

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