

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

in the data sheets of both the companies who market mianserin. However, we should also like to point out that there is still considerable controversy concerning this possibly serious interaction and we do not believe there is an absolute contra-indication for this combination of drugs. We point out under the heading 'Drug Interactions' in our data sheet:-

"Concurrent anticoagulant therapy of the coumarin type (e.g. Warfarin) is also permissible, but close additional monitoring procedures should be carried out."

We cannot account for the omission of this possible interaction in the British National Formulary and C.S.M. 1982 Report, but we trust that the situation has now been put in its true perspective.

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CLASSIFICATION: REVISING DSM-III AND ICD-9

DEAR SIR,

I should be grateful for the opportunity to air some suggestions about future versions of the Diagnostic and Statistical Manual of Mental Disorders, Third Edition (DSM-III) and the psychiatric section of the International Classification of Diseases, (Ninth Revision, ICD-9). This discussion concerns only the clinical descriptive axes of the future classifications, although it is presumed that both of them are likely to be presented as multi-axial systems.

Both these major classifications have some serious drawbacks, particularly for the busy clinicians who must form the largest group of users. ICD-9 is still very general in its descriptions, gives little guidance about the relative diagnostic importance of symptoms, and contains no comments on differential diagnosis. In contrast, DSM-III has provided for most of its categories a full set of research diagnostic criteria. However, the elicitation and recording of these may not be appropriate in busy clinical situations. In many ways the innovations in DSM-III are praiseworthy attempts to improve the quality of psychiatric diagnosis, but the pressure for innovation and the desire for an all-purpose classification have caused problems. Surely no single classificatory document can satisfy the very different needs of administrators, planners, clinicians and research workers.

The suggestions which follow have two aims; first, to provide ways in which the next revisions of the two classifications can be brought closer together, and second, to improve their suitability for use in clinical and service settings. Even if further divergence cannot be prevented, at least the origins and nature of

differences will be made more obvious if some of the suggestions are followed.

It is suggested that those who are responsible for the production of ICD-9 and DSM-III should be prepared to present their classification by means of three separate but closely related documents. The first would be a description of a set of concepts upon which the classification is based. The second would be a statistical classification presented in a form suitable for use by busy clinicians under ordinary working conditions, and also by those interested in reporting the statistics of psychiatric services. The third would be a set of precisely specified diagnostic criteria, suitable for research.

1. *A set of concepts.* This would be in the form of descriptions of the disease entities, syndromes and symptoms which constitute the classification. The descriptions would be in some detail, although strict definitions would not be achieved. Conceptual similarities and differences between different disorders would be described, and notes on the history of the concepts would be included.

2. *A statistical classification for clinical and service use.* Users would need to be familiar with the set of concepts already described. This statistical classification would have a lay-out similar to the ICD-9 *Glossary and Guide*, showing clearly the nomenclature and code numbers at three and four-digit levels, and possibly more besides. Only a brief summary of the clinical features of each condition would be required (perhaps between five and twenty lines of text). A list of the main symptoms in order of importance would occupy most of this space, and comments on differential diagnosis would follow. Guidance would be given as to how many and which symptoms might usually be required before a confident diagnosis could be made, but this would not be as rigid as in the research diagnostic criteria. Some of the problems about confidence of diagnosis or "goodness of fit" could be dealt with by providing an additional digit, to be coded according to the extent to which the clinical diagnosis fulfils the full set of Research Diagnostic criteria (for instance: 1 = full set of RDC met; 2 = RDC not met but a confident clinical diagnosis can be made; 3 = provisional diagnosis only).

3. *Research Diagnostic Criteria.* In this document, the nomenclature and code numbers of the statistical classification would be accompanied by detailed diagnostic criteria suitable for use in research, as in DSM-III. Restrictive criteria that are potentially controversial, such as age-limits, or duration of symptoms, would be justified in preliminary comments upon each set of criteria. Different degrees of restriction could be specified for some conditions by