by Adshead *et al* (*Journal*, December 1988, **153**, 821–823) and put pen to paper. While paradoxical strategies are useful and effective in the treatment of many problems from thumbsucking to schizophrenia (Seltzer, 1986), either as an adjunct to other treatments or on its own, unscrupulous or erroneous application may lead to disastrous consequences for the patient, the therapist, and their therapeutic relationship. Adshead *et al* would see themselves as lucky at just feeling uncomfortable to "maintain a firm sceptical stance" and to face the disruption of therapeutic relationship if they knew that some physicians in ancient China (as early as 280 BC) even got killed for treating (successfully!) their emperors with paradoxical strategies (Wang, 1986).

As a non-specific method, paradoxical strategies can be applied to any number of neurotic and psychotic conditions irrespective of the aetiological basis. It acts through three main mechanisms: (a) breaking the vicious cycle of symptom-formation by reducing the performance anxiety, e.g. in the treatment of insomnia and sexual dysfunction; (b) eliminating resistance against therapeutic changes by putting the patient into a therapeutic double-bind no-lose situation so that the patient is held responsible for the control of symptom and the change, e.g. paradox used in hypnosis (Ericksonian) and paradoxical psychotherapy; (c) providing a new frame of reference to look at the pathological context, distancing the patient from the symptom by the use of humour, ridicule, sarcasm, and absurdity. Paradoxical intervention is appealing to the person's integrity and depends on the therapist's accurate and intuitive understanding of the psychopathology and assessment of the patient's resources. One of the prerequisites of paradoxical intervention is the intense relationship between the therapist and the patient rather than the content of the intervention (Seltzer, 1986).

Dr Adshead *et al*'s case report serves well to demonstrate what can go wrong with the use of paradoxical intervention. Instead of putting the patient into a therapeutic double-bind, no-lose situation, Dr Adshead has trapped her into a pathogenic double-bind, damned-if-you-do-it-and-damned-if-you-do-not position by the anti-exposure treatment of "Do not practice exposure". She was doomed either to comply with the psychiatrist's words and refrain from practising exposure, which was effective in the beginning, and probably stay on with her symptoms for another 10 years, or to disrupt the therapeutic alliance and mobilise other resourses to help herself. Luckily this woman had enough integrity to seek help from the nurse therapist (angel-delegate) and another psychiatrist and finally gained improvement. As for the psychiatrists (the devil-delegate in this case), maybe they can escape from their self-inflicted no-win predicament by changing their anti-exposure treatment to "Do not practice exposure if you don't really want to change". Whatever the patient's choice or outcome turns out to be, the psychiatrists will not be confronted with hostility and ungratefulness from the patient.

Another comment on the case report is that despite the prominent depressive features and the possibility of an underlying affective illness giving rise to the obsessive/compulsive symptoms, and despite the interesting coincidence of a relapse of symptoms at the time of returning home on discharge or weekend leave, with the couple refusing marital therapy and denying any relationship problem while frequent arguments could be seen when the husband was involved in the treatment scheme, the authors were ascribing the failure of treatment to the patient's non-compliance instead of looking into other psychosocial factors relevant to the perpetuation of the symptoms.

Finally, the main therapeutic techniques responsible for the favourable outcome in this case seem to be the exposure and response prevention (or maybe the 'support' by the other psychiatrist?) instead of the paradoxical intervention. Giving unjustified credit to the paradoxical intervention may be doing more harm than good to our understanding and mastery of this psychotherapeutic technique. Cautious evaluation and clear rationale may be the best guiding principles for the application of this effective and flexible armament in psychotherapy.

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Psychiatric despotism?

SIR: Returning from Hungary, that most oriental and Asiatic of European countries (in every locality there is a thoroughfare named in honour of Attila), I find two Hungarians, Imre Karacs in the *Sunday Times* and Thomas Szasz in the *Journal* (June 1989, **154**, 864–869), using the terms "Asiatic despotism" and "oriental despotism" respectively, to describe that of which they do not approve.

Is this Hungarian self-hatred or racism? Szasz would have us believe that occidental despotism is made more acceptable by what he calls Judeo-Christianity. But Moses, Paul, and Jesus and all his disciples were worthy oriental gentlemen!

Stalin, Hitler, Mussolini, Franco and Rudolf Hoess (Commandant at Auschwitz) were all Christians. Not one was excommunicated. Two, Stalin and Hoess, studied at religious seminaries and had considered taking Holy Orders. The only oriental to compare with this European class in recent times is Pol Pot.

I hope that the Editor will guard against any hint of racism creeping into the *Journal*.

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Anorexia nervosa and Chinese food

SIR: From my personal experience both here in Hong Kong and in the UK, I agree with the paper by Lee *et al* (*Journal*, May 1989, **154**, 683–688) that there are far fewer cases of anorexia nervosa in the Chinese.

However, I think the exact reason why this is so is still far from clear. Dr Lee *et al* cited three cases and concluded that socio-cultural factors are the most important. Three years ago, I arrived at the same conclusion, although by a common-sense approach from the discussion I had with my tutor in the Maudsley hospital. Then, as now, I think that at least three other factors are also important. The first is the immense importance attached to food and eating in the Chinese culture. There is a Chinese proverb saying that "of all things in life, food is the most important". Indeed, to the Chinese, food is a bit like God, paramount and ubiquitous. Secondly, Chinese food is delicious. I think it is simply so delicious that one can hardly resist eating it. Thirdly, it is the Chinese custom to eat meals with their family. Everyone is expected to eat a certain amount, and it is quite difficult to go unnoticed if one departs from one's usual quantity. There is thus always a social pressure from the family for people to conform in order to avoid undue concern to other family members.

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Oculogyric crises and schizophrenia

SIR: I found the paper by Chiu (*Journal*, July 1989, **155**, 110–113) very interesting. I would like to report a further case.

Case report: Miss M had a long-standing schizophrenic illness. Eight years ago, at the age of 31, she was admitted 4 weeks after a reduction in dose of depot zuclopenthixol followed by increased frequency of auditory hallucinosis. This consisted of multiple voices in the second or third person. The episodes would last from 1 to 24 hours. Unless very mild, they were associated with oculogyric crisis associated with dysphoria. A typical episode would start with auditory hallucinosis, increasing in severity and becoming associated with oculogyric crisis, and finish as auditory hallucinosis alone, dying away. During the oculogyric crisis, the eyes were deviated up or up and to the right. Pursuit eye movements laterally and downwards were possible but impersistent, and associated with flickering of the eyelids. Bringing the eyes down to the normal position voluntarily improved the auditory hallucinosis. Convergence was not possible. The right pupil was minimally larger than the left, and reacted more sluggishly to light. The only other abnormality on physical examination was mild postural hypotension. As well as zuclopenthixol, she was also being treated with chlorpromazine and an anticholinergic. Some further anticholinergic medication parenterally produced temporary improvement. An increased dose of chlorpromazine produced complete disappearance of the oculogyric crisis over 12 hours and of the auditory hallucinosis over 24 hours. She continued to show de Clérambault's syndrome, believing that the Prince of Wales had intentions towards her despite his impending marriage.

The cases reported suggest that the association of oculogyric crisis and auditory hallucinosis is not fortuitous. The relative contribution of disease and drug-induced disorder to the phenomenon is difficult to elucidate now, because the use of neuroleptic medication is nearly universal in schizophrenic illnesses. Strong conjugate upward rotation of the eyeballs, lasting for hours at a stretch with constant rapid flickering of the eyelids, was reported in schizophrenia in the pre-neuroleptic era at the time when oculogyric crisis was first being described in epidemic encephalitis (Farran-Ridge, 1926). Thus oculogyric crises may have been a feature of schizophrenic illness before the introduction of neuroleptic medication. They may have been given other descriptions, such as 'mannerisms' (Rogers, 1985). If they were part of the disease process in some cases, this would make an association with other features of the disease process such as auditory hallucinosis more understandable. Medication obviously makes a significant contribution to the expression of both dystonic eye movements and hallucinosis, as in this case. The relative contribution of specific neurotransmitter disturbances to the oculogyric crisis is difficult to establish. Increase in either anticholinergic or anti-dopaminergic medication had a beneficial effect in the case reported.

Auditory hallucinosis in association with oculogyric crisis has only rarely been described, and then