monosymptomatic hypochondriacal psychosis—of which "pure" delusional parasitosis may be but one manifestation (Reilly, 1977; Munro, 1980).

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SEVERE DEPRESSION: ANOTHER PATIENT

DEAR SIR,

I should like to make a few points in response to Dr Gray's interesting article, *Journal,* October, 1983, **143,** 319–22. During the last ten years I have suffered bouts of depression diagnosed as severe. A spell in hospital, a few sessions of ECT, a fortnight in a nursing home, and continuous drug- and psychotherapy have made me familiar with much of the medical care available to depressive patients. Acceptable drugs, now, include Parnate, Surmontil, lithium carbonate, Eltroxin for thyroid problems, Mogadon as an aid to sleep and, occasionally, Serenid for acute anxiety.

Identity: In depression, loss of a sense of identity is paramount. "I am not what I used to be when not depressed, therefore I am nobody", or "I do not know who I am". Dr Gray does not mention feelings of guilt about depression, of moral failure as well as loss of identity. Depression is still "unacceptable" to the ordinary world; it is still easier to say ". . . seems to be a virus" or "just a bit under the weather, I'm afraid". "I am depressed, clinically depressed" is an alienating response to general enquiries about health. I wholly endorse Dr Gray's point that the patient feels physically ill, but she may also feel guilty and cut off from general comforting remarks: "Better in a day or two" etc. The patient knows she is most unlikely to get better quickly, and meantime a job has somehow got to be got on with and daily life continued. The psychiatrist's task must be to re-establish the patient's sense of identity, not with false promises, but by reinforcing an identity known from past experience of the patient or elicited from early interviews. "Despite your present condition, you have not disintegrated totally as a personality: you are still you". If the vital link of trust has been established between psychiatrist and patient—the patient, even on a monthly visit, may be greatly helped by a positive reminder that her identity, as a person functioning in a family and in society, has not been totally impaired.

Feeling ill: The depressed patient is likely to take a grim view of all her activities and of her non-activity. If she is capable of functioning at all, the outside world may see no more than someone suffering from the after-effects of a bout of influenza. The patient has to put up with continuous tiredness, lethargy, inability to concentrate, to generate ideas and to make (even small) decisions. A stomach-churning anxiety may sometimes preclude rest. As Dr Gray makes clear: the patient feels ill. She also feels guilty about failing to conquer her illness, but is eventually forced to realise that "strong-mindedness" cannot, alone, overcome the mind's disease. It is a help if family, friends and GP can get the patient to see that it is not surprising she feels ill and is functioning at a very low level. The depressed person needs to be allowed to feel ill, and at times to give up, to become "inert" as Dr Gray explains.

Activity: If the patient is not in hospital and is attempting to continue a job, it may not be practical to stay "inert" for long. She may have convinced doctors and those close to her how bad she feels, and along with drugs and psychotherapy, many ideas for changing her condition may have been suggested. But changing a life-situation is quite impossible when to walk out of the front door is a frightening and burdensome decision. Doing a job, while in this condition, must rely on repetition, on known routine, not on anything new. Dr Gray speaks of "optimistic self-grooming", but a stage before this can start to happen may be, not the repetition of "looked forward

to" acts, but the repetition of *any activity at all* which reminds the patient of the past structure of her life. The steadiness of this structure has been greatly disturbed by the experience of depression. Putting out milk bottles, locking the front door, feeding the cat, may all acquire a new significance in that they can give the patient a hint of achievement, a sense of not succumbing completely to negative forces.

Help: The patient longs for outside help and yet, after a while, realises that no-one can work miracles and take depression away. It has to be lived with, and the undepressed times duly treasured. When depression lifts, there may be a sudden access of energy and activity; it is important to remember that overtiredness is then a danger. Trying to make up for lost time, too quickly, may lead back to depression. The patient may find that she still needs reassurance and this may be puzzling to the outside world. She needs to feel that she is doing all right at work or at home when it is obvious to others that all is well. The question remains "Am I now me?" and the doubt "How long will this last?" Much work on depression has raised the status of this debilitating illness; it has also brought a variety of remedies that can be tried. But, caught in a cycle depression, the patient repeats again and again the same question to the medical profession:

> Canst thou not minister to a mind diseas'd,
> Pluck from the memory a rooted sorrow,
> Raze out the written troubles of the brain . . . ?
> (*Macbeth,* V.iii. 40–42)

There is no "sweet oblivious antidote", but the patient, in the 1980's, will, at least, be offered help.

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THYROID ABNORMALITIES AND VIOLENT SUICIDE

DEAR SIR,

We note with interest the study of 51 women by Linkowski and colleagues, (*Journal,* October 1983, **143,** 401–405). A poor TSH response to TRH was associated with a history of violent suicide. Three of the patients with an abnormal TSH response subsequently died by violent suicide. This prompted us to examine our own data of patients who attended the Maudsley Hospital and subsequently died by suicide as determined by the coroner's court. Forty eight case records were randomly selected from the Camberwell Register.

Four of our sample, all females, had abnormalities of thyroid function diagnosed and subsequently died by violent suicide:

Case 1. This patient suffered from depression and erotomania. At the age of 50 she was noted to have a repeatedly raised PBI and T4. Two years later she died by cutting her throat. She had previously made suicidal attempts by throwing herself under a train, running out into the road in front of traffic and had taken several overdoses.

Case 2. Thyrotoxicosis was diagnosed at the age of 29 and treated by partial thyroidectomy. Eleven years later she was diagnosed as suffering from paranoid schizophrenia. At this time her thyroid function tests were abnormal. She drowned herself 2 months later whilst being assessed for treatment of her thyrotoxicosis.

Case 3. Thyrotoxicosis was diagnosed and treated by partial thyroidectomy at the age of 34. She subsequently presented to the hospital and was diagnosed a paranoid personality with depression. At the age of 40 she threw herself out of a window to her death.

Case 4. At 66 myxoedema was diagnosed and treated with thyroxine. Subsequently she was noted to be clinically and chemically hyperthyroid and at other times hypothyroid due to poor compliance. Agitated psychotic depression was subsequently diagnosed at a time when she threw herself under a train and narrowly escaped death. She killed herself by hanging aged 69.

Whilst our data are not directly comparable with those of Linkowski *et al.* they must add weight to the hypothesis that violent suicide is associated with abnormalities of the hypothalamopituitary thyroid axis.

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MIANSERIN AND WARFARIN

DEAR SIR,

With reference to the recent correspondence of Dr Warwick and Professor Mindham (*Journal*, September 1983, **143,** 308) concerning a case of drug interaction between mianserin and warfarin, we should like to point out that there are suitable warnings