thesis of the essays is contained in the preface; "Philosophical clarity ... arises when we see that behind every scientific construction there lies the inexplicable". He suggests that philosophy "prevents us from being dazzled by what we know".

In an essay on 'Science and psychology' he says; "in psychology the real problems that confront us, and the experimental methods which are being increasingly elaborated, pass each other by". Elsewhere, while commending studying logic, ethics, and metaphysics along with psychology, he points out that any study of psychology must quickly lead to puzzlement about "the self", which immediately brings the student into the realms of logic. Such considerations lead him to say that whatever advances are made in psychiatry, it should not be forgotten that there is "a mystery about mental ill-health which makes it different from any disease of the body".

Early on, having quoted Claude Bernard, who once wrote that he did not "reject the use of statistics in medicine," but that he condemned "not trying to get beyond them", Drury suggests we bear these words in mind, "next time you find one more mass of statistical information in the *British Journal of Psychiatry*." Hence, "I sometimes wish it was a law that every scientific paper had to be allowed to mature for ten years in bond, like good whisky, before being allowed in print."

Drury was adamantly not against scientific medicine nor "biological" forms of psychiatric treatment – indeed, this was his life's work. Yet he believed that "good physical health, good mental health are not the absolute good for man."

Drury, M. O'C. (1973) *The Danger of Words*. London: Routledge and Kegan Paul.

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Blood-letting in bulimia nervosa

Sir: Parkin & Eagles (*Journal*, February 1993, **162**, 246–248) concluded that the blood-letting described in the three case histories was a function of the patients' bulimia nervosa.

On reviewing the clinical data presented, it seems that in each case an additional diagnosis of borderline personality disorder could also have been made. The comorbidity of the two conditions has been noted in the literature (Mitchell *et al*, 1991), and in my experience. Furthermore, where there are comorbid conditions in terms of an eating disorder and personality disorder, the overall severity of psychopathology tends to be increased (Yates *et al*, 1989).

There may, in fact, be no causal link between bulimia nervosa and blood-letting *per se*, as suggested by the authors. In this regard, I would like to suggest that the blood-letting could be viewed as an indicator of severity of psychopathology in these patients. I do acknowledge, however, that such behaviour should be considered in anaemic bulimic patients with medical backgrounds.

Mitchell, J. E., Specker, S. M. & de Zwaan, M. (1991) Comorbidity and medical complications of bulimia nervosa. *Journal of Clinical Psychiatry*, **52**, 13–20.

Yates, W. R., Sielni, B. & Bowers, W. A. (1989) Clinical correlates of personality disorder in bulimia nervosa. *International Journal of Eating Disorders*, **8**, 473–477.

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Neglect of anger in Western psychiatry

Sir: Having read Lee's letter (*Journal*, December 1992, **161**, 864) commenting on the neglect of anger in Western psychiatry, and the seven emotions from the *Huang-ti-Nei-ching*, I cannot help but write to make some corrections on these issues. Firstly, most American psychiatric textbooks do include anger as an important area for consideration in the context of psychopathology (e.g. medea syndrome), diagnosis (e.g. impulse control disorders), management, and treatment. In clinical practice, anger and aggression are almost a *sine qua non* of psychodynamic psychotherapy. I would like to know if Dr Lee has other sources to substantiate his opinion that there is a neglect of anger in Western psychiatry. It would be of great interest to know what school of thought or system he uses to deal with anger in his psychiatric patients in Hong Kong. Is there an Oriental or Eastern psychiatry in Hong Kong?

Secondly, Dr Lee's source of quotation and understanding of the seven emotions invite correction and academic discourse. The word 'contemplation' could hardly be regarded as a psychological term to depict an emotion or a feeling. The eighth edition of the Concise Oxford dictionary's definition of the word 'contemplate' is "survey with the eyes or in the mind; regard as possible", and contemplation means a meditative state also. Contemplation is meant as a

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translation for the Chinese word *si*. Even *si* has no connotation of any emotional state at all in the Chinese language. Interestingly, Kaptchuk (1983) used the word 'pensiveness' for the word *si*, which does carry an emotional meaning of melancholy and sadness. How he came to use pensiveness to translate *si* is interesting indeed. In the *Dictionary of Traditional Chinese Medicine* (Beijing Medical College, 1984), *si* is translated into the word 'anxiety'. Furthermore, not all of the seven emotions were brought into clinical use.

Before the sinologists can translate the Chinese words correctly, and the lexicologists interpret the exact meaning of these words, we are just a group of armchair transcultural psychiatrists studying tautology, philology, analogy, and end up with pleonastic epistemology.

BEIJING MEDICAL COLLEGE (1984) *Dictionary of Traditional Chinese Medicine*. Hong Kong: The Commercial Press.
KAPTCHUK, T. J. (1983) *Chinese Medicine*, p. 129. London: Rider.

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The ethics of resource allocation

SIR: A point not mentioned by Dr Healy (*Journal*, January 1993, **162**, 23–29) is the enormous savings made every time a long-stay patient is discharged subsequent to clozapine introduction. But there is another matter. Compared with the money spent on computer systems, and information technology departments to service them, the money spent on clozapine is chicken-feed. Has any attempt been made to evaluate the benefit to patients arising from the introduction of so much technology?

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Personality disorder and self-report questionnaire

SIR: Coid (*Journal*, February 1993, **162**, 265) asserted that Dowson (*Journal*, September 1992, **161**, 344–352) had provided evidence that the assessment of personality disorder by self-report instruments is invalid. We have tested a computerised version of Dowson's modified Personality Diagnostic Questionnaire (PDQ) on a group of 20 patients, and clinically assessed each of the positive responses against the DSM–III–R criteria which they are intended to assess. Schizotypal and borderline personality disorders, and many traits in the other categories were significantly overdiagnosed.

A subsequent systematic comparison of the PDQ (modified) with the DSM–III–R criteria indicated, in disagreement with Dowson, that many of the items have poor face validity. Several items have confusing double negatives, and many produce false positive responses. However, the face validity of the clinician-administered Structured Clinical Interview Schedule (SCID-II) employed by Coid appears high, and this difference could explain the discrepancy. I would therefore question Coid's rather sweeping conclusions that self-report instruments "should not be employed in the future". We are improving the construct validity of our computerised version of the PDQ by rewording many of the items through a process of trial and error. As a self-report assessment instrument of personality, it is becoming clinically useful.

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Computerised assessment of depression in the medically ill

SIR: Meakin (*Journal*, February 1992, **160**, 212–216) states that "the main rival of paper and pencil tests at present is the brief standardised interview", and "there are few other options available as screening tests". We would like to point out another available option overlooked: computer-administered assessment of depression. We recently developed a computer-administered version of the Hamilton Depression Rating Scale (Hamilton, 1960; Kobak *et al*, 1990). Correlations with the clinician-administered version of the scale were high (0.96), and the mean score difference was not significant. The scale showed high internal consistency reliability (0.91). Using a cut-off score of 17, the computer correctly identified 94% of patients with major depression, and did not incorrectly identify any control subjects as having an affective disorder.

The need for identification and treatment of depression in medically ill, primary care patients is apparent. The National Institute of Mental Health multi-site Epidemiologic Catchment Area study found that while only 31% of patients identified with an affective disorder had sought help in the previous six months, 45% of these patients had sought treatment from their primary health care provider for a

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