Photography for Anorexia Nervosa

SIR: May I add to the comments by Byrne (*Journal*, December 1988, **153**, 848)? I have also found the use of visual recording of the physique of anorexic subjects to be of value both in documenting progress and as an adjunct to therapy. In particular, I have found confidential video-recording of the subject's physical presentation has been useful. Often, the appearance of parts of the body not easily viewed, such as the back and buttocks, has prompted anorexic subjects to comment spontaneously about the degree of emaciation that is present, when they tolerate viewing equally emaciated parts of their bodies that they can view more frequently. I look forward to the results of Byrne's prospective study.

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ECT mythology?

SIR: Several points made by Russell (*Journal*, December 1988, **153**, 850) concerning the effectiveness of pulse-type ECT stimuli, are in need of clarification.

Dr Russell mentions recovery rates of over 90%, with small numbers of treatments using sine-wave ECT apparatus, but no quotes of specific references were given. The majority of research performed during the era of the sine-wave equipment is unlikely to have included standardised depression scales, and must, hence, be viewed cautiously. Abrahams *et al* (1983) found an 81% success rate of six bilateral ECT treatments with pulse-wave machines, which demonstrates the high level of efficacy of the method.

Certainly there is evidence to suggest the decreased effectiveness of unilateral ECT with the newer machines, and also an increased vulnerability to sabotage by inexperienced operators, with the lower currents involved. However, these factors seem to play little part in bilateral treatments.

Addressing the subject of side-effects, a study by Weiner *et al* (1986) reported a considerably increased level of cognitive impairment, following treatments with sine-wave equipment, when compared with pulsed bilateral ECT.

Now that it has been demonstrated that fits in excess of 32 seconds bestow the maximum benefit, I feel that the way forward is by the accurate measurement of ECT-induced seizures, with EEG monitoring equipment, so that seizures of optimum length can be more easily induced. I feel that this approach has mconsiderably more merit than relying on anecdotal successes of the past.

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Manic Features During a Course of ECT

SIR: The development of manic symptoms or a complete manic syndrome in patients receiving antidepressent medication is well recorded and the clinician's response, reduction in medication with the additional prescription of major tranquillisers, is probably uniform. The management of manic features developing during the course of the ECT is, I suspect, less uniform. In training I encountered at least two patients who developed manic symptoms during a course of ECT which was, as a consequence, stopped. Thereafter the patients (both with major affective disorders) appeared to take a rather chronic course. My practice as a consultant has been to carry on a course of ECT if manic symptoms develop, on the basis that mania itself can be treated with ECT and the development of these symptoms suggests only that the affective disorder has been modified rather than fully treated. I cannot find much help in the literature on these alternative courses, and would be interested to know readers' views and experience in this area.

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Philosophy for trainees

SIR: I recently had to prepare a journal club, and I selected Yorke's incisive article entitled "A defect in training" (*Journal*, February 1988, **152**, 159–163). His article led me to Benjamin's letter on the mind–body problem (*Journal*, July 1988, **153**, 124) in which he introduced the need for some sort of

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philosophical education during the training of junior psychiatrists. Inevitably, I came across Simpson's comments (*Journal*, December 1988, **153**, 846) on Benjamin's letter, and I would like to express my concern and disagreement with Simpson, on which philosophy to choose to enlighten the dark and sometimes erratic future of the young trainees.

Simpson considers dialectical materialism (DM) as the ultimate pathway that will lead us to clarify the irritating mind–body problem. Moreover, he implies that DM is a philosophy that "in a scientific manner" will help us to explain the problem.

Is there enough room in the decade of the post-anarchist epistemology for DM? Not only did Sir Karl Popper critically attack the scientific basis of DM but Paul K. Feyerabend went even beyond demolishing the sophisticated apparatus built by Popper.

Not long ago, Mario Bunge, Professor of Philosophy of Science at McGill University, published *Materialism and Science*. He concluded that the only philosophical materialism valid was that based on physics, and he, therefore, introduced us to the fascinating territory of quantum mechanics, matter, and reality. Nevertheless, he dismissed DM on the grounds of lack of an adequate scientific basis and an excess of 19th-century rhetoric. Furthermore, he warned us of the danger of omnipotent ideologies, e.g. DM, explaining away every form of human activity.

Having said this, it appears quite clear that any philosophy that wants to address the question of what matter is needs the aid of the new physics. Therefore, to study that complex arrangement of matter called man, we need a non-linear science that should not enter into contradiction with the principles formulated by physics. This science may well be evolutionary biology. Hence, any philosophy must be in accordance with this particular approach to reality.

I therefore think that what should be offered to a psychiatric trainee immersed in a confused materialist paradigm is a sensible blend of history of science and a thorough study of the evolution of the ideas on human nature. It would also be necessary to exploit current contradictions like the paradoxical shift from a materialist paradigm (brain) to a non-materialist one (mind) that is usual in psychiatric clinical practice.

In summary, there are certain properties of matter explained by physics; there are some emergent properties that are not explained by physics but that are not in contradiction with it, hence the need for biology and thus neurosciences. The mind–body duality is a pseudoproblem and what is needed is a paradigm, not to bridge the divide between mind and body, but to explain how matter organises itself to generate that complex set of functions with the impressive name of soul, spirit, and perhaps mind.

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Hyperventilation Causing Asthma

Sir: Hibbert & Pilsbury's paper (*Journal*, November 1988, **153**, 687–689) is interesting, but the important thing to emphasise is that it is possible to make an assessment of the situation by careful attention to the clinical history and physical signs without the use of any special technology. The inter-relationship between hyperventilation and asthma is well known in the chest world. The fact that hyperventilation may proceed to asthma or that asthma may be complicated by hyperventilation or that the two may be closely interwoven has been known to me at least since 1960, when as far as I can remember I was introduced to the idea by Dr J. G. Scadding, who was then Dean of the Institute of Diseases of the Chest at the Brompton Hospital where I was an honorary consultant. It is referred to in a number of reviews, and in particular in my chapter in the Brompton textbook on asthma (Cohen *et al*, 1983). Asthma is a common disorder, and asthmatic patients may be anxious for the same reasons that make other people anxious. If an anxious asthmatic hyperventilates, there is a risk that his disorder will be misdiagnosed as asthma and if that happens and he is treated, say, with steroids, treatment will be ineffective. It is therefore very important to make an assessment whether one or other disorder is present or, much more frequently, since they are both commonly present simultaneously, which is the more important at the particular time and therefore which line of treatment, anti-asthmatic, anti-anxiety, or both, would be the most effective. This assessment can be made clinically as the following two patients illustrate.

Case (1). A married male teacher aged 34 seen in 1982, referred by Dr Duncan Geddes from The London Chest Hospital for an exacerbation of asthma which had prevented him from working for some weeks. He had suffered from asthma since the age of 13, and his presenting complaint was "I think my nerves are precipitating my asthmatic attacks." At the age of 18 he had been treated by a psychiatrist for an anxiety state, and he recalled an attack in which he said he felt "tense, worried, tension in the neck, I went rigid, heart pounding, throat dry, gasping but not

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