

other studies. A different interpretation of the results could be that no less than 31% of an essentially unselected group of subjects who had attempted suicide suffered from a syndrome of depression which carries a considerable degree of morbidity and mortality, and for which we have, for the most part, effective treatments.

The adequate treatment of depression remains the most effective way in which we as clinicians can assist suicidal patients. The word "only" in this context appears to be singularly inappropriate.

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### Molecular genetics and ethics

SIR: I would like to take up the issues aptly raised by Pelosi (*Journal*, October 1988, **153**, 570) and David (*Journal*, January 1989, **154**, 119) and suggest that the ethical implications of the new genetics are of immediate importance, not least because its practical implications have been quickly grasped by those such as insurance companies who play a significant role in the provision of health care in the Western world, if not yet in Britain.

Abuse of new technology is rarely the sole prerogative of doctors. (On the evidence of past enquiries, the public have more to fear from backward than enlightened practitioners, but that is another story.) Ethical abuses depend as much, if not more, on the ideological climate in which the advances occur. The real life counterparts of Drs Moreau and Frankenstein prosper under suitably unethical political regimes. Psychiatrists must ask themselves what implications the current ideological views of health care will have on the new genetics.

This is especially important in view of the fact that these advances promise more than they can, in the

short term, deliver. They do not currently hold out any early hopes for treatment, nor do they, if the chromosome 5 studies are representative, imply a simple correspondence between genetic lesion and diagnostic category, an important caveat given the variety of impairments and prognoses across categories. Their preventative power is constrained by the multiplicity of causes for mental illness and its link with further ethical questions surrounding procedures such as abortion. What they do offer, and what will no doubt be seized upon, is increased predictability of general morbidity within, and possibly outside, the affected pedigree.

The effect of all this in the current ethos may be unfortunate. In emphasising the predictable, and therefore inevitable, aspects of mental illness we do not put ourselves in a strong bargaining position for resources, but improve the position of those who might wish to further limit the amount of money spent on the mentally ill and see in the new discoveries both a reason for, and a potential means of, doing so. Genetic approaches to the mentally ill have an unpleasant social history, and given the above it is easy to see why.

Outside science fiction, ethical choices for doctors are not simply between hubris and humility but a more insidious business of resisting the carrots and sticks of ideology. In the present case the carrots may be more visible than the sticks: there are enough pedigrees, mental illnesses, and slots on the 23 chromosomes to occupy researchers well into the 23rd century. This is all the more reason for collective responsibility. This might entail: (a) strong guidelines on the use of predictive tests; (b) a monitoring of future research to ensure a balance with management issues, be they psychological, social, or physical; and (c) a reasoned debate on where these advances are leading, especially with regard to the everyday clinician and his patients. The most obvious source of such an initiative would be the Royal College of Psychiatrists.

Although some of the above smacks of Luddism, I hope it challenges enough to stimulate a discussion which, as your previous correspondents suggest, is overdue. Whatever history says about us, it will not accept the excuse that we were taken unprepared.

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### Lipid-lowering drugs and violence

SIR: I was interested to see the letter from McLoughlin & Clarke (*Journal*, February 1989, **154**,

275–276). I agree that this is an important topic. Among the 7887 men in the two lipid-lowering drug trials mentioned (Lipid Research Clinics Program, 1984; Frick *et al*, 1987), there was an excess of 17 coronary deaths in patients assigned to placebo as compared with those assigned to the drug, but there was an excess of 13 violent deaths in those assigned to the drug. Since there was an excess of 8 other deaths in the drug groups, there were overall 4 more deaths in the drug than in the placebo groups.

Thus lipid-lowering drugs are not saving lives. At best they are merely changing the cause of death. It is therefore of major importance that they should not be causing side-effects which may change the quality of life for patients and those close to them. Death is an extreme outcome of violent or impulsive behaviour. Drugs which increase violent deaths are also likely to produce greater increases in milder forms of violence, leading to more aggression at home and at work, more abuse of spouses and children, and generally more unhappiness.

There is other evidence, not mentioned by Drs McLoughlin & Clarke, which supports the relationship between violence and lowered cholesterol levels. Virkkunen, a forensic psychiatrist from Finland, was the first to draw attention to this when he noted unusually low blood total cholesterol levels in men who had committed violent and impulsive crimes, including murder (Virkkunen, 1983). He then went on to study aggressive children and found a similar relationship there (Virkkunen & Penttinen, 1984).

This is a potentially serious problem in view of the likely rapid increase in the numbers of men taking lipid-lowering drugs, and the likely lack of attention which will be paid to violence as a possible side-effect. It deserves serious investigation by psychiatrists concerned with aggressive behaviour.

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#### Paradoxical intervention

SIR: Adshead *et al* (*Journal*, December 1988, **153**, 821–823) describe the use of paradoxical intention in a non-compliant ritualiser. It is assumed in the report that the patient relapsed after initial improvement with behaviour therapy because she did not comply with instructions given. The paradoxical intervention (which took the form of 'masterly inactivity' being formally recommended by the psychiatrist) produced a successful outcome, but the authors drew attention to the discomfort experienced by both the patient and the treatment team concerned.

Paradox is a useful therapeutic technique (Cade, 1979). However, it is not a single prescriptive act or magic formula. Paradox is part of a therapeutic programme requiring a sensitive adjustment to the patient's needs and a recognition of the importance of the patient's attitudes to the problem, the treatment, and the therapist (Fisch *et al*, 1982). For best results, improvement should be greeted with caution, puzzlement, and an (apparent) acceptance that the patient's recovery is due to factors other than the therapist and the intervention.

This flexible and understated response is hard for eager therapists to apply, but often serves to avoid the reactions described in this interesting report.

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#### The near-death experience

SIR: In their thorough and timely review of the near-death experience (NDE), Roberts & Owen (*Journal*, November 1988, **153**, 607–617) note that the dissociative anaesthetic ketamine can reproduce many of the features of the NDE. Several recent discoveries in neuroscience suggest a physiological explanation for at least some NDEs which involves a ketamine binding site in the brain.

Like its congener phencyclidine (PCP, 'angel dust'), ketamine can bind to a site on the N-methyl-D-aspartate (NMDA) receptor (Sonders *et al*, 1988). Many of the substances which bind to this site are also powerful dissociative hallucinogens. There has been an enormous increase in research activity involving the NMDA receptor, as it has been shown