1963) do not "recommend 600–800 mg. and up to 3,000". They say, "300 mg. or more of chlorpromazine a day in three divided doses is given initially and increased progressively until symptoms respond or side-effects become too troublesome. Doses of up to 3,000 mg. a day *have been reported*, but we have rarely had to give more than 1,200 mg. a day. *Seriously disturbed* patients should be started on 600–800 mg. a day." For maintenance therapy they advise "between 150 and 300 mg. a day", although "larger doses are sometimes needed". (Our italics.)

Henderson and Gillespie (*Textbook of Psychiatry*, 9th ed., revised by Henderson and Batchelor, 1962) say that "chlorpromazine is prescribed usually in doses of 150 to 400 mg. daily by mouth, and as much as 800 mg. daily has been given". Noyes and Kolb (*Modern Clinical Psychiatry*, 6th ed., 1963) say that "there is no standard dose of the drug; this must be individualized", the reference to approximately 600–800 mg. a day is in relation to the chronically *disturbed* patient.

The N.I.H. study to which Dr. Kline refers (presumably "Phenothiazine Treatment in Acute Schizophrenia", *Arch. gen. Psychiat.*, **10**, 246–262, 1964) is concerned with the treatment of *acute* schizophrenia. It covers a range of doses from 200 to 1,600 mg. a day, with a mean of 654·8 mg. No conclusion is drawn about the value of doses below 300 mg., nor is it stated that doses of 500–600 mg. constitute a "practical working minimum".

We have not checked on the doses given on "the package inserts in the United States" (nor on the manufacturer's recommendations in this country). Dr. Kline may well be right on this point.

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INFANTILE PSYCHOSIS

Dear Sir,

In their very interesting paper (*Journal*, November 1967, p. 1169) Michael Rutter and Linda Lockyer include a most valuable table of the "behavioural characteristics of psychotic and control children", which verifies that many of the signs are (quantitatively) shared by the two groups. It is common experience and practice among child psychiatrists, however, to recognize a *qualitative* element in the diagnosis of either "psychosis" or "organic" brain damage in children. This is bound to elude any tabulation, and I am sure that, although it carries the danger of inaccuracy due to unchecked clinical "impressions", it is nonetheless the very essence of the clinician's ability to utilize the non-measurable elements that many an illness offers for diagnosis.

Having worked as Dr. James Anthony's Registrar in the Children's Department of the Maudsley Hospital during the period that Michael Rutter and Linda Lockyer cover in their stimulating paper, it is most likely that I have examined several of the psychotic children mentioned in their report, and I feel I could make the following point: the label of "autism" given to some of the "control" patients (Table IV, p. 1173) raises the question that these might approximate to either cases of "organic brain damage" (a term that I remember the late Dr. Cameron often using in case-conferences) showing psychotic behaviour, or, possibly so-called "psychotic-defectives". In any event, even if these terms are not in preference today, the label of autism in some of the *control* patients indicates a certain heterogeneity which, if somewhat awkward methodologically, is a very interesting finding with regard to the psychopathology of these patients. It would be interesting to know if the "autistic" controls had achieved communicative speech or not, and what was their final "diagnosis". It is also a pity that the authors did not provide a table about the presence of brain damage in the control children, corresponding to their Table X. Finally, one might remark that "brain damage" (i.e. organic dysfunction) cannot be equated with "brain disease" (p. 1178), and that developmental delays in brain maturation are sufficiently "organic" in origin to be placed together with "organic brain dysfunction". This would substantially alter the analysis of results of Table X, and might explain the greater incidence of fits which the investigators found in the follow-up during adolescence.

Whatever the answers to these minor queries may be, Dr. Rutter and Miss Lockyer are to be most warmly thanked and congratulated for a very useful description of the clinical status and of the follow-up of psychotic children, and also for showing us that this can be done with the use of a control design.

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COGNITIVE DISORDER IN THE SCHIZOPHRENIAS

Dear Sir,

The findings of Foulds *et al.* (*Journal*, December 1967, pp. 1361–1374) are of considerable interest, but it is a pity that they were unable to obtain a more useful clinical rating of thought disorder. In an unpublished study (Costello, 1966) I showed that when