

In 'A Case of Tranlycypromine ('Parnate') Addiction' (*Journal*, September 1979, 135, 273-4), Ben-Arie and George pointed out that even though the supposed 'addict' had previously abused barbiturates and alcohol 'when depressed', there was 'no history of alcohol or other drug abuse during the period on tranlycypromine'. However, these investigators should realise that the patient's drug abuse just prior to being placed on tranlycypromine therapy could have kept his hepatic microsomal

enzyme system in a stimulated state. Indeed, it might have taken several weeks before a normal, slower metabolizing rate could be restored (Conney, 1967). As this system metabolizes tranlycypromine, the need to rapidly increase the daily dose of this drug to relieve depression may not be due to an 'addiction', but just increased metabolic demands.

The possibility of autoinduction of metabolizing enzymes by tranlycypromine should not be ruled out either. This has been observed with several other drugs used in psychiatric practice, including chlorpromazine (Rivera-Calimlim *et al*, 1979) and phenobarbitone (Prescott, 1978). Autoinduction may result in faster metabolism and hence increasing dosage requirements of tranlycypromine.

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OVERDOSE-TAKERS AND SELF-MUTILATORS

DEAR SIR,

It is widely accepted that deliberate overdose-takers and self-mutilators have many characteristics in common. For example, they are usually young, adult and female (Smith and Davison, 1971; Roy, 1978). Many ingest alcohol prior to self-injury (Ellis *et al*, 1966; Simpson, 1975). In most cases the self-injury was impulsive (Smith, 1972; Simpson, 1976), and many such patients have a personality disorder.

We report on 130 patients, 100 overdose-takers and 30 self-mutilators (by laceration). They were all consecutive referrals from the wards and casualty departments of two general hospitals in Newcastle upon Tyne. A standard history was completed on each patient, the data were analysed by chi-squared test and where the numbers were small Fisher's Exact Probability Test was used.

On the following items the two groups did not significantly differ:—sex, age, employment status, marital status, time when self-injury occurred,

probability of the act being discovered by others, writing of a suicide note, whether the patient's last visit to the general practitioner was for psychiatric or medical reasons, the nature of the precipitating stress and psychiatric diagnosis.

On the remaining items, however, the self-mutilators were more significantly represented ($P < 0.05$):—alcohol used before self-injury, previous history of self-injury, impulsiveness of the act (defined by the patient not having contemplated the self-injury for more than two hours), contact with general practitioners and psychiatrists within one month of the act, previous psychiatric referral, evidence of personality disorder, and contact with the Samaritans (see Table).

Our results, therefore, show that despite their similarity on a number of items, the self-mutilators are a more unstable group than the overdose-takers. It also supports the general impression that as a group they are more often refractory to therapeutic intervention.

With regard to the Samaritans, our results for the overdose-takers are substantially similar to those of Greer and Anderson (1979).

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Percentages on items significantly separating self-mutilators and overdose-takers ($P < 0.05$)

	Alcohol use before self- injury	Previous self- injury	Impulsive- ness of self- injury	GP contact one month	Psychiatric contact one month	Previous psychiatric referral	Personality disorder	Samaritan contact
Overdose-takers (N = 100)	42	44	70	47	18	46	42	7
Self-mutilators (N = 30)	67	73	90	67	43	70	67	27

CORRECTION

In the letter from Drs Spear and Mehta (*Journal*, November 1979, **135**, 483) right-hand column, second table, detainees in 1977 should read 128.