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.

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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]

Of 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). Of the serious physical abuse experiences, the most important for later alcohol abuse was insecure familial base (P=0.03): the probability of alcohol problems in adulthood increased from a baseline of 11.3% to 62.5%, if the person experienced serious physical abuse and 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 in 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.

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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.

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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

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