apparently be totally resistant to physical treatments when other acute reactive psychotic states typically get better quickly if arousal levels are reduced by tranquillising drugs (Lerner *et al*, 1979)? The answer I believe is that hysterical psychoses are pseudopsychoses in the sense that they are generated by ideas and experiences normal in the patient's culture, and they are probably not associated with ego-boundary disturbances. The latter may occur in true psychoses because of abnormal awareness of internally arising stimuli which many authors conceptualise as the result of a defective perceptual filter mechanism (e.g. see Johnson, *Journal*, April 1985, **146**, 429–435). In these cases, major tranquillisers probably help firstly by reducing over-arousal when this contributes significantly to defective information processing, and secondly, and more fundamentally, by directly reducing awareness of internally arising psychotogenic stimuli. Although biological mechanisms which may underlie hysterical conversion and dissociation remain a mystery, the resistance of hysterical 'pseudopsychoses' to neuroleptics suggests that they are quite distinct from those mediating true psychotic states. The apparent presence of ego-boundary disturbances as reflected by Schneiderian first rank symptoms may not reliably exclude hysteria, because elements of these may be incorporated into ideas which determine symptoms in hysterical patients who have had previous contact with psychiatry and psychiatric patients.

From the point of view of management, once a hysterical psychosis is suspected, it may be fruitless to persist with aggressive drug treatment to quell excitement. Instead, an effort should be made to understand the reminiscences from which the patient is suffering, and from which he is trying to escape through the vehicle of culturally determined ideas and disturbed behaviour. This may set the scene for effective catharsis through argument, explanation, or ritual, as appropriate to the patient's culture.

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References

GIFT, T. E., STRAUSS, J. S. & YOUNG, Y. (1985) Hysterical psychosis: an empirical approach. *Archives of General Psychiatry*, **142**, 345–347.

LERNER, Y., LWOW, E., LEVITIN, A. & BELMAKER, R. H. (1979) Acute high-dose parenteral haloperidol treatment of psychosis. *American Journal of Psychiatry*, **136**, 1061–1064.

Cavernosal Alpha Blockade: A Treatment for Erectile Impotence

DEAR SIR,

We read with interest Professor Brindley's article (*Journal*, December 1983, **143**, 332–337) describing his treatment of erectile impotence. We employed this method at the Repatriation General Hospital, Greenslopes, and found it satisfactory.

We have since adopted modifications to the original treatment which have resulted in improved convenience to the patient. The intracavernosal injection of 30 mg of Papaverine and 1 mg of Phentolamine produces a penile tumescence which results in erection when followed by sexual stimulation within 8 hours of injection.

We have found that apparently intractable cases of impotence spanning two to thirteen years respond well. Patients have been instructed in self-injection after being observed fully at outpatients, and are thus able to become autonomous in their control of the treatment. Some have found that erections occur spontaneously without injections after three or four treatments.

Of 13 men treated this year all except two had excellent results and four did not need injections after a course of 6 cavernosal injections. They were able to maintain spontaneous erections.

Three were diabetic and one of these had no response. One man developed priapism which was successfully treated with a Tru-Cut biopsy needle.

Phenoxybenzamine was not used after 1984 because it was felt the response was not physiological. It caused erection without stimulation and did not subside after intercourse. The papaverine/phentolamine injection allows intercourse after stimulation and subsides spontaneously after it.

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Epilepsy, Psychosis, Kraepelin and Bleuler

DEAR SIR,

I was very interested to read the letter by Stevens (*Journal*, September 1985, **146**, 321–322) about 'Epilepsy and Psychosis'. However, I would like to correct the attribution of "formal thought disorder, disturbances of affect and autism" to Kraepelin. He was in fact the one who coined the term "dementia praecox" with all its implications for symptomatology, age of onset and prognosis. This was replaced in 1911 by E. Bleuler's term "schizo-