older patients in the community are not likely to be improved by 'term'-inally induced therapeutic nihilism. If we are to avoid such confusion, we should heed the words of another Lewis Carroll character:

> " 'When I use a word,' Humpty Dumpty said in a rather scornful tone, 'it means just what I choose it to mean – neither more nor less.' "

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Anorexia nervosa: treatment with olanzapine

Anorexia nervosa is a multiply determined disorder of unknown aetiology. Restriction of food intake culminating in profound emaciation is considered to be pathognomic (Kaye *et al*, 1999). One of the diagnostic criteria for anorexia nervosa is body image disturbance that is characterised by feeling and judging oneself to be fat and by claiming to 'see' oneself as fat despite being underweight. The bizarre body self-image in anorexia nervosa can be regarded as a psychotic way of thinking. We tried to treat anorexia nervosa as a psychotic disorder with olanzapine. Hansen (1999) has previously reported a case of treatment of anorexia nervosa with olanzapine; here we report three further cases.

A 50-year-old woman with anorexia nervosa since she was 17 years old applied for treatment in our clinic with an initial weight of 34 kg and height of 157 cm. By that time she had already been treated with antidepressants, traditional neuroleptics and psychotherapy, without success. She was commenced on olanzapine, 5 mg daily. The first 2 months were difficult because she had to accept the side-effects of hunger and weight gain. After 2 months she stopped talking about being overweight; according to her drawings, her body self-image changed towards normality. Now she weighs 53 kg and feels herself completely healthy. She still receives 5 mg olanzapine daily.

A 30-year-old woman with anorexia nervosa since she was 18 years old additionally developed bulimia nervosa 5 years before presentation to our clinic. She was treated traditionally for many years without significant positive results. When she applied to our clinic her weight was 44 kg, height 167 cm. Mental state examination revealed severe body self-image disturbance. We commenced her on 5 mg olanzapine daily. In 9 months her weight was 53 kg, and she recovered from symptoms of both anorexia nervosa and bulimia nervosa. According to her drawings her body self-image changed from a fat little girl to an attractive grown-up woman. She still receives 5 mg olanzapine daily.

A 34-year-old woman had been suffering from anorexia nervosa and borderline personality disorder since puberty. When she came to our clinic her weight was 60 kg, height 180 cm. She complained of confusion, having too many thoughts in her head at one time. She had a seriously disturbed body image – in her drawings she looked like a little fat girl without hands and secondary sexual signs. She was started on olanzapine 5 mg, and after 2 months her body image has improved (she now sees herself as a grown-up woman) and she feels healthy.

In all three cases olanzapine was well tolerated. Our patients restored their body weight and appetite as well as their body self-image. They now think of themselves as normal, mature adults. The problem is to convince the patient to start and to continue with olanzapine therapy within the first 2 months, because it takes a few weeks before a full antipsychotic effect is achieved. We think that further investigations in this area should take place.

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Nicotine reduction: effectiveness of bupropion

Hayford *et al* (1999) and others have found sustained-release bupropion useful as part of nicotine reduction treatment programmes. However, our clinical experience suggested the primary benefit of sustained-release bupropion (300 mg/day) occurred within the first month of treatment and the recommended second month of medication was probably not helpful.

We evaluated the treatment progress of 74 (30 one-month, 44 two-month) research volunteers (further details available from the first author upon request). Treatment condition assignment was random but one-month patients had the option of an additional two months of medication if they were not successful at quitting at immediate follow-up, thus decreasing the number of one-month participants for this study. Volunteers had a mean age of 56 and were primarily male (91%), cigarette smokers (96%) and White (92%). One- and two-month groups did not differ significantly on a number of treatment motivation measures, demographic variables and self-reported health variables.

All patients signed consent forms and received the same behavioural treatment information in the first session. All were also instructed to return to a second meeting at which time their progress was evaluated and they received more behavioural strategy information and their assigned sustained-release bupropion. Participants were followed (a) as soon as convenient after nicotine quit date, (b) three-months after immediate follow-up, and (c) six-months after initial group meeting. About 80% of potential subjects volunteered for this project and follow-up return rate averaged 81%.

Use of one or two months of bupropion did not significantly affect self-reported quit rates at immediate, three-month or six-month follow-up periods. Self-reports of decreased nicotine intake among patients who did not quit entirely also did not differ between one- and two-month groups at immediate, three-month, or six-month follow-up periods. Only weight gain was associated with six-month treatment success. Participants who were successful reported more weight gain than those who were not. However, one- or two-month dosing schedule was not significantly associated with reported weight changes. Quitting success at six months was not related to age, gender, tobacco type, income category, race, combat exposure, years' service, side-effect ratings, health problem ratings concerning breathing, heart, general medical, psychiatric, or substance dependence areas, religious behaviour, immediate weight gain, or initial self-ratings of treatment programme helpfulness/motivation/self-control/completion.

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