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.

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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

can be so devastating as to cause death. In lesser cases recent research has shown a significant increase in physical illness in the bereaved, especially cardiovascular disease.

Dr. Sunder Das suggests converting grief into suffering to mitigate its effect. Might this not also apply to converting unnecessary and unreal depression, anxiety, delusions, etc., into more adaptive reactions?

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THE N.A.M.H. 'GUIDELINES'

Dear Sir,

In trying to justify his opinion that the N.A.M.H.'s 'Guidelines' will be of very little value, Dr. Alexander Walk says, amongst other things, that all textbooks on mental nursing have something to say about violence (this *Journal*, September, pp. 347-8). How satisfactory in this respect are the textbooks? Miss Altschul makes a few sensible points in her *Aids*. Brian Ackner's textbook skates quickly over the problem. Maddison, Day and Leabeater's describes a variety of procedures from sympathy to seclusion, and makes the suggestion: 'The very angry patient may be given rags and hessian to tear up or allowed to carry out violent hammering.' Boorer and Boorer's advises that 'the nurse should stay with the patient and encourage her to let off steam in an energetic way such as scrubbing floors or making a sponge cake'. Very little is said in any of the textbooks about the conditions in which violence occurs, with a notable exception. Noyes-Haydon and Van Siekel's contends that the aggressive patient may have 'heightened erotic drives and make vulgar and profane remarks'. It continues: 'If the patient uses obscene language, the nurse may suggest to him that there must be some reason why he needs to use such words.'

Perhaps these excerpts are unfair. Nurses will find in the textbooks some advice—not always good advice—on what to do, but will get little help in understanding why and when patients become violent. To be told that violence is a symptom of the illness is not helpful and may be seriously misleading. Even if they were fully satisfactory, textbooks, unhappily, are few and far between on the wards of psychiatric hospitals. Few of the staff have had the opportunity of following any of the syllabuses Dr. Walk has helped to draw up. The demand for N.A.M.H.'s booklet has been heavy and continues. It seems to be getting into the hands of the staff on the wards, both untrained and trained, for whom it was written.

Dr. Walk underestimates the concern felt by the staff of psychiatric hospitals about the problems of violence. We do not doubt the need for something like the 'Guidelines'. We hope, as many do, that N.A.M.H.'s booklet will soon be superseded by something much better.

The 'Guidelines' were written for nurses by nurses. Doctors gave some modest help. Dr. Walk's reference to 'the fashionable medical abdicationism' suggests to us that he has misunderstood—or is perhaps out of sympathy with—the kind of partnership it was.

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Dear Sir,

Mr. Bury and Professor Russell Davis must have read my letter (*Journal*, September 1971, Vol. 119, p. 349), rather cursorily, for I did not contend that the 'Guidelines' were of little value in general, but that they would not be very helpful to nurses on the ward—referring, of course, to paragraphs 1 and 2; I added that the administrative sections contained much that was to be commended. The writers, taking an *illi quoque* line, disparage existing textbooks and make the very sound point that many of them do not explain why and when patients become violent. But this was precisely my criticism of the 'Guidelines', in which the nurse will find nothing but a few well-worn clichés about 'establishing a good relationship' and 'removing what the patient perceives as threatening', without even the sketchiest account of the widely ranging 'whys and whens' that may result in violence.

I am at a loss to understand what the writers can mean by the statement that 'few of the staff have had the opportunity of following any of the syllabuses" of the G.N.C. Something like 20,000 nurses have passed final examinations based on these syllabuses, and, as I have said, questions on the causes and prevention of violent incidents have been frequent and have been well answered.

I am glad that Mr. Bury and Prof. Davis agree that something much better is needed. I hope that the Joint Working Party will take the widest possible