he concentrated on the badness it would have been the badness which would have taken permanent shape. The parental aspect of the healer's role embraced the whole family. To be a healer also needs magic, and therefore we turn to Prospero and discover that Shakespeare had added yet another dimension—the ability to know when to discard the magic robe.

'When Prospero finds it possible to enlighten Miranda about her origins, this is what he says:

> "Tis time
> I should inform thee further; lend thy hand
> And pluck my magic garment from me—So!"

The stage direction then states—"Lays down his mantle." Winnicott was always able to pluck away *his* magic garment when talking to a small child. He could use the language of intuitive thought to bridge the generations, but in his writings he referred to the communication of feelings that are (and these are his own words) "unverbalized and unverbalizable except perhaps in poetry". It was his special quality to be able to reach these levels, especially those of barely recollected grief, to offer comfort and to recognize that depression is reparative and even creative in its effects on the development of personality. For the description of this experience we may call again upon Shakespeare, Prospero recalls to Miranda their perilous escape when she was barely three years old, and she responds:

> "Alack for pity:
> I, not remembering how I cried out then,
> Will cry it o'er again . . . ."

This is the father/infant couple, and, like the mother/infant couple (and here I quote Winnicott once more), "it can teach us the basic principles on which we may base our therapeutic work when we are treating children whose early mothering was 'not good enough', or was interrupted".

'In some sense every therapeutic session is a drama and is bound by the dramatic unities of time, place and action. It has its beginning and it has its end; and, though life is a unity, help comes in acts that are episodes with intervals in between. Winnicott commented on the fact that the untutored child accepts artistic limits when he places a drawing in a size and shape that is related to the size of the paper. Thus, every activity of Winnicott's, complete in itself, became part of an integrated whole in which patients, students, colleagues and readers of his works joined together in the discovery of new levels of understanding and of functioning.

'He was a philosopher giving meaning to life in the balance of opposites.

'Time comes into this once more, as in *Ecclesiastes*:

> "A time to keep silence and a time to speak; a time to love and a time to hate";

and, as the verses continue with their complex messages, a note of joy breaks in:

> "I have seen the task which God hath given to the sons of men to be exercised therewith. He hath made everything beautiful in its time. I know that there is nothing better for them, than to rejoice. . . ."

'Winnicott the teacher, the healer, the parent, the magician, the poet, the dramatist, the philosopher, and the friend, was also an optimist; and we who are his beneficiaries and his inheritors can therefore take comfort and say with Miranda:

> "O brave new world that hath such people in't." '

J. H. KAHN.

ARE MAOI AND OTHER PSYCHOTROPIC DRUGS REALLY COMPATIBLE?

DEAR SIR,

We read Dr. Winston's paper ('Combined Antidepressant Therapy', *Journal*, March 1971, Vol. 118, p. 301), with great interest and tend to concur with him on 'massive overdose of the combined drugs'.

Without a detailed and reliable medical and social history, it is extremely difficult to differentiate the severe adverse side effects (i.e., hypertension, delirium, convulsion and hyperpyrexia) from the medical emergency. It has long been the established medical practice not to use the tricyclics and MAOI drugs simultaneously. However, more recently Schuckit *et al.* report the combination of tricyclic drugs and MAOI's to be effective in the treatment of depression (1). In Great Britain, several papers (2, 3) had been written on this subject. We present our current case just to warn that great danger indeed exists in combining the tricyclic drugs and MAOI's in large dosage.

Mrs. E.R., a 43-year-old, divorced white woman, was admitted as a case of schizophrenia. She was of medium stature, well developed, well nourished, and an attractive blonde was appeared to be her stated age. On admission, she was very agitated, disturbed, belligerent, singing and screaming. Intra-muscular chlorpromazine, 50 mg. was given twice in four hours' time. She gradually calmed down, but was noticed to be very confused, crawling around the room. Her vital signs at admission were: BP 120/80 mm. Hg; T. 96·7°F., pulse 80/m. Twelve hours after her admission she was running a temperature of 103°F., pulse rate 125/min., BP 165/86 mm. Hg, and she did not respond to external stimuli. She was in a comatose state, and at the same time she suffered two convulsions. She was transferred to the Medical Service for further investigation and treatment.

About 8 years ago she was admitted to a state hospital

because she was deluded that strange people were in her house and that they were planning to kill her, and at the same time they cursed her and called her a 'son-of-a-bitch'. Her delusions as well as both visual and auditory hallucinations were off and on in the past and she had been treated with various tranquillizers. Before her current admission she had in her possession fifteen bottles of drugs, such as ferrous sulphate, Multi-vitamins, laxatives, chlorpromazine, trihexyphenidyl, barbiturates, amitriptyline and phenelzine. She was taking all the drugs simultaneously in large quantities. More specifically, she took 3 tablets of phenelzine 3 to 4 times daily, along with amitriptyline, 25 mg. t.i.d. for 10 days, trihexyphenidyl, 2 mg. t.i.d. for 12 days, chlorpromazine, 50 mg. t.i.d. for 10 days, phenobarbital, 100 mg. h.s. for 30 days and Dulcolax as needed for several days. In addition, she drank two bottles of beer shortly before her admission, and that was when she became so disturbed that she was bought to the hospital for treatment.

While she was in the Medical Service, all medication was discontinued except the intravenous administration of large amounts of fluid and a small amount of sodium amytal to control her convulsions. She was in a comatose state for two days and gradually regained consciousness. After 5 days she was transferred back to the psychiatric unit.

Laboratory Findings

The Cbc, urinalysis, FBS, BUN, EKG, skull, chest and abdomen X-ray all normal except the following:

Date	LDH	SGOT	EEG	CSF
1st day	700 mμ.	820 mμ.		
3rd day			Slow theta wave	
9th day				VDRL+ FTA+
14th day	160 mμ.	40 mμ.		
23rd day			Normal	

This is a case of toxic psychosis which was the result of taking large amounts of MAOI and other psychotropic drugs. Without medication, the patient recovered very well and was released from the hospital. A hypertensive crisis described by Blackwell (4) was observed in the current case and was characterized by high temperature, high blood pressure, convulsions, agitation and coma (a 20 per cent incidence of which has already been reported (5)). All of these symptoms returned to normal after two days. Abnormal liver function was noted, with extremely high LDH and SGOT levels which returned to normal within two weeks. Toxic hepatitis has been reported, which is difficult to differentiate from infectious heptatitis (6). During the acute stage the EEG was of slow theta waves several days after the convulsions took place and became normal again three weeks later.

A fatal combination of phenelzine and amitriptyline has been well documented in the literature (6). The hypertensive crisis of our case could be explained as follows: beer contains tyramine (7) which elevated the patient's blood pressure; amitriptyline induced convulsions, hypertension and hyperpyrexia; barbiturates contributed to the patient's coma; trihexyphenidyl potentiated the other drugs; phenelzine resulted in agitation, tremor, hyperpyrexia and liver damage; chlorpromazine increased extrapyramidal reaction.

Great caution should be exerted in prescribing MAOI and other psychotropic drugs. The patient's clinical condition was entirely due to the adverse side effects arising from the poor combination of drugs.

Pang L. Man.
Ayten Aleem.

Northville State Hospital,
41001 Seven Mile Rd.,
Northville Michigan 48617,
U.S.A.

References

1. Schuckit, M. *et al.* (1971). 'Tricyclic anti-depressants, and monoamine oxidase inhibitors.' *Arch. gen. Psych.*, **24**, 6.
2. Gander, D. R. (1965). 'Treatment of depressive illnesses with combined anti-depressants.' *Lancet*, *i*, 107–9.
3. Randell, G. (1965). 'Combining the antidepressant drugs.' *British Medical Journal*, *i*, 521.
4. Blackwell, B. (1963). 'Hypertensive crises due to monoamine oxidase inhibitors.' *Lancet*, *ii*, 849–51.
5. Excerpta Medica Foundation (1966). Vol. **5**, p. 16–25.
6. Holdworth, C. D., Atkinson, M., and Goldie, W. (1961). 'Hepatitis caused by newer amine-oxidase inhibiting drugs.' *Lancet*, *ii*, 621–3.
7. Cole, J. O. (1964). 'Therapeutic efficacy of antidepressant drugs.' *J. Amer. med. Ass.*, **190**, 448–55.
8. Goldberg, L. I. (1964). 'Monoamine oxidase inhibitors, adverse reactions and possible mechanisms.' *J. Amer. med. Ass.*, **190**, 456–62.

GRIEF AND THE IMMINENT THREAT OF NON-BEING

Dear Sir,

In his article (*Journal*, April 1971, Vol. 119, pp. 469–70), Dr. Sunder Das emphasizes what is well-known to all bereaved people, that grief is directed towards the unreal and takes place in a vacuum.

The supposedly negative character of grief can be usefully compared with the pain and distress caused by the *real presence* of a phantom limb in the 'vacuum' left by the loss of an arm or leg: fundamentally, as in the case of grief, it is a reaction of the central nervous system to the sudden interruption of a very complex and sustained set of stimuli. The effect of bereavement