meeting serve a useful purpose? Is its purpose clearly defined? Does it have the power to make anything happen? Why is there a tendency for issues not to be resolved? A friend of mine asked, "Why do we discuss the same things over and over again, with no action ever being taken?" The Chairman asked him to place 'Lack of action on decisions reached' on the agenda for the next meeting!!

A written Constitution of the Division of Psychiatry spells out membership, frequency of meetings, its responsibility, what authority it has, and how it relates to management. Given such definition, the individual Division of Psychiatry becomes a force.

It is perhaps a warning shot that one of the first acts of an outer London, self-governing Hospital Trust was to abolish the Division of Psychiatry!! Those who had been opposed to the Division were very pleased. The others felt that a very useful resource had been lost. Only time will tell.

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Treatment of anorexia nervosa

DEAR SIRS

In the light of recent and pending health cuts, I want to make a personal plea to those in the psychiatric profession, who are involved in the treatment of anorexia nervosa, not to opt for cheap short term behavioural or medical interventions in order to save money; or worse, to make money by attracting customers to fast turn-over "feeding units". They may look economical on paper but my own personal experience leads me to believe that they are very expensive in terms of human suffering. Indeed, they are abusive and only serve to compound the problems of most anorexics, whose symptoms are merely the tip of the iceberg and perhaps to them, ironically, their only hold on life. To attempt to remove that hold, with little regard for what may lie beneath, is surely inhuman, ineffective, and hence a waste of money.

I am an ex-anorexic and symptom-free. However, I remember the six years of my illness, beginning in 1971, as a nightmare in which I was subjected to all the treatments available to the medical and psychiatric profession. I list them:

1. six different drugs
2. 20 doses of ECT (in one block)
3. insulin shock therapy
4. hypnosis (plus narco-analysis)

(1–4 were administered during one 6 month admission)

5. heavy sedation (chlorpromazine) plus force feeding (through a tube)
6. the token economy (daily weighings, huge meals, loss of privacy and privileges, bribery and total loss of autonomy).

All these treatments left me worse off; more desperate, depressed and self-destructive. Finally, in 1975 I was admitted to a psychiatric unit, which although not renowned for its eschewing of the medical model, offered me my first real chance of recovery. There I found a psychiatrist/therapist brave enough to view anorexia in its context of a badly damaged personality. He allowed me to gain weight at a rate that I could cope with psychologically, and he listened to what I had to say. He took the responsibility for helping the child inside me keep up and grow with my body. I took the responsibility for eating and keeping myself alive. We worked together for several years. I was an in-patient for 11 months. This was my first successful relationship, and within it I recovered.

It was also my first non-punitive, non-abusive experience of psychiatry.

For many women (and some men) anorexia is an illness stemming from some kind of abuse in childhood. Force feeding, enforced feeding, and harsh regimes only serve to reinforce the idea that the anorexic's body is not her own to control: which is the very idea that may have produced the symptoms in the first place. She, in this last ditch attempt to establish that control, meets with more abuse in the guise of treatment from a supposedly caring professional, a treatment which is symbolically frighteningly close to sexual abuse; with its forced and bribed entries into the body. Once more her trust is abused and her right to control violated.

In my own experience, this kind of regime only seems to reinforce self destructive behaviour, the need to control something of the self becoming more and more desperate until for some, sadly, suicide becomes the only option.

I have survived. That first therapeutic intervention gave me the strength to face up to the cause of my illness. It has been a long haul and I could not have done it had I not been allowed to grow slowly into my adult body and feel safe enough to relinquish the symptoms that hid the underlying problem. It has taken a further 12 years and two more 2 year psychotherapies with another therapist to put together my borderline personality.

It is one thing to re-live childhood abuse with the long-term help of an experienced and trusted therapist, something altogether different to have the cycle of abuse perpetuated by short-sighted authoritarian behaviour therapy. The stream of abused anorexics is not going to dry up overnight. Please consider their future and that of their children and choose a more

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holistic and non-punitive approach to the problem. They/we have suffered enough already.

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The Russian epidemic

DEAR SIRS

Having become a news junkie over the momentous events in August it struck me that little has been said about the virulent disease that has singled out the upper echelons of Soviet society. The first the West heard of it was at dawn one Monday when President Gorbachev was reportedly afflicted. This resulted in 72 hours of isolation from which he emerged slightly disoriented and hesitant. Within hours of the Emergency Committee being formed several members had been taken ill. Many important officials had been unable to oppose the coup due to ill health. Their recovery was rapid once a victor in the ensuing power struggle emerged.

The use of "illness" to dispose of one's enemies plays on the notion of illness being contagious and resulting in stigma. Supporters are then by association equally tainted. Another group appeared to use ill health as a matter of political expediency to avoid conflict and to provide a sanctioned excuse for indecision. The regression to bed and adoption of the sick role would appear to be a powerful defence mechanism and ensure survival.

Crises have a defined anatomy. Those who cannot cope with the situation may retreat to bed denying the fact that something is happening. One's own values play an important part as Gorbachev declared when confronted by the plotters that he would "stand up for my position and will not yield to any blackmail or any pressure and will not take any other decision at all". Once the tide had turned and men were on their way to arrest Pugo, a member of the Emergency Committee, he chose suicide to imprisonment and the humiliation of a trial. His wife also attempted deliberate self harm with him – a testimony to the strength of their values.

Several people died on the streets of Moscow during the coup. The situation is not over yet. The physical symptoms have been taken over by mental indecision, irritability and in some cases grandiosity. Post traumatic stress disorder may affect the outcome in some of the key players. One thing, however, is certain: a coup is not good for one's health.

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Logical terminology?

DEAR SIRS

I understand that the problem of the so-called 'slur' of mental illness is very much in the mind of psychiatrists in this anniversary year.

I consider that the reason for the slur may lie in the very name itself – 'mental illness'. The word 'mental' has disturbing associations for most people. Is it, anyway, a logical name?

In many cases the trouble starts in the 'psyche' and not in the 'mens' primarily – psychiatrists, after all, do not call themselves 'mind experts'. Here is a case of a name mattering very much.

'Psychological illness' would not have the same frightening effect and has a more familiar ring to it.

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Teams work

DEAR SIRS

Our multidisciplinary community mental health team business meeting was half through, when a wasp flew in through an open window.

It alighted upon an occupational therapist, who had reason to fear anaphylactic shock but calmed the creature by professionally employing an unruffled and immobile posture. As the team psychiatrist, I immediately contributed several theoretical lines of management that could be followed. Simultaneously a member of the social work department invoked an innovative new role for the minutes of the previous meeting and the unfortunate insect was effectively dispatched, to the sound of a community psychiatric nurse empathically stating the case for the minority insect group in the room.

It struck us that we might have seen enacted a microcosm of the working of a multidisciplinary team, and intend to come to some conclusion about this just as soon as we can all find something to agree on.

Name and address supplied