psychiatric patients experience severe dysphoria and are preoccupied with the experience of experiencing depersonalisation.

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References

MAYER-GROSS, W. (1935) On depersonalisation. *British Journal of Medical Psychology*, **51**, 335–342.

NOYES, R. & KLETTI, R. (1977) Depersonalisation in response to life-threatening situations. *Comprehensive Psychiatry*, **18**, 375–384.

Globus Hystericus

SIR: I suppose that if any group of psychiatrists was asked to define globus hystericus, the majority would agree with Wilson *et al* (*Journal*, September 1988, **153**, 336–339) and say that it is the sensation of a lump in the throat causing difficulty in swallowing. Modern textbooks of psychiatry, e.g. Gelder *et al* (1983), confirm this usage. However, before this venerable term sinks irrecoverably into misuse I would recall its origin, since a great part of the history of concepts of psychiatric disorder is bound up with it. Those who would recall the history in more detail should read the brilliant account by Veith (1965).

The origin of the concept of globus is the sensation of a swelling rising from the epigastrium toward the throat, accompanied by a sense of churning and fear; this is the epigastric aura of the temporal lobe fit. In ancient times, predating Greek medicine, this was attributed to the uterus taking leave of its moorings in the pelvis and led to the concept of the 'wandering womb' and to the term 'hysteria' itself. The idea that unsatisfied sexual urge is related to emotional disorder, especially in women, runs through the whole history of psychological medicine. Shakespeare expressed it in *King Lear*:

> O, how this mother swells up toward my heart
> *Hysterica passio*, down thou climbing sorrow,
> Thy element's below.

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References

GELDER, M., GATH, D. & MAYOU, R. (1983) *The Oxford Textbook of Psychiatry*. Oxford: Oxford University Press.

VEITH, I. (1965) *Hysteria: The History of a Disease*. Chicago and London: Phoenix Books, Chicago University Press.

The Mind-Body Problem

SIR: Benjamin (*Journal*, July 1988, **153**, 123–124) contends that the 'mind-body problem' is essentially a philosophical one. He also acknowledges the influence of philosophy on everyday psychiatric theory and practice. His argument for a place for philosophy in the medical curriculum deserves support. He correctly points out that most psychiatrists use philosophical arguments to justify their approach without fully working out the consequences for their clinical and research practice.

I take issue with Dr Benjamin, however, on a point of philosophy. The "hard-line behaviourist or materialist" who rejects the proposition that the human mind is a spiritual thing would not necessarily "discover that there is a great deal which he must either ignore or violently corrupt". There is room for a materialist approach which recognises the dynamic nature of matter and the myriad processes of interaction which occur within it. It is quite clear that this philosophy cannot, at this moment, explain all of the complexities of the 'mind-body problem'. The importance of this dynamic or dialectical materialism is that it provides a philosophical framework for the scientific investigation of the problem.

The philosophy of dialectical materialism can be explained simply as follows. The human mind and spirit cannot exist without a human brain. That individual human mind and spirit together cease to exist when the material of that human brain ceases to exist in the particular form which constitutes a human brain. Other human beings may continue to recognise that individual's mind and spirit as perceived by their own human brain if they have experienced direct or even indirect interaction with that individual.

Thus dialectical materialism does not recognise a dichotomy between mind and body. It requires of theories purporting to explain the complexity of the human mind to show that they are based on material facts and that the conclusions offered can be tested. It accepts that our present level of knowledge and current methods of investigation are not yet capable of explaining everything about the human mind. It poses the question, how can we explain this or that phenomenon? It is thus a spur to research. This philosophical approach allows room for all clinical findings, not just those that fit a rigid conceptual scheme as suggested by Dr Benjamin.

Dialectical materialism was the philosophical method pioneered by Karl Marx and Frederick Engels to investigate the economic, social, and political relations of man in a scientific manner. It is also the, often unspoken, philosophy that underscores scientific investigation in any field.

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Once again I offer support to Dr Benjamin's appeal that philosophy should have a place in the medical curriculum. A medical school which would facilitate philosophical debate among its students and teachers could not fail to improve the quality of its graduates both by sharpening their minds and perhaps even uplifting their spirits.

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Anorexia Nervosa

SIR: We read with great interest the recent report by Shur *et al* (*Journal*, July 1988, **153,** 72–75) who found blood cell alterations in eight out of twelve patients with anorexia nervosa. We would like to add to their interesting report our recent findings in 13 patients with anorexia nervosa (Geissler *et al*, 1988): granulocytopenia (granulocytes $<2000/\mu l$) and anaemia (haemoglobin < 12.0 g/dl) were found in five and one patient respectively. However, the number of myeloid and erythroid stem cells in the circulating blood using a colony assay described previously (Geissler *et al*, 1986) was significantly decreased compared with age-matched controls, showing a more pronounced haematopoietic abnormality in anorexia nervosa than was hitherto inferred from blood counts. Some patients maintained normal peripheral blood counts despite decreased numbers of stem cells. It is reasonable to suggest that careful haematological observation during treatment with certain drugs with potential haematotoxicity is mandatory in patients with anorexia nervosa, even if normal blood counts seem to reflect intact haematopoiesis.

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References

GEISSLER, K., KISS, A., HINTERBERGER, W. & WIESNAGROTZKI, S. (1988) Low incidence of peripheral blood haematopoietic stem cells in patients with anorexia nervosa. *Clinical Nutrition*, **7,** 113–115.

GEISSLER, K., HINTERBERGER, W., BETTELHEIM, P. *et al* (1986) Myeloid progenitor cells in the peripheral blood of patients with hairy cell leukemia and other "lymphoproliferative" disorders. *Leukemia Research*, **10,** 677–681.

SIR: Touyz *et al*'s paper (*Journal*, August 1988, **153,** 248–250) on anorexia nervosa developing in a blind woman refers to absence of hallucinatory or other psychotic thought processes and no abnormalities on testing cognition. This statement seems to be contradicted by perception of this woman of her wasted biceps muscle, saying, "I am worried about this fat". This kind of perceptual disturbance is not uncommon in anorexia nervosa, and I think that it reflects psychotic phenomena. Furthermore, I would stress that hallucinatory phenomena belong to the level of perception, not to the level of thought processes as Dr Touyz *et al* suggest.

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SIR: In their study on body shape dissatisfaction in schoolchildren, Salmons *et al* (*Journal*, July 1988, **153,** Suppl. 2, 27–31) commented on the finding of concern about undersized thighs in boys over 16, significantly more so than in girls of the same age (although the majority of boys of this age in their sample were satisfied with the thigh size). From their results it would appear that in the same group of boys there was also a concern about undersized stomach, significantly more so than in the girls. It is not clear specifically what their concern was, but presumably in boys the concern would be about undersized muscles. We have recently been following up a group of early onset anorexic children and have found a 16-year-old boy fully recovered on most of the usual indices of outcome who was, it seemed to us, preoccupied with body building and concerned that his thigh and leg muscles were too small. Perhaps, given the findings of Salmons *et al*, this preoccupation is within normal limits, but our subject also scored strongly on the self-deprecation item of the PSE. We would postulate that in recovering anorexic males whose self-esteem is still fragile, a need to have well-developed musculature and act on this need is a reflection of the ongoing struggle to resolve the anorexic experience.

It would be interesting if Salmons *et al*'s findings of some boys' concern about undersized thighs and stomachs could be replicated and then further clarified, (a) as to whether it is specifically musculature which is considered too small, and (b) as to whether they feel so strongly about their concern as to take steps to remedy the perceived defect. This would help gauge the normality or otherwise of the

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