dose of 80 mg. daily for a period of seven weeks. (She had been seen two years previously by a psychiatrist when a diagnosis of anxiety state with associated depression had been made. This had responded well to a ten-session course of psychotherapy and treatment with diazepam 15 mg. daily.) The patient was given clear instructions by her doctor that she was not to stop taking fenfluramine suddenly, but when she realized that she might be pregnant, because her period was overdue, she immediately stopped taking the drug because she was afraid it might harm the unborn baby. Ten days later she was referred to a psychiatrist. She gave a history of being 'strung up' and nervous for about a week. Although she had wanted to be pregnant she was convinced that the baby was deformed and therefore wanted her pregnancy terminated. She was tearful and appeared mildly depressed. She had no suicidal feelings at that time. Her sleep pattern was normal. No drug treatment was given, but she was seen every other day for supportive psychotherapy. A week later a pregnancy test was positive. At that time she appeared more depressed and had sleep disturbance (initial insomnia and early wakening) and some suicidal thoughts ('I want an abortion and I don't care if I die'). She found it difficult to cope with her child and neglected her housework. Treatment with fenfluramine was recommenced at a dose of 80 mg. daily. Three days later her clinical condition had improved strikingly. She no longer wanted a termination, she was sleeping well and did not appear depressed. After two weeks at this dosage, fenfluramine was tailed off over a period of three weeks. The patient reported some symptoms of anxiety during this time but did not become depressed. She subsequently had a twelve-week spontaneous abortion to which she responded by a period of grief lasting three to four weeks. She remained well four months later.

These cases lend further support to the suggestion that depressive illness may be precipitated by abrupt withdrawal of fenfluramine. Two cases responded well to restarting fenfluramine, which was then tailed off gradually.

Fenfluramine should therefore not be used in patients with a history of depressive illness (and depression is common in middle-aged obese women (Anderson, 1972)). It is important that all patients taking fenfluramine should be given clear instructions not to stop taking the drug abruptly. Nevertheless some patients will ignore or forget such advice. The possibility of recent fenfluramine withdrawal should therefore be considered in all patients presenting with a depressive illness.

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## 'THE DEATH OF A PROFESSION'

DEAR SIR,

Mrs. Jansen's paper on 'The death of a Profession' coincided with the publication of a study by Dr. Hakki and myself on the use of hospital beds in neighbouring East London Boroughs (Robin and Hakki, 1972), in which we show some of her fears to be demonstrably true, and in particular that a community based social work service was less successful than a hospital related service in preventing hospital chronicity, while at the same time making little impact on the use of short stay beds.

We may perhaps be forgiven if, like many others, reading the comment on the Worcester Development Project (Department of Health and Social Security, 1971) and *Hospital Services for the Mentally Ill,* (H.M.S.O., 1971), we understood that the provision of 65 day places per 100,000 population was in addition to the 50 beds provided for in-patients. In fact since Dr. Hakki's departure to the United States I now learn from the Department of Health and Social Security that 'the day places will be available for those in-patients who are well enough to leave the ward and spend the whole, or part of the day in the day hospital along with patients who will attend from the community' (personal communication, March, 1972). In practice there will therefore be 15 day patient places per 100,000 population, as in a modern psychiatric unit one would expect the in-patients to use the day facilities to the full. If, however, one accepts that a quarter of in-patients do not, however, leave the wards, then there will be 28-day patient places. This would mean that in East Ham one day patient place would be required to relieve occupancy of one bed, while in West Ham one day patient place would be required to relieve occupancy of three beds—perhaps a little optimistic.

I also understand that the Department have suggested a standard of 30 beds per 100,000 population or 250 beds per 100,000 population over the age of 65 for psychogeriatric patients. These figures almost exactly coincide with those derived from our calculations.

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## 'THE MODERN SADO-MASOCHISTIC SYNDROME'

Dear Sir,

We have spent several years in trying to help people with their marital problems. Recently we have been struck by the similarity of a particular reaction which we have called 'The Modern Sado-Masochistic Syndrome'. If one is aware of what the husband is 'doing' to his wife and vice versa, it helps. Below we outline this 'syndrome'; we wonder if it might help some of your readers to follow the apparent vagaries in their problems of husbands and wives:

The husband has to overcome the 'masculinity' of his wife. That is, to destroy the image of his own father within her. If he is successful he can then 'make love' to his 'mother'. Once the love is over he must restore her to being the symbol of his father once again—but *only* if she is desirous of achieving this role, or he gives her the go-ahead to be the male.

The wife has to destroy the 'mother' within her husband; she does this by denigrating him. He then becomes the aggressive overpowering 'father' and she allows him to make love to her, bitterly disappointed, however, that he still is not her 'mother', so she restores him to his role as quickly as possible, particularly if he should desire to be the feminine member.


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