HENRY, J. A. (1991) Overdose and safety with fluvoxamine. *International Clinical Psychopharmacology*, **6** (suppl. 3), 41–47.

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Treatment of drug-induced anorgasmia

SIR: Arnott & Nutt (*BJP*, June 1994, **164**, 838–839) reported the treatment of fluvoxamine-induced anorgasmia with cyproheptadine. Fluoxetine-induced anorgasmia has been successfully reversed with both cyproheptadine and yohimbine, an alpha-2 antagonist (Segraves, 1993). I would like to report the successful treatment of six cases of sertraline-induced anorgasmia (2 men, 4 women) and four cases due to paroxetine (3 men, 1 woman), with 5.4 mg yohimbine taken approximately 1–2 hours prior to planned coitus. To date, all cases of serotonin reuptake inhibitor-induced anorgasmia encountered in my practice have responded to small, appropriately timed doses of yohimbine.

SEGRAVES, R. T. (1993) Treatment-emergent sexual dysfunction in affective disorder. *Journal of Clinical Psychiatry*, **11** (monograph 1), 1–4.

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Violence in psychiatric units

SIR: Studying violent incidents in psychiatric units, Walker & Seifert (*BJP*, June 1994, **164**, 826–828) found that nurses were assaulted most often. Nurses make up the majority of the staff on most psychiatric units, and the greater frequency of assault may simply reflect their greater numbers and increased patient contact.

The authors suggest that a forensic history is a predictor of violent behaviour as an in-patient, and that this should be used as an indication that these patients should receive extra attention. Taking this as a screening test, where a forensic history is used as an indicator, a forensic history provided a sensitivity of 0.81 and a specificity of 0.69. Predictive values are of greater use in assessing the value of a screening test in routine practice and the positive predictive value of a forensic history in this population was 0.56 (i.e. 56% of those with a forensic history would assault). In effect, the use of this as a screening test would result in twice as many patients being identified as potentially assaultive as would eventually assault. Our concern would be that staff would recognise that the forensic history was a blunt predictive instrument, and would relax their vigilance over time.

Walker & Siefert's work confirms the frequency of violent behaviour, and emphasises the need for appropriate training. The limited help provided by aspects of the clinical history lead us to believe that it is essential to strive to develop safe systems. Rather than staff relying on the identification of high risk patients, ward and hospital management should endeavour to create safe environments by the appropriate use of observation, alarm systems, staff support and training.

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Male erotomania and dangerousness

SIR: Boast & Coid (*BJP*, June 1994, **164**, 842–846) describe a case of male homosexual erotomania featuring dangerous behaviour directed at the delusional object, and comment that the question of dangerousness in such cases remains unresolved.

When discussing dangerousness in relation to erotomanic delusions it is useful to distinguish between dangerous behaviour related to the delusions, such as assault on the object or 'rival', and unrelated dangerous behaviour which may precede the onset of the delusions. In a sample of 27 cases of men with erotomanic features (Menzies *et al*, in press), we found that dangerousness (related to the delusions) was significantly associated with both the presence of multiple delusional objects ($P<0.0005$) and dangerousness unrelated to any erotomanic delusion ($P<0.05$). The only cases which exhibited dangerous behaviour (related) had either multiple delusional objects (42%) or a history of unrelated dangerous behaviour (25%) or both (33%).

Boast & Coid did not report any other delusional attachments in their case but there was a history of an assault, unrelated to the erotomanic delusion, and an additional diagnosis of personality disorder. They referred to two other cases of male homosexual erotomania. One (Doust & Christie, 1978), with a single object, exhibited no dangerous behaviour, while the other (Peterson & Davis, 1985), with

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multiple objects, displayed dangerous behaviour related to the delusion, and probably suffered from a personality disorder.

This would suggest that dangerousness (related) in male homosexual erotomania, like male heterosexual erotomania, is associated with multiple delusional objects and unrelated dangerous behaviour. Whether these factors are predictive of similar behaviour in female erotomania remains to be seen. In the female homosexual erotomania case quoted (Urbach *et al*, 1992), there were several delusional objects (possibly up to five) and the individual engaged in both related and unrelated dangerous behaviour.

DOUST, J. W. L. & CHRISTIE, K. (1978) The pathology of love: some clinical variants of de Clerambault's syndrome. *Social Science and Medicine*, **12**, 99–106.

PETERSON, G. A. & DAVIS, D. L. (1985) A case of homosexual erotomania. *Journal of Clinical Psychiatry*, **46**, 448–449.

URBACH, J. R., KHALILY, C. & MITCHELL, P. P. (1992) Erotomania in an adolescent: clinical and theoretical considerations. *Journal of Adolescence*, **15**, 231–240.

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Outdated ECT machines

SIR: Arnott & Wilkinson (*BJP*, April 1993, **162**, 572–573) found that mean seizure duration and the proportion of seizures lasting longer than 25 seconds increased when they upgraded their Ectron Duopulse Series 3 ECT (E3) machine to an Ectron Series 5 model (E5). They attributed the increase in successful seizures to the "higher electrical output" of the E5 machine. We encountered similar differences in patients treated in an ECT clinic equipped with a (modified) Series 2 Ectron Duopulse (E2) – an earlier version of the E3, identical in terms of stimulus parameters and power output – and one equipped with an E5. We could not confidently attribute the differences to the machine owing to a variety of unmatched variables, for example the clinics catered for different populations (over 65 and under 65 respectively).

Arnott & Wilkinson did not state whether their machine was the basic (unmodified, E3u) or modified (E3m) version, and at what setting on the respective machines patients were stimulated. An E3m may, at certain settings, deliver a greater total electrical charge than the E5. The maximum output of the E5 is 400 mQ at 200 ohms, compared to 350 mQ for an E2/E3m at the 'ECT2' setting over 6 seconds. The difference in power output between the E5 and E2/E3m (14%) is, therefore, not great, but they do differ markedly with respect to stimulus intensity. The E5 delivers its maximum power in 3.25 seconds, whereas the E2/E3 does so in 6 seconds. Thus it is only in terms of stimulus intensity that the E5 is 'more powerful' than the E2/E3m.

No-one knows which variable – total electrical charge (mQ), or stimulus intensity (mQ/s) – is more important (Special Committee on ECT, 1993). A useful, much needed and relatively easy audit research project would be to compare two groups of matched subjects allocated to receive treatment by means of an E5 machine (set at 300 mQ) or an E3m machine (set at ECT2; stimulus duration 5 seconds).

SPECIAL COMMITTEE ON ECT OF THE ROYAL COLLEGE OF PSYCHIATRISTS (1989) *The Practical Administration of ECT*. London: Royal College of Psychiatrists.

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Cognitive function and fall-related fractures

SIR: Jaborian *et al* (*BJP*, July 1994, **165**, 122) provide evidence of strong correlation between poor scores on a battery of tests and prior fall-related fractures in the elderly. They conclude that "low scoring in psychometric tests is a major risk factor for falls".

Correlation is not causation, but a causal link may be the reverse of that suggested, with fat embolism from the fractures impairing cognitive performance.

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Creativity and psychopathology

SIR: Post's impressive survey of 291 famous men (*BJP*, July 1994, **165**, 22–34) supports a link between high levels of psychopathology and creativity, especially in artists and writers. The psychotic diagnosis for the painter Edvard Munch would further strengthen such a link.

Post lists three artists – Van Gogh, Modigliani and Rossetti – as suffering from a psychotic disorder, all of them organic in nature. My reading of the biographies of Munch is that he suffered from persecutory delusions and auditory hallucinations. Heller (1984) describes Munch's flight from Germany in a vain attempt to avoid his delusional