illness. Abnormality as a criterion is not sufficient to distinguish illness from other forms of deviance. The meaning of the terms illness and disease is derived from the context of physical, bodily conditions and implies more than deviation from the norm. These concepts characterise processes which are discrete from the subject's will or intentionality and whose course is biologically determined. To suggest that behaviours and utterances are "symptoms" of illness is therefore to classify them as events that have no relation to the voluntary activity and purposes of the individual and are therefore devoid of meaning. This seems to me to be an impoverished approach to the myriad of complex human behaviours that comprise psychiatric problems and is likely to hamper the process of finding imaginative solutions.

Characterising mental disorders as existential conditions rather than as illnesses does not mean that medical techniques have no place in helping people to manage or survive them. A different emphasis in psychiatry might liberate psychiatrists and patients alike from the shackles of the "illness" paradigm.

KERR, A. & HOWARTH, P. (1996) Commentary on " 'Audible thoughts' and 'speech defect' in schizophrenia". *British Journal of Psychiatry*, **168**, 538–539.
SZASZ, T. (1996) 'Audible thoughts' and 'speech defect' in schizophrenia. A note on reading and translating Bleuler. *British Journal of Psychiatry*, **168**, 533–535.

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SIR: Szasz (1996) has provided us with another sample of his inimitable linguistic *legerdemain*, this time concerning the phenomenology of schizophrenic thought disorder and auditory hallucinations.

Firstly, *contra* Szasz, there is a clear difference between *hearing* one's own thoughts spoken aloud, as if they were coming from outside oneself, by a (stranger's) voice at the same time as one is thinking them (*Gedankenlautwerden*) and "hearing" one's own inner voice or even thinking aloud. There is no confusion between these two distinct phenomena in psychopathology.

The comparison between schizophrenic thought insertion and "projection" is a typical Szaszian disanalogy. The belief that others are somehow beaming their thoughts into one's head is categorically different from accusing others of having feelings that one is unwilling to recognise in oneself. Again the psychopathologies are unmistakably distinct, and certainly not applied *post hoc* after deciding whether the patient is sane or insane.

Finally, how can he assert that "ordinary medical maladies are not diagnosed by making inferences from the way the patient speaks"? We routinely do so in terms of both the form and the content of the patient's speech; the former is utilised to diagnose cerebellar staccato speech and Parkinsonian speech; the latter whenever we reach any diagnosis from the history alone; perhaps a mixture of the two with the aphasias. These 'speech defects' certainly do not arise from "incorrect use of the muscles of [the] mouth and tongue" as Szasz would have it, but from brain diseases. It also seems particularly wilful to suggest that schizophrenic speech is "deviant" in the way that a thick Yorkshire accent deviates from Received Pronunciation.

Perhaps the only worthwhile point I could draw from this paper was that we should more properly speak of schizophrenic *speech* disorder and *inferred* thought disorder since we do not have direct access to the thoughts of others.

SZASZ, T. (1996) 'Audible thoughts' and 'speech defect' in schizophrenia. A note on reading and translating Bleuler. *British Journal of Psychiatry*, **168**, 533–535.

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Tricyclics and SSRIs

SIR: Taylor & Lader (1996) usefully point out the potential dangers of combining tricyclic antidepressants with selective serotonin reuptake inhibitors. The tertiary referrals received at this unit, which specialises in treatment-resistant depression, indicate that this practice is becoming increasingly common and usually occurs without the monitoring of serum tricyclic antidepressant concentrations. We would like to extend their clinical recommendations by suggesting that this combination should not be routinely used. It is difficult to justify theoretically as adequate doses of tertiary amine tricyclic antidepressants would produce the same effect on cerebral amines as combinations of tricyclics and selective serotonin reuptake inhibitors. If adequate doses of tricyclic antidepressants are not tolerated then perhaps venlafaxine would be the next logical step because of its effect on both serotonin and noradrenaline neurotransmitters.

A clinically important cytochrome-mediated interaction that Taylor & Lader do not mention is