

role as an emotional substitute for this loss. The hypothesis may be spurious, but until it is explored and refuted casts a shadow of doubt on the conclusion that maternal viral infection is an important cause of schizophrenia.

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Declining incidence of hysteria

SIR: The declining incidence of hysteria in an Indian state (Nandi *et al*, *Journal*, January 1992, 160, 87–91) is an interesting example of sociocultural changes influencing the expression of emotional distress. In a similar way, as modernisation and an emphasis on individual freedom have led to an increase in personal autonomy and introspection in the Western world, it has been speculated that the expression of emotional distress has moved from the bodily mode to the psychological mode, causing a dramatic reduction in the incidence of conversion disorders (Leff, 1988).

As a parallel phenomenon, deliberate self-harm has been increasing in the past few decades in the West. In India, it is unusual to find the syndrome of deliberate self-harm which involves repetitive episodes of low-lethality deliberate self-harm in non-psychotic, non-mentally impaired individuals. This common, well-recognised and stable syndrome in the West shows several consistent similarities with hysteria, especially conversion reactions (Merskey, 1979). These include: (a) a preponderance of younger females, (b) a common direction towards an escape from an unbearable situation, (c) the occurrence of gain from resolution of a conflict, (d) dependency and regression in the personalities involved, (e) a strongly manipulative effect upon the environment leading to secondary gains and (f) association with sexual conflict. In addition, there is often (g) a tendency to cluster in epidemics and (h) the indifference of the wrist-slasher to the act of cutting closely resembles the “belle indifference” of the hysteric. Psychiatrists who have worked in both the developing world and the West are immediately struck by these similarities. The personal reaction of the treating doctor is identical in both cases with unconscious resentment at apparent deception, resulting in the labelling of such behaviour as ‘immature’ and ‘silly’.

Patients who harm themselves often describe a state of dissociation during the act and an analgesia to the pain resulting from the act, both are apparently hysterical mechanisms. It is also interesting to note that eating disorders have been reported in association with both hysteria (Kay & Leigh, 1954) and deliberate self-harm (Favazza *et al*, 1989). There is also some anecdotal evidence of a combination of dysorexia, female genital self-mutilation, and hysteria, described as Caenis syndrome (Goldney & Simpson, 1975). Diagnostically most cases of manipulative, impulsive and low-lethality self-harm are now placed under the broad category of Borderline Personality Disorder. Merskey (1979) has argued for a special category of “Hysteriform Borderline Disorder” for cases where borderline ego defences of projective identification, massive denial and splitting are present along with conversion symptoms.

As a reaction against helplessness, both hysteria and deliberate self-harm are possibly similar “physical preverbal messages”. The pathoplastic influence of cultural differences that determine these presentations are most likely to be in the autonomy–dependence and activity–passivity domains. It would be interesting to see if a parallel increase in the incidence of deliberate self-harm follows in India.

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Anorexia nervosa and XY gonadal dysgenesis

SIR: We recently reported (McCluskey & Lacey, *Journal*, January 1992, 160, 114–116) a case of anorexia nervosa in a woman with XY gonadal dysgenesis: the anorexia stemming not only from the biological and psychological confusion inherent in the dysgenesis but also from its investigation and treatment.

Dr Lee (*Journal*, May 1992, 160, 713–714) makes an important diagnostic point about which we agree,

but bases it on a misreading of our data. When a patient has two diagnoses, each of which has a low BMI as a diagnostic criterion, clearly the concept of a premorbid body weight must be contentious. We, however, have no doubt that our patient had anorexia nervosa. She demonstrated a phobic avoidance of normal body-weight which Crisp (1980) describes as the pathognomonic feature of anorexia nervosa, that is, the feature which clearly demarcates anorexia from all other psychological and physical conditions. In addition, our patient exhibited anorectic behaviour, particularly self-starvation, but the *Journal's* editorial deletions prevented us from going into details of the psychopathology. (We would not, of course, dispute that a number of psychological factors would be common between the two disorders and act synergistically, and indeed say that in our article.)

Dr Lee states that our patient was "happiest" when 23-years old during her only sexual relationship: we do not say this in the paper and it was not true. Dr Lee chides us, stating that our patient could have had anorexia at this time. There is no need to chide because we totally agree! – and say it in our paper. We believe her anorexia began at 21 years when our patient was 41 kg and had a body mass index of 13.6 (the psychological reasons are given in our paper).

Dr Lee's anxieties arise because of the difficulties inherent in DSM-III-R criteria for anorexia nervosa. Emphasis on a necessary weight loss of 15% of standard body-weight begs questions about what the psychiatrist does with a patient who loses, say, 14.5%, and even more about what "standard body-weight" means. "Amenorrhoea" is useless when a patient, such as ours, describes primary amenorrhoea. We completely agree with Dr Lee that terms such as "intense fear of obesity" or "body image distortion" are difficult to define, non-specific and demonstrated by too many "normal" Western women to have much diagnostic significance. We have ourselves reported this in our own studies (Birtchnell *et al*, 1985; Dolan *et al*, 1987a,b). It is for these reasons that we strongly urge Crisp's diagnostic criteria. Although these may appear complicated, that is only to be expected for anorexia nervosa is a complicated disorder. Crisp's emphasis on a core psychopathology, with concepts such as body weight, amenorrhoea and disturbed eating patterns taking a necessary second place, give clarity to the diagnosis and would prevent the sort of confusions outlined in Dr Lee's letter.

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Propofol and ECT

SIR: We read with great interest Pippard's audit of ECT in two National Health Service Regions (*Journal*, May 1992, **160**, 621–637). We would like to comment further on his finding of inconsistencies in the choice of anaesthetic. Pippard found propofol was always used in one of 29 ECT clinics he visited and sometimes used in a further two. This causes concern since, although propofol has anaesthetic advantages, namely smooth induction and rapid recovery, it shortens seizure duration in ECT (e.g. Dwyer *et al*, 1988; Simpson *et al*, 1988) and appears to raise the convulsive threshold (Lowson *et al*, 1990), both serious drawbacks for effective ECT. Pippard concludes that propofol should not be used in ECT unless the anaesthetic indications are particularly strong, a sentiment endorsed by the American Psychiatric Association (1990).

In a questionnaire survey of all anaesthetists working in the North West Health Region ($n=460$) carried out between November 1990 and February 1991 we examined views on anaesthetic practice. Completed questionnaires were returned by 261 anaesthetists (57%), all of whom had anaesthetised for ECT at some point in their careers and 128 (49%) who had done so within the last six months. In response to the question 'What anaesthetic do you regard as the drug of choice for ECT?' we obtained the following responses: methohexitone – 74% (192); thiopentone – 11% (30); propofol – 11% (30); methohexitone and propofol equally suitable – 2% (5); no preference between methohexitone, thiopentone and propofol – 2% (4).

A second question asked whether respondents had personal experience of using propofol in ECT; 25% (64) had.

Clearly a significant proportion of anaesthetists are using propofol, thereby increasing the chance that patients will experience inadequate seizures or failure to convulse. This risk is exacerbated since early constant current machines are still in use which