Admission trends

SIR: The effect of the growth of general-practice-based psychiatry warrants investigation. However, Williams and Balestrieri's demonstration (*Journal*, January 1989, **154**, 67–71) of a correlation between admission trends and increased psychiatric input at general practice level could be accounted for by other factors not examined in their study. These factors include community psychiatric nursing services, day hospital usage, and frequency of domiciliary visiting. The levels of these may reflect the style of services which are also more likely to include general-practice-based psychiatric clinics. It may be that the most important contribution of such clinics to the service is that they enable contact to be made with patients who would be reluctant to attend other forms of psychiatric clinics.

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The mind-body problem

SIR: Simpson (*Journal*, December 1988, **153**, 846–847) and I (*Journal*, July 1988, **153**, 123–125) agree that there is a place for philosophy in the medical curriculum, but he finds my dualism too uncompromising and suggests that a dialectical materialism as pioneered by Marx and Engels is a framework sufficiently complex to allow for the 'scientific' study of mind.

Let me admit at once to being a *reluctant* dualist. I only wish a tidy monist solution (especially for the biological – psychological controversy in psychiatry) were in sight, not to say at hand. But the prospect seems remote.

I used the word 'dynamic' not to allude to the give-and-take of various forces described by dialectical materialists (usually in the field of economics) and by some psychologists (usually discussing the unconscious), but as a short-hand label to distinguish 'psychoanalytic' psychiatry from 'organic' psychiatry. The feature of the former that makes it an unsuitable topic for a materialist is not its dynamism, indeed, but its *mentalism*.

A six-year-old boy complains of a stomach-ache every weekday morning, and the doctor thinks he does not want to go to school. The case is referred to a psychiatrist who happens to be a dialectical materialist. He explains the stomach-ache as the brain's perception of muscle cramps, and these as a result of various conflicting neural and humoral stimuli. The stimuli originate in conflicting attitudes to school-going which have their counterparts in other brain-states.

But what does the dialectical materialist psychiatrist do with the aches, the desires, and the doctor's opinions themselves? They are not material entities. (We cannot CT scan them, and would be nonplussed if they turned up in a CSF sample). They are mental entities (if one is a dualist), or statistical probabilities of certain behaviours (this works modestly well for desires and opinions – less so for aches); or perhaps they are the 'software' or 'program' that charts the logical connections between the various brain-states involved (the 'hardware') (this is the modern solution called 'functionalism'). Or again, the aches and the brain-states may be two different aspects of a more basic thing we simply cannot understand called 'persons', as the wave theory of light and the corpuscular theory of light describe different aspects of a subtle physical phenomenon to which no one theory can do justice.

I cheerfully admit that each of these solutions is imperfect. But materialism has its shortcomings no less than any other theory.

I hope that this correspondence reinforces the point on which Dr Simpson and I agree: that even the simplest psychiatric formulations have philosophical underpinnings, and that these underpinnings are problematic. That is why we should occasionally unearth them and study them.

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Psychological-mindedness and the alexithymia construct

SIR: Coltart's description of psychological-mindedness (*Journal*, December 1988, **153**, 819–820) and the guidelines she provides for assessing this feature in the diagnostic interview should prove helpful to psychiatrists in detecting patients who are unlikely to benefit from analysis or analytical psychotherapy. We would like to point out that the absence of psychological-mindedness is now usually subsumed under the broader construct of 'alexithymia', which evolved from observations of the cognitive/affective style of patients who were unresponsive to insight psychotherapy (Taylor, 1984). The clinical assessment of psychological-mindedness can be supplemented by administering to patients a recently developed self-report measure of alexithymia – the Toronto Alexithymia Scale (TAS). Investigations have shown that this is a reliable and valid instrument (Taylor & Bagby, 1988).