our patients are becoming alienated from us, because they feel we do not speak the same language. I also agree that the increasing concentration on biological explanations emphasises individualism, as opposed to a broader perspective encompassing social and personal dimensions, and that as a result of the positive developments in neuropsychiatry and psychopharmacology we may focus increasingly on narrow medical interventions. However, I suspect the majority of psychiatrists would acknowledge that the social framework within which they are working is also changing the focus of their practice, and thereby the educational environment for postgraduate trainees.

I work in a psychiatric day hospital, where we have managed to protect a multidimensional approach to patient care. Even in this relatively protected setting, however, we have to defend ourselves against the increasing pressure to treat patients in as short a time as possible. We are expected, appropriately, to justify our interventions, and the easiest measure of improvement is a change in the patient's mental state. My colleagues in the acute service are faced with an ever-increasing demand with ever-decreasing resources, and they find it difficult, if not impossible, to pay attention to their patients' needs in a way that does justice to the complexity of their situations. In these circumstances the only way to survive with one's integrity intact is to focus on an increasingly narrow model of psychiatry, in which doctors deal with the medical problem, and leave everything else to their colleagues from other disciplines. For some psychiatrists this fits in with their personal view, but in my experience the majority find such a limited approach frustrating and unsatisfying. There is a serious danger that a new generation of psychiatrists who have been trained in this environment will lose sight of the intellectually more rewarding, and clinically more effective, broad perspective of mental illness.

Thomas, P., Romme, M. & Hamelijnck, J. (1996) Psychiatry and the politics of the underclass. *British Journal of Psychiatry*, **169**, 401–404.

M. Greenberg Jules Thorn Day Hospital, St Pancras Hospital, 4 St Pancras Way, London NW1 0PE

Authors' reply: The responses to our editorial (Thomas *et al*, 1996) demonstrate the inherent problems of psychiatry. No one doubts the profession's commitment in wanting to do its best to help patients, but, as Greenberg points out, the practice of psychiatry is time-consuming. We work under pressures of time, which force us to practise in ways that do not provide us with the opportunity to listen carefully to what our patients really have to say to us. Under these circumstances the use of biological models and disease entities which have no established scientific validity (Boyle, 1990) becomes attractive. This means that we interpret our patients' experiences in terms of mental state phenomena, without really listening to what they have to say. This leads to dissatisfaction and disenchantment for the psychiatrist as well as the patient, because psychiatry is a speciality which attracts those who are fascinated by the necessity to juggle with the complex and unresolvable. This, ultimately, is a resource issue, one which needs to be located firmly within political discourse, because governments are elected on the basis of policies which determine economic priorities in the country as a whole. As a profession we must engage in political discourse if we are to change this situation.

Our starting point was the disaffection of service users with psychiatry, and this basic premise remains unchanged by resource issues. What point is there in increasing the availability of psychiatrists if they continue to practise in the same way? Our argument has major implications for the training of psychiatrists. Kraemer & Roberts observe that child psychiatrists have always recognised the importance of the interaction between biology, psychology and sociology in understanding individual development, and this suggests that all psychiatric trainees should be exposed to child psychiatry. But there is more to it than that. Collaboration between the profession and other organisations, including user groups such as the Manic Depression Fellowship, is important and valuable. This welcome development must be extended to other areas, particularly the involvement of service users in the training of psychiatrists. There is a growing number of service users who are involved in training, and some are starting to make contributions to the education of psychiatrists. We regard this as vital if we are to balance the 'technology' which increasingly dominates academic teaching.

There remains, however, an insoluble conflict between all specialist languages (whether neuroscientific, psychological or social) and that of our patients' experiences. The two are locked in a dialectic; oppositional discourses which express a tension with which psychiatrists must engage. If we fail to do this, and we lose our ability for self-reflection, our patients will become even more alienated, and the disillusionment of our profession will increase.

Boyle, M. (1990) *Schizophrenia: A Scientific Delusion*. London: Routledge.

Thomas, P., Romme, M. & Hamelijnck, J. (1996) Psychiatry and the politics of the underclass. *British Journal of Psychiatry*, **169**, 401–404.

P. Thomas, M. Romme University of Wales College of Medicine, Hergest Unit, Ysbyty Gwynedd, Bangor, Gwynedd LL57 2PW

Ethology and self-injury

Sir: The article by Jones & Daniels (1996) is a welcome addition to the ethological conceptualisation of suicidal behaviour. In the model proposed by Jones & Daniels there remains the need to link the "feelings of frustration, threat, abandonment or arousal" with the subsequent behaviour. The concept of "conservation withdrawal"; Engel (1962) appears to provide this link. Engel (1962) noted that conservation withdrawal "may lead to behaviour to h[elp] cling, ingratiate, reward, force or seduce external object so as to prevent or replace [the] loss and ensure continued supply. With the failure of such changes or mechanisms to provide the solution, the affect is felt with increasing intensity . . . the drive aspect is s[o] preservative, but in a primitive 'last ditch' sense. It is essentially a conserving and includes a heightening of the barriers to reduce incoming stimu[li] reduction of activity to save ene[rgy] 'holding action' until the arrival supplies, help in the form of a s[uit]able object".

While such a formulation c[an] criticised as lacking specificity t[o] behaviour, it is consistent with th[e] invariably reported wish to escape who take drug overdoses. Furthe[r] those who cut themselves it is c[om]mon reports of the cutting bringing reality (Simpson, 1976; see [also]

The application of this clinical and theoretical adva[nce] clinical point of view an[d] suicidal acts as examples o[f] withdrawal, as relatively un[re]sponses to stress with the wis[h] an intolerable situation, allows a no[n]

https://doi.org/10.1192/S0007125000146380 Published online by Cambridge University Press

judgmental approach to such patients to be more readily achieved. From the theoretical point of view, much of the nosological debate incorporating inferred degrees of suicidal intent is rendered unnecessary, as the differences are more apparent than real, with the primary activity being that of conservation withdrawal in order to escape an intolerable situation.

Engel, G. L. (1962) Anxiety and depression – withdrawal: the primary effects of unpleasure. *International Journal of Psychoanalysis*, **43**, 89–97.

Goldney, R. D. (1980) Attempted suicide: an ethological perspective. *Suicide and Life Threatening Behaviour*, **10**, 131–141.

Jones, I. H. & Daniels, B. A. (1996) An ethological approach to self-injury. *British Journal of Psychiatry*, **169**, 263–267.

Simpson, M. A. (1976) Self-mutilation and suicide. In *Suicidology: Contemporary Developments* (ed. E. S. Schneidman), pp. 281–315. New York: Grune & Stratton.

R. D. Goldney University of Adelaide, The Adelaide Clinic, 33 Park Tce., Gilberton, South Australia, Australia 5081

D. Lester Richard Stockton College, New Jersey, USA

Sexual abuse in people with alcohol problems

Sir: It was with great interest that we read the article by Moncrieff *et al* (1996) about the significance of sexual abuse in people with alcohol problems. We, too, have done research on the relationship of adverse sexual, physical and emotional childhood experiences to later alcohol problems in a non-clinical sample. We feel our findings confirm and supplement Moncrieff's [illegible]

In the 274 male probands, 31 (11.3%) [illegible]–10 diagnostic criteria for alcohol abuse. Compared with the teetotallers and normal alcohol consumers, the men with alcohol problems significantly more frequently reported serious physical abuse experiences in childhood (P=0.0005). Such serious physical abuse experiences were of most importance for later alcohol abuse (P=0.03): the probability of alcohol problems in adulthood increased from a base rate of 11.3% to 62.5%, if the person experienced serious physical abuse in an insecure familial base during childhood. The probability of alcohol abuse in adulthood increased further from 62.5% to [illegible], if the person also experienced sexual abuse during childhood.

Our results indicate that childhood sexual abuse and, in particular, physical abuse and insecure attachment experiences within a dysfunctional family background must be given due consideration in the treatment of people with alcohol problems.

Moncrieff, J., Drummond, D. C., Candy, B., *et al* (1996) Sexual abuse in people with alcohol problems. A study of the prevalence of sexual abuse and its relationship to drinking behaviour. *British Journal of Psychiatry*, **169**, 355–360.

J. F. Kinzl, W. Biebl Department of Psychiatry, Innsbruck University Clinics, Innsbruck, Austria

Venlafaxine-induced increased libido and spontaneous erections

Sir: The potentially beneficial sexual side-effects of antidepressant drugs such as increased libido, improved erection and delayed ejaculation are less frequent and less often recognised than the adverse effects. Venlafaxine is a novel antidepressant which inhibits reuptake of both serotonin and noradrenaline. We report a case of venlafaxine-induced increased libido and spontaneous erections.

Mr X, a 50-year-old married man, was referred with a first episode of major depression. Premorbidly, his sexual functioning was normal. Since becoming depressed his libido was non-existent and he had not had any sexual contact. His depression was resistant to treatment with a series of antidepressants. He was commenced on a combination of lithium and venlafaxine. A week after venlafaxine was increased to 375 mg/day, he reported increased libido, much higher than premorbid levels, and frequent spontaneous erections, while continuing to be depressed. After six weeks on the same medication, this side-effect gradually waned and his depression improved.

Venlafaxine's unique properties of serotonin and noradrenaline reuptake inhibition were probably responsible for this side-effect. Noradrenaline facilitates libido and erections (Pfaus & Everitt, 1995) and the facilitatory effects of serotonin on sexual function become manifest only when central noradrenaline activity is intact (Fernandez-Guasti *et al*, 1986).

The literature on beneficial sexual side-effects of antidepressants is scanty. Power-Smith (1994) reported increased libido, improved erections and improvement in premature ejaculations in two elderly men treated with fluoxetine. Increased libido has been reported with nomifensine, which inhibits reuptake of noradrenaline and dopamine (Freed, 1983). Mianserin and trazodone, which increase synaptic noradrenaline, improve libido and erections in one-third and two-thirds of subjects, respectively (Kurt *et al*, 1994). Lal *et al* (1990) reported the case of a psychiatrist who self-treated his erectile impotence with trazodone and enjoyed the associated increased libido. In all these reports the beneficial sexual effects were independent of the antidepressant effects. To our knowledge, this is the first report of increased libido and spontaneous erections induced by venlafaxine.

Fernandez-Guasti, A., Hauser, S., Archer, S. T., *et al* (1986) Noradrenaline–serotonin interaction in the control of sexual behaviour in the male rat. DSP4-induced noradrenaline depletion antagonizes the facilitatory effect of serotonin receptor agonists, 5-MeODMt and lisuride. *Brain Research*, **377**, 112–118.

Freed, E. (1983) Increased sexual function with nomifensine. *Medical Journal of Australia*, **1**, 551.

Kurt, U., Ozkardes, H., Altug, U., *et al* (1994) The efficacy of antiserotonergic agents in the treatment of erectile dysfunction. *Journal of Urology*, **152**, 407–409.

Lal, S., Rios, O. & Thavundayil, J. X. (1990) Treatment of impotence with trazodone: a case report. *Journal of Urology*, **143**, 819–820.

Pfaus, J. G. & Everitt, B. J. (1995) The pharmacology of sexual behaviour. In *Psychopharmacology: The Fourth Generation of Progress* (eds F. E. Bloom & D. J. Kupfer), pp. 743–757. New York: Raven Press.

Power-Smith, P. (1994) Beneficial sexual side-effects from fluoxetine. *British Journal of Psychiatry*, **164**, 249–250.

A. Michael, A. Owen Department of Psychiatry, Addenbrooke's Hospital, Cambridge CB2 2QQ

Paroxetine-induced chorea

Sir: A 42-year-old patient was found by her husband exhibiting dysarthria and choreiform movements in all limbs. Her general practitioner had started paroxetine 20 mg that day for a depressive episode. She had felt increasingly unwell and lethargic all day. She later described after the event that involuntary movements had suddenly come on 14 hours after taking the first dose of paroxetine. She was unable to summon help. Symptoms had continued for two hours until her husband had returned home. At presentation she was severely distressed and unable to control any of her movements or communicate. There was no other relevant history of note. Physical examination confirmed choreiform movements, and found signs of an oculogyric crisis and

https://doi.org/10.1192/S0007125000146380 Published online by Cambridge University Press