and includes a wide range of phenomena following bereavement, including withdrawal, tearfulness, weight loss, obsession with death, health problems, increase in fits, faecal incontinence and regressive behaviour. Carers reported the continuing effects of bereavement. For example, one man, who had had a close but difficult relationship with his father, was still working through the bereavement with a psychologist, and taking psychoactive medication, some five years after his father's death. Another man, after a similar period of time, still cried out for his mother when something went wrong; Miss F is said still to break down easily, crying "My mother's dead!", illustrating the immediacy that a bereavement can have even after a number of years.

The work we reported adds to the growing body of evidence that bereavement can cause psychological distress and behavioural symptoms, which may well be overlooked or misinterpreted.

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Maternal eating disorder and mother–child conflict

Stein *et al*'s study (1999) provides essential reading for clinicians involved in treating anorexia nervosa or bulimia. However, in light of recent research concerning pregnancy and eating disorders (Morgan *et al*, 1999), three further areas of investigation seem to have been unexplored.

First, we have demonstrated that a third of women with bulimia developed postnatal depression, rising to two-thirds in women with previous anorexia nervosa. Second, Stein *et al* treat 'eating disorders' with unwarranted homogeneity; we found profound differences between pregnant women with bulimia and those with previous anorexia nervosa. The latter predicted postnatal depression, absence of breast-feeding and postpartum relapse into eating disorder. The most striking differences were apparent at a descriptive level, where women with previous anorexia nervosa appeared highly alienated from their infants. Third, the majority of pregnancies described in our study (Morgan *et al*, 1999) were unplanned due to mistaken beliefs regarding fertility.

It would be interesting if Stein *et al* were able to re-examine their data with reference to specific eating disorder diagnoses, presence of affective disorder and planning of pregnancy, all of which might generate maladaptive responses to the antecedents of conflict.

Stein, A., Woolley, H. & McPherson, K. (1999) Conflict between mothers with eating disorders and their infants during mealtimes. *British Journal of Psychiatry*, **175**, 455–461.

Morgan, J. F., Lacey, J. H. & Sedgwick, P. M. (1999) Impact of pregnancy on bulimia nervosa. *British Journal of Psychiatry*, **174**, 135–140.

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Authors' reply: Dr Morgan makes some interesting points in the light of his own study concerning factors which might influence the nature of the relationship between mothers with eating disorders and their infants. However, the purpose of our paper was to examine the evolution of conflict between mothers with eating disorders and their infants using detailed observations of sequences of interactions. In particular, we wanted to establish whether the way in which mothers and infants responded to different situations during mealtimes influenced development of conflict. We found that whether or not the mothers responded to the infants' cues determined whether or not conflict arose. In addition, the infants' behaviour also contributed to the evolution of conflict in some circumstances. The elucidation of these features of interaction, which was only possible through sequential observations and analyses, offers the potential for intervention irrespective of which background factors influence interaction. In particular, it is critical to help mothers to recognise the positive aspects of their infants' communications and cues during mealtimes in order to facilitate this interaction.

Obviously, we are very interested in the other factors in the mother's history or mental state which might influence the course of these interactions, such as those detailed in the Morgan *et al* paper cited above. However, in order to carry out the analysis of sequential interactions as we have done, and to determine the relative influence of a variety of other factors on the course of these interactions, a much larger study would be required. This would be valuable but well beyond the scope of our paper.

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Compulsory treatment in anorexia nervosa

I read with interest the paper by Ramsay *et al* (1999).

The matter of compulsory treatment in anorexia nervosa is clinically important. The lifetime risk of women developing this disease is 0.5%, that is half the lifetime risk of schizophrenia. The mortality rate is unacceptably high, reaching nearly 20% at 20-year follow-up. This would suggest the need for compulsory treatment in certain circumstances. However, there is disagreement between authorities about the issue, and in relation to the right of anorexic patients to receive life-saving treatment if they are unable to consent to it by reason of their mental disturbance. Various viewpoints have been presented in a recent multi-authored book (Vandereycken & Beaumont, 1999). As Ramsay *et al* point out, the only other empirical study attempted in this area was by Griffiths *et al* (1997) in New South Wales. The situation in New South Wales at the time of the latter publication was rather different from that in the UK inasmuch as anorexia nervosa is not considered a mental illness as defined in the Mental Health Act of this State. On that ground, Mr Justice Powell of the Supreme Court of New South Wales ordered the discharge of a severely ill patient with anorexia nervosa in 1986, setting a precedent that persisted until 1999. Incidentally, the patient in question died some time after her discharge.

In the absence of suitable mental health legislation in this area, the management of severely ill patients with anorexia nervosa who refused treatment became an issue for the Guardianship Board. Unfortunately, no new provisions were inserted into the Guardianship Act to deal precisely with this responsibility. Consequently, the treatment of patients has often been severely impeded, the public guardian demanding formal requests at each stage of treatment, and hence causing a considerable delay, and sometimes refusing treatment on grounds which appear ridiculous, for example refusing a cognitive–behavioural programme because it was not 'medical' treatment.

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As recently as 1999, the situation in New South Wales has again changed. At a hearing concerning a 19-year-old severely ill patient with anorexia nervosa, Mrs Brennan, senior member of the Mental Health Tribunal, decided that she was a mentally ill person, and hence did fall under the Act even though anorexia nervosa as such was not considered a mental illness (mine not to comment on the niceties of the use of words in law, merely to report). This brings our State in line with legislation in the UK, and other states of Australia.

Griffiths, R. A., Beumont, P. J. V., Russell, J., *et al* (1997) The use of guardianship legislation for anorexia nervosa: a report of 15 cases. *Australian and New Zealand Journal of Psychiatry*, **31**, 524–531.

Ramsay, R., Ward, A., Treasure, J., *et al* (1999) Compulsory treatment in anorexia nervosa. Short-term benefits and long-term mortality. *British Journal of Psychiatry*, **175**, 147–153.

Vandereycken, W. & Beumont, P. J. V. (eds) (1999) *Treating Eating Disorders: Ethical, Legal and Personal Issues*. London: Athlone Press.

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Resource allocation for mental health care

We read with interest the editorial by Gyles Glover on allocations to health authorities for mental health care (Glover, 1999). It is important that the sums of money allocated to health authorities for mental health care be widely known. This will allow all interested parties to have ready access to information upon which to base any claims about the adequacy or otherwise of funds made available to health care providers.

We are aware there is wide variation in the amounts actually spent by health authorities, as opposed to the amounts allocated. For example, in the year 1997/98 Worcester Health Authority spent £24 per head of population on mental illness (excluding mental handicap), Solihull Health Authority spent £32 per head of population, and Lambeth and Southwark spent £138 (Chartered Institute of Public Finance and Accountancy, 1998). These amounts represent 4, 5.5 and 17.4 per cent, respectively, of the overall expenditure on health care per head of population. We do not have any information on the actual amounts allocated to health authorities in this period, but are concerned at the observed variation. We do not believe that this variation can be easily explained.

There is cause for further concern. The York formula, which is used in determining the level of resource allocation, for example, ranks Birmingham 8th in order of need but 20th in order of spend per head of population. But more worryingly, Birmingham is ranked 38th in order of spend : needs index ratio (further details available from Dr Oyebode upon request). This suggests that whatever the actual amount of money allocated, using a formula devised to take account of factors predictive of high psychiatric morbidity, health authorities may not be spending the indicative amounts allocated to them.

We believe that it is important that mental health services be adequately funded. The transparency of the arrangements for funding will become even more important as we move into an environment controlled by primary care groups or trusts. The risk is that substantial sums will be allocated but not spent on mental health services. It is clear that this is already the case but the situation could very well worsen if there is no control in the system.

Chartered Institute of Public Finance and Accountancy (1998) 1997/98 Health Authority accounts summarisation schedule HAAOI. In *The Health Service Database*. London: IPF

Glover, G. (1999) How much English health authorities are allocated for mental health care. *British Journal of Psychiatry*, **175**, 402–406.

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Fluoxetine-induced anaesthesia of vagina and nipples

Antidepressant drugs cause a variety of sexual side-effects. However, antidepressant-induced changes in sexual sensations are rare. We report a case of fluoxetine-induced loss of sensation of vagina and nipples.

A 48-year-old married woman with recurrent depression had good antidepressant response to fluoxetine 20 mg. However, her compliance with the medication was poor resulting in recurrences. While euthymic and on no antidepressants, her sexual function was normal. When depressed she has moderate decrease in libido. With fluoxetine 20 mg her depression remitted and her libido returned to normal. However, she developed a complete loss of sexual sensation of her nipples and vagina. Touch and pain sensations were also impaired, but only to a lesser extent. This lead to decreased satisfaction with sexual life and consequently poor compliance with the medication. Even when she became briefly hypomanic on fluoxetine, the lack of sensation persisted. We substituted her fluoxetine with trazodone 400 mg. She remained euthymic. By the fifth week her vaginal and nipple sensations returned to normal. The frequency of sexual intercourse and satisfaction improved to premorbid levels.

This is the first report of fluoxetine-induced loss of sensation of vagina and nipples. Fluoxetine-induced anaesthesia of penis (Neill, 1991; Measom, 1992) and vagina (King & Horowitz, 1993), which did not improve with dosage reduction or addition of cyproheptadine, but did with discontinuation of fluoxetine, have been reported. Ellison & DeLuca (1998) reported a case of genital anaesthesia caused by fluoxetine that did not improve with addition of cyproheptadine or yohimbine but responded to *Ginkgo biloba*. *Ginkgo biloba* is a Chinese herbal remedy for a variety of disorders and has diverse neurochemical effects. The mechanism of antidepressant-induced sexual anaesthesia remains elusive. The fact that the anaesthesia persisted even during the fluoxetine-induced hypomanic state confirms that this was not part of the depressive syndrome.

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.

Ellison, J. M. & DeLuca, P. (1998) Fluoxetine-induced genital anaesthesia relieved by *Ginkgo biloba* extract. *Journal of Clinical Psychiatry*, **59**, 199–200.

King, V. L. & Horowitz, I. R. (1993) Vaginal anesthesia associated with fluoxetine use. *American Journal of Psychiatry*, **150**, 984–985.

Measom, M. O. (1992) Penile anaesthesia and fluoxetine. *American Journal of Psychiatry*, **149**, 709.

Neill, J. R. (1991) Penile anaesthesia associated with fluoxetine. *American Journal of Psychiatry*, **148**, 1603.

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