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).

Derived from clinical observational data, the alexithymia construct encompasses several of the characteristics discussed or alluded to by Coltart, including (a) difficulty identifying and describing affects, (b) an inability to use affects as signals of inner conflict or of responses to external situations, (c) restricted imaginative processes, as evidenced by a paucity of dreams and fantasies, and (d) an externally-oriented cognitive style. Lacking access to feelings and other inner experiences, alexithymic individuals tend to focus on and amplify the physiological component of emotional arousal. This is thought to explain their tendency to somatisation and their proneness to discharging tension through binge-eating, substance abuse, and other compulsive activities – behaviours that were first reported in this type of patient by Horney (1952).

While some psychiatrists associate psychological-mindedness with socioeconomic status, educational level, and intelligence, our research with the TAS has shown no relationship between alexithymia and these variables in normal adults. Investigations with the TAS have also provided considerable empirical support for the validity of both the scale and the alexithymia construct (Taylor & Bagby, 1988). For example, factor analysis studies of the TAS have demonstrated a stable and replicable 4-factor structure theoretically congruent with the alexithymia construct. In addition, the TAS has been shown to correlate in predicted directions with measures of other constructs, including the psychological-mindedness subscale of the California Personality Inventory, the Need for Cognition Scale, the Anger Expression Scale, and the Short Imaginal Processes Inventory. Consistent with Coltart's view that the prospect of successful treatment is influenced by the level of psychological-mindedness, the TAS was also found to correlate strongly and negatively with Barron's Ego Strength Scale, a test that was designed to predict successful response to psychotherapy.

Given their unsuitability for analytical psychotherapies, patients who are not psychologically-minded have been largely neglected by psychoanalysts. The formulation and validation of the alexithymia construct, however, has focused attention on this difficult group of patients and prompted some analysis to devise modified psychotherapeutic techniques for treating them (Krystal, 1988, Taylor, 1987).

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Illicit drug use in strength athletes

SIR: We are currently conducting a psychological investigation with strength athletes, some of whom illicitly self-administer performance-enhancing drugs. The use of these drugs, mainly anabolic steroids, is widely recognised (Pope & Katz, 1988). We have been surprised by the willingness of these amateur athletes to try new drugs offered by friends and fellow competitors, despite little knowledge concerning their effects. In a recent example, a young male bodybuilder (aged 22) took 1000 mg L-dopa per day for three days in the belief that it would make his veins more prominent, thus enhancing muscular definition (an important attribute in bodybuilding competitions). He suffered flashes and pulses of pain in his head and experienced auditory hallucinations. This confirms the hallucinogenic properties of L-dopa reported elsewhere (Bradley & Hirsch, 1986). Following drug withdrawal these symptoms disappeared, and he has now returned to taking anabolic steroids. Steroids, however, may also cause negative side-effects: feelings of anger and hostility (Goldman, 1984), physical acts of violence (Pope & Katz, 1989), manic or psychotic episodes (Pope & Katz, 1988), and depression on drug withdrawal (Pope & Katz, 1988). Similar occurrences have been noted in our study, although causation could not be established.

The honesty of this athlete in admitting to drug use contrasts with the more frequently encountered reluctance. Amateur or professional athletes may therefore present for medical consultation with symptoms relating to illicit drug use. It is suggested that this should be suspected and objectively monitored before alternative diagnoses are offered.

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