she presented and the quality of life that she now leads; she goes out regularly for afternoons and occasionally spends weekends at home. It is interesting that she now menstruates regularly, whereas before lithium therapy she was amenorrhoeic.

The significance of self-mutilation is obscure, but two broad categories have been defined: primitive self-mutilation occurring in conditions of ego impairment or immaturity (mental retardation or infancy), and self-destructive activity related to mental conflict, in particular depression (4). The virtual disappearance of self-mutilation with lithium therapy raises the possibility that this patient's behaviour may have been, in part at least, the manifestation of an affective disorder. Her response to lithium suggests to us that similar patients might benefit from treatment with this drug, and that pilot studies of its efficacy in groups of subnormal patients showing aggressive and self-destructive behaviour should be undertaken. Such a study is presently being carried out at Strathmartine Hospital.

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FLUPENTHIXOL AND THE OUT-PATIENT MAINTENANCE TREATMENT OF SCHIZOPHRENIA

Dear Sir,

I am flattered that my friend Dr. Freeman (*Journal*, January 1973, page 121), should have devoted so much space to criticising my brief interim report on flupenthixol (*Journal*, October, page 458). As I hope to publish a fuller account shortly, I intended my letter to convey clinical impressions rather than a statistical analysis. As Dr. Freeman has so rightly pointed out (*Journal*, September 1970, page 351), 'the pursuit of methodological purity in itself is no guarantee that information of value will result'.

I agree wholeheartedly with him that flexibility in the use of anti-psychotic depot injections and the judicious exhibition of preparations to counteract the side effects are essential if withdrawals from treatment are to be avoided. Therefore I am pleased to find that flupenthixol has advantages over fluphenazine with respect to range of dose (up to 120 mg.), infrequency of side effects and—more importantly—the virtual absence of the more severe extra-pyramidal syndromes, like akathisia. The patients seem alert and participate more fully in activities and social relationships.

I am also pleased to see that Dr. Freeman appears to agree that depression does occur in schizophrenics under treatment with these injections. Like others (Johnson, 1969; Alarcon, 1972), I am uncertain as to its precise aetiology. However, unlike Dr. Freeman, I am quite certain that any condition resulting in serious disability and suicide cannot be over-emphasized. The point surely is that these injections, though greatly improving the prognosis in discharged schizophrenics, are no substitute for careful follow-up and frequent contact with such patients. The three suicides among Dr. Freeman's patients should make my point obvious.

I have never believed that the long-term prognosis in schizophrenia depends upon pharmacological factors alone. The complexity of the situation has been convincingly demonstrated by the recent work of Brown *et al.* (1972). However, the outlook is not improved when patients, families, neighbours, social workers, hostel wardens and even general practitioners are rendered antagonistic towards the regimen by the dramatic appearance of bizarre, distressing neurological syndromes, as may happen with the phenothiazines.

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THE COMPARABILITY OF NATIONAL SUICIDE RATES

Dear Sir,

In assessing the significance of the differences between reported suicide rates from different coun-