Correspondence

EDITED BY MATTHEW HOTOPF

Contents ▪ Fear reduction by psychotherapies: a response ▪ Psychological debriefing: historical military perspective ▪ Psychosocial treatment programmes for personality disorders: service developments and research ▪ More disappointing treatment outcomes in late-life depression ▪ Medication and alcohol in nursing homes ▪ Talmudic, Koranic and other classic reports of stalking ▪ Venlafaxine-induced painful ejaculation

Fear reduction by psychotherapies: a response

Dr Snaih (2000) misquotes us (Marks & Dar, 2000) on an important point. We do not conclude that “all elements . . . have therapeutic potential and that any assertion of superiority of one approach over another is unwarranted”. We specifically state that non-applied relaxation, avoidance (anti-exposure instructions), diary keeping, treatment set, giving a rationale, and regular homework assignments are not particularly therapeutic per se. Several approaches are less helpful than others.

We are grateful to Dr Snaih for reminding us of his results with anxiety control training (ACT). His paper (Snaih, 1974) noted that several ACT patients did imaginal or live exposure, which is covered by our discussion on exposure. He described his 1982 trial (Constantopoulos et al, 1982) of ACT briefly in a non-peer-reviewed chapter. Just 12 patients were randomised to either experience anxiety scenes or just cope with anxiety without exposure. His papers (Constantopoulos et al, 1982; Snaih, 1998) give too little detail to judge how much each treatment used imaginal exposure (imposition) or irrelevant fear exposure (stress immunisation). The reports give no mean ratings and standard deviations before and after treatment, preventing judgement of how much each group improved. Though both groups improved with no significant differences between them, the study lacked power – a very big difference would be needed to yield significance when comparing two cells containing just six patients each. Dr Snaih’s results with “just coping with anxiety” may echo those with irrelevant fear exposure and support our idea that stress immunisation (irrelevant fear exposure) may reduce anxiety. Snaih et al’s (1992) paper did not describe randomisation to ACT or a contrasting procedure.

Our call for psychotherapists to work towards a common psychotherapy language that defines each procedure in a standard accepted terminology is bolstered by examining Dr Snaih’s terms. What he calls “meditation” has relatively little in common with Kabat-Zinn’s (1996) mindfulness meditation, and his ACT, for example, includes components which are not specified regarding relevant v. irrelevant exposure. If psychotherapists agreed to call the same procedures by the same names, that would be a huge step forward. European and American associations in the field (the European Association for Behavioural and Cognitive Therapy (EABCT) and the Association for Advancement of Behavioural Therapy (AABT)) have appointed a joint task force to develop a common psychotherapy language.


I. Marks Institute of Psychiatry, De Crespigny Park, Denmark Hill, London SE5 8AF

R. Dar Department of Psychology, Tel Aviv University, Tel Aviv 69978, Israel

Psychological debriefing: historical military perspective

May I offer a historical military perspective on the paper by Mayou et al (2000). Proponents of psychological debriefing have missed the military experience from the Russo-Japanese War 1904/5 onwards to justify early psychological intervention using PIES – proximity (close to the scene – in safety), immediacy (as soon as possible), expectancy (that individuals will return to duty – not to prevent ensuing psychological illness) and simplicity (respite, rest, recollection, rehabilitation and return to duty). Proponents conveniently forget that PIES was only ever applied to those who were deemed to be suffering and was conducted by individuals who shared and understood their experience.

There may be many reasons why Mayou et al arrived at their conclusions but the same caveats apply as are appended to Bisson et al (1997), Kraus (1997) and Turnbull et al (1997), among others. Perhaps we (psychiatrists) are at fault in trying to categorise human responses to unpleasant events into medical conditions and are naïve to think that one intervention could prevent post-traumatic stress reactions and illnesses that are multi-factorial and complex in genesis.

In trying to understand and manage post-traumatic stress reactions there are a number of useful metaphors. Garb et al (1987) find the grieving process particularly useful as both post-traumatic and grieving are responses to loss events. Although an unfashionable term, psychological defence mechanisms exist to protect the individual (at least initially); to interfere with such mechanisms carelessly courts disaster. Perhaps psychological debriefing does just this. In both post-traumatic reactions and grief there is a period of introspection during which individuals do not wish to talk. Such needs should be respected, and usually are in the case of grief. Why should traumatic events be different?

This period is followed by a time when assistance and advice is welcome, even sought, and in post-traumatic situations, as in grief, this should first be sought from the social support network. If this does not work, then professional help may be required, but we as professionals must question the seemingly ubiquitous societal belief that exposure to
traumatic events is always an entirely negative experience and that post-traumatic stress disorder is the only post-traumatic mental illness.

I do not share the authors’ reassurance that the three-year follow-up rate was only 48% as it provides ammunition for those who will, I fear, continue to provide psychological debriefing. Perhaps it is cynical to question their motives but I am troubled by the almost pornographic nature of human experiences outwith the normal. There is a voyeurism and the potential vicariously to become part of a traumatic event, even of history, by intervening. Society’s or is it the media’s cry is ‘something must be done’, and despite the growing body of evidence that psychological debriefing does not work, or is harmful, I suspect such work will not be halted unless society changes from its ‘psychologicalisation’ of human distress. There is an old military adage that applies here: ‘the only thing harder than trying to get a new idea into a military mind is trying to get the old one out’.

Perhaps Mayou et al’s paper reinforces the reality that there are no ‘quick fixes’ for human experiences. The provision of help should be directed towards those who are defined as affected by their experiences. Identifying such cases should be the challenge for psychiatry. Perhaps then the advice proffered by Salmon (1917) will be correctly applied, although such interventions are unlikely to be so simple.

**Psychosocial treatment programmes for personality disorders: service developments and research**

Chiesa & Fonagy (2000) clearly demonstrate the beneficial effects of therapeutic community treatment for personality disorder, and more so in the treatment limb with less hospitalisation and more day care.

The logical extension of this is to offer these programmes with only day care. Several units around the country are now doing this, including new units in Aberdeen and Maidstone, as well as long-established units such as our own in Reading and the Red House in Salford.

The evidence from systematic reviews and meta-analyses for the effectiveness of therapeutic communities in treatment of personality disorders is strong (Lees & Manning, 1999) and, together with the Cassel study, demonstrates the need for new, creative ways of setting up effective treatment programmes.

A multi-centre research project funded by the National Lotteries Charities Board is now underway, which should help in this endeavour. It is using multi-level modelling and a path-analytic equation modelling technique to determine the impact of a number of features that therapeutic community programmes have. This research is more complex and sophisticated than a simple randomised controlled trial design, but for treatments that do not fit a drug model paradigm it will be much more helpful in designing effective programmes of therapy. The protocol is available at www.petarchiv.org.uk/ptc-protocol.htm.

**More disappointing treatment outcomes in late-life depression**

Tuma (2000) reported disappointing outcomes in the treatment of late-life depression. Suicide rates are highest in the elderly in many countries (Shah & De, 1998), while treatment with drugs and electroconvulsive therapy consistently results in full recovery rates of less than 30% (Murphy, 1983). Some studies show slightly more optimistic findings, such as Baldwin & Jolley (1986) and Brodaty et al (1993) who demonstrated prognosis in later life approaching that in younger adults at one year. Yet others suggest that longer follow-up reveals a worse outcome (Forsell et al, 1994). These studies use standard physical treatments but make no mention of adjunctive psychological treatments of any kind.

There are still too few studies demonstrating the effects of psychological interventions in older people (O’Rourke & Hadjistavropoulos, 1997). More recently published data have shown improved outcome using a combination of drug and psychological treatments, including interpersonal therapy and cognitive–behavioural therapy (Reynolds et al, 1999). In addition, important research by Ong et al (1987) demonstrated relapse prevention for individuals attending a support group.

In a recent postal survey, I enquired of members of the Royal College of Psychiatrists’ Faculty for the Psychiatry of Old Age whether elderly patients in their care had specifically requested psychotherapy. The overall response rate was 65%, of which 49% had experience of patients asking for psychotherapy. One can only assume that those already in receipt of such treatments would not ask for it. Patients rarely demand drug treatments as they are often already taking medication. The National Health Service (NHS) Executive (1996) review of psychotherapy services endorses the need for older patients to have access to similar service opportunities as the young.

Since elderly consumers of our service are asking for psychotherapy, and because there is some evidence (Roth & Fonagy, 1996) that it is a useful adjuvant in the war against late-life depression, why are we still producing research which appears to ignore this approach?


I. Palmer Royal Defence Medical College, Fort Blockhouse, Gosport, Hampshire PO12 2AB


**R. Haigh West Berkshire Psychotherapy Service, Winterbourne House, 53–55 Argyle Road, Reading RGI 7YL**
Medication and alcohol in nursing homes

Furniss et al (2000) report the findings from a promising trial which addresses the inappropriate use of medication in nursing homes. They conclude that a pharmacist’s review followed by a reduction in medication does not necessarily increase rates of morbidity or mortality. However, one commonly used drug that was not included in their review was alcohol.

Significant rates of alcohol misuse have been recorded in nursing home settings (Johnson, 2000), and interactions between prescribed (as well as over-the-counter) medication and alcohol pose significant risks for older people drinking unregulated amounts of alcohol. Alcohol interacts with many of the commonly prescribed medications cited in the study, especially antidepressants and sedatives. Therefore, residents in the study who drink alcohol will have benefited from the intervention of stopping medication by removing the risk of a potentially dangerous drug reaction.

As part of a survey in Bristol, I approached the managers of several residential homes to find out whether they held a policy regarding alcohol use in the home. None of the seven homes surveyed had such a policy in place, despite some residents having alcohol problems, and it was not unusual for homes to sell alcohol on the premises, either across a bar or in a shop.

Pharmacists have a key role in advising patients of potential interactions with alcohol (Ward, 1997). The provision of clear and up-to-date information about these interactions could form part of an alcohol policy in nursing and residential homes.

Talmudic, Koranic and other classic reports of stalking

Kamphuis & Emmelkamp’s (2000) review on stalking gives an acute clinical perspective to the Hebrew myth of Joseph and Zuleika related in Genesis XXXIX. After being sold as a slave, Joseph became the target of his master’s wife’s wanton passion. He steadfastly rejected all her amorous advances and was eventually condemned to prison on account of her calumnies.

This archetype of stalking has many derivations in Jewish, Arabic, Syriac, Persian, Indian and medieval European lore (Rappoport, 1995). Talmudic and midrashic accounts emphasise the complex behavioural sequence of the stalker: implicit seductive manoeuvres; explicit proposals; verbal menace; planned physical aggression; false accusations; humiliation and punishment.

Moslem tradition, based on Moham med’s twelfth sura, elaborates on the eroticistic aspects of the myth. Yusuf was also in love with Zulaikha, but had no hope of reciprocity. When Yusuf had been freed from prison and appointed in the place of his former master, he married his widowed former mistress and stalker (Weil, 1845). Islamic comments also acknowledge Zulaikha’s love as her only excuse. This theme of the stalker’s irresistible charm, already explicit in the Koran, is refined by Persian poets such as Firdusi (933–1025) and especially Jami (1414–1492), whose powerful metaphor of the ‘fair gazelle’ applied to Yusuf conveys the ambivalence of feminine grace and quick escape (Jami, 1882). Ephrem Syrus addresses the stalker’s distorted insight: “Out of love for him, I treated him unjustly; and yet he owes his present greatness to us” (Grumbaum, 1901).

Christian authors tend to draw a parallel between Joseph and the Saviour. Emphasis is therefore placed on forgiveness by the stalkee. The stalker’s insight is finely verbalised in 14th-century passion plays: “Principal mente une dame / Comme moy; je suis esha hye / Je considere ma foylie / Mais, bref, amour me contraint tant / Qu’il sera force que je pri / Joseph pour estre mon amant” (Anonymous, 1881). In 16th-century Yiddish dramas composed for Purim, a festival celebrating the liberation of Jews from a deadly plot, the slave’s and the mistress’s alienation and freedom are dialectically discussed and Joseph’s stalker goes by many different names (but not Zuleika). Zuleika’s syndrome is also staged with other nuances by Goethe and in a famous Broadway show. This overview reinforces Kamphuis & Emmelkamp’s view of a typical phenomenon which has remained a contemporary challenge, and also their suggestion of cultural biases in the perception of stalking.


B. Dan Neurology Department, University Children’s Hospital Queen Fabiola, IS Avenue J J Crocq, B-1020 Brussels, Belgium

C. Kornreich Institute of Psychiatry, Brugmann University Hospital, Université Libre de Bruxelles, B-1020, Belgium

Venlafaxine-induced painful ejaculation

Antidepressant drugs cause a variety of sexual side-effects. Painful ejaculation is a
rarely reported side-effect of antidepressants, especially the newer drugs.

A 59-year-old man with recurrent depression had normal sexual function while euthymic and mild decrease in libido while depressed. Although his previous episode of depression responded well to fluoxetine he was not keen on trying it again because of fluoxetine-associated diarrhea. During a depressive relapse he was treated with venlafaxine 75 mg daily which was later increased to 150 mg daily. The antidepressant response was good. Unfortunately, he developed painful ejaculation. It was sharp and burning in nature and located deep in the shaft of the penis. It would begin just before ejaculation and lasted until the penis became flaccid. This was so unpleasant that it not only interfered with the pleasure of intercourse, but also led him to avoid sexual intercourse. The pain persisted despite reducing the dose of venlafaxine to 75 mg. When venlafaxine was stopped the pain disappeared. Later, he made a good recovery on citalopram 40 mg daily. He denied experiencing pain or any other sexual side-effects and also denied having ever previously experienced painful ejaculation.

This is the first report of venlafaxine-induced painful ejaculation. Painful ejaculation/ orgasm have been reported with various tricyclic antidepressants (Kulik & Wilbur, 1982; Aizenberg et al, 1991). Some of the people in question improved with dosage reduction or after changing to other tricyclics, but others improved only when they stopped the medication. Hsu & Shen (1995) reported a case of fluoxetine-induced painful ejaculation that improved when the dosage was reduced from 20 mg daily to 20 mg on alternate days. Thus, painful ejaculation, when it occurs, could be a dose-dependent side-effect in some individuals. It has been suggested that partial blockade of peripheral sympathetic adrenergic receptors could interfere with coordinated contractions of smooth muscles involved in semen transport and thus induce painful spasms or retrograde ejaculation (Kulik & Wilbur, 1982). However, venlafaxine has little if any adrenoceptor-blocking action. Thus, the mechanism of antidepressant drug-induced painful ejaculation remains elusive.

Sexual side-effects of antidepressant drugs cause distress, strain relationships, impair quality of life and reduce compliance with treatment.Enquiring routinely about side-effects, especially sexual side-effects, of antidepressants would help to improve compliance with treatment.


A. Michael Department of Psychiatry,West Suffolk Hospital, Bury St Edmunds IP33 2QZ

---

**One hundred years ago**

**The duties of an asylum superintendent**

A recent number of the *Portadown News* (May 19th) contains an account of the monthly meeting of the Board of Management of the Lunatic Asylum at Portadown, at which various opinions were expressed by the members concerning what they conceived should be the duties of a medical superintendent. Among such duties – in addition to the professional duties – expected of the medical superintendent appeared the following: keeping the subsidiary financial account of the institution, the care and supervision of china and crockery, and the planting of potatoes. The question of acquiring additional land was negatived [sic] as the committee were unanimously of opinion – considering that Mr G. R. Lawless (the resident medical superintendent) did not know when potatoes should be planted – that there was no need of additional land. Among other things which fell within the medical superintendent’s province was the selling of old clothes belonging to the patients as ordered by the board, though he (the medical superintendent) was of opinion that such clothes should be destroyed. On the motion of Mr Best, seconded by Mr Armstrong, “the board further instructed the medical superintendent to have mortar made on the grounds,” and to keep a supply of the same for the needs of the institution. A member of the committee inquired if they could feed more pigs than they had at present and Mr Lawless replied that they had not accommodation for more. The *Portadown News* concludes its report as follows concerning the committee and their doings: “After the meeting was over several of the governors visited the piggeries, and on finding that a number of them (the pigs) were over two hundredweight and that in the ordinary course it would be two months before they could be disposed of by tender, it is said that some unprintable expressions were used regarding the management of the institution in general.” It appears clear that the medical and professional duties required to be performed by the medical superintendent as the responsible physician in charge of the patients and of the administration of the asylum could not be performed were he to have to do the other work required by the committee. Evidently some of the committee think that the superintendent should be made a beast of burden and a jack-of-all-trades – a state of things which is not conducive to the best interests of the public asylum service if a medical officer in charge of patients is required to do the work of a steward, an accountant-clerk, a farm-bailiff, a housekeeper, and a manager of the piggeries.

**REFERENCE**


Researched by Henry Rollin, Emeritus Consultant Psychiatrist, Horton Hospital, Epsom, Surrey
Psychosocial treatment programmes for personality disorders: service developments and research
R. Haigh
Access the most recent version at DOI: 10.1192/bjp.177.3.281

References
This article cites 1 articles, 1 of which you can access for free at:
http://bjp.rcpsych.org/content/177/3/281.1#BIBL

Reprints/permissions
To obtain reprints or permission to reproduce material from this paper, please write to permissions@rcpsych.ac.uk

You can respond to this article at
/letters/submit/bjprcpsych;177/3/281

Downloaded from
http://bjp.rcpsych.org/ on April 4, 2017
Published by The Royal College of Psychiatrists