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Correspondence

Editor: Ian Pullen

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Psychiatry is more than a science

SIR: Professor Cawley's paper (*Journal*, February 1993, **162**, 154–160) is interesting in very many respects. I am surprised, however, at the paper's tendency to present obvious notions, as if Professor Cawley had just come up with totally original concepts.

Professor Cawley "insists" in his paper that philosophy is the missing dimension in psychiatry. "Among the humanities", he states, "the one subject that may prove to have relevance to appropriate theory and competent practice is philosophy". In other words, Professor Cawley believes that philosophy – and I assume he means Western philosophy – will not only provide answers to our many perplexing questions, but also will enable us to practise psychiatry more competently! This, of course, is manifestly misguided, for it reveals a lack of apprehension of the limits of philosophical knowledge.

According to Bertrand Russell (1912):

> "Philosophy is to be studied, not for the sake of any definite answers to its questions, since no definite answers can, as a rule, be known to be true, but rather for the sake of the questions themselves; because these questions enlarge our conception of what is possible, enrich our intellectual imagination, and diminish the dogmatic assurance which closes the mind against speculation; but above all because, through the greatness of the universe which philosophy contemplates, the mind also is rendered great, and becomes capable of that union with the universe which constitutes its highest good."

The value of philosophy, therefore, lies in the profound beneficial effects, on our inner life, of speculation and contemplation.

We should certainly study philosophy, but not with the hope that it will answer our questions about mental illness, or make us more competent psychiatrists. We should study it because it will "enlarge our conception of what is possible", for this is of crucial importance to the success of our endeavours. The greatest problem that we face, as scientists, is that we have always operated from the perspective of preconceived notions, picking and choosing what to accept as true and what to reject as false, even when we secretly suspect that our viewpoints are mistaken. Our lack of humility prevents us from admitting our ignorance. Given the advantage of an open mind, we will know what is true and what is not. Philosophy will help us overcome our prejudice against the truths of life.

I commend the efforts of our College's Philosophy Interest Group, and would like to encourage its membership to balance the speculative intellectualisation which is the essence of philosophy, with equal interest in psychical (i.e. parapsychological) research.

RUSSELL, B. (1912) *The Problems of Philosophy*. Oxford: Oxford University Press.

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SIR: I support Professor Cawley's hypothesis that; "Psychiatry depends on science and considerably more besides" (*Journal*, February 1993, **162**, 154–160). He asks; "Is it correct to say that there is a substantial non-science component in understanding and treating mental illness?" A work published 20 years ago answers the question in the affirmative, and should be a prescribed philosophical text for trainee psychiatrists.

Maurice O'Connor Drury was a psychiatrist at St Patrick's Hospital, Dublin, from 1947 until his death as senior consultant in 1976. He was a friend and pupil of the philosopher Wittgenstein, and in 1973 he published a collection of essays to some extent inspired by him (Drury, 1973). Perhaps the main

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 co-morbid 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