

preoccupations and actions of recovering anorexic males.

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Photography for Anorexia Nervosa

SIR: Body image problems have long been recognised as a major factor in anorexia nervosa (Bruch, 1962). The inability to perceive the degree of weight loss or emaciation in these patients has made treatment difficult, as patients who cannot see themselves as underweight are less likely to agree to hospital admission and treatment. We report the case of an anorexic patient who found that serial photographs of her frame provided sufficient evidence of emaciation to convince her to continue with treatment. This idea stemmed primarily from an observation of the attitudes of people to their appearance in photographs, and this was used in a particularly resistant case of anorexia to gauge her reaction to a photographic image.

Case report: Ms F., a 25-year-old lady, had an 11-year history of anorexia and amenorrhoea, and repeatedly refused admission for treatment. She was finally admitted when her weight fell to 30 kg, and family pressures prevailed. Following admission, Ms F. continuously asserted that she was fat, had an enormous stomach and legs, and was being treated inappropriately. Photographs of the patient were taken, using both front and side views, and these were presented to her. The effect was quite dramatic. Ms F. was appalled by her appearance in the photographs, and she burst into tears, immediately resolving to improve her personal appearance at whatever cost.

Prior to the photographs being taken the patient was going to leave hospital, but as a result of her exposure to pictures of her body she became very involved in her own treatment, and gained weight quite rapidly over the following weeks. She agreed to the setting of a target weight of 40 kg, and was totally compliant with treatment. She actually requested that further photographs be taken prior to discharge, and the improvement she saw has strengthened her resolve still further. She has been discharged from our unit in good physical shape, and follow-up reveals that she is maintaining her weight. She carries her photographs to the out-patients and is pleased with her own progress.

We suggest that the use of serial photographs of anorexic patients may well have a role in their treatment. Although previous studies using distortion techniques have tended to disprove overestimation

of body size (Garner *et al*, 1976; Touyz *et al*, 1984), our initial impression is that photographs draw attention to body shape, and not to size *per se*. We plan to use this approach in a series of patients, and thereafter to assess the usefulness of the technique.

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Supportive Psychotherapy

SIR: We were pleased to see the article by Holmes (*Journal*, June 1988, **152**, 824–829). He asserted that supportive analytical therapy is much practiced but little described. He included two cases of successful supportive therapy with two very impaired patients, and stated that supportive therapy is an “attenuated analytical psychotherapy” that may be therapeutically effective and cost-effective in dealing with such patients.

We disagree with Dr Holmes’ use of the word ‘attenuated’. Supportive therapy is not a weak or diluted treatment that consists primarily of being humane to patients. It is instead an emphasis on active, but non-interpretive, interventions based on therapists’ assessment of ego strength, ego structure, transference, and countertransference.

Two books have been written recently that describe supportive therapy well (Werman, 1984; Weiner, 1986). They place supportive analytical therapy on an equal footing with analytical therapy in terms of it being specifically indicated in a number of situations in which analytical therapy might also be considered, and in cases in which it is specifically indicated instead of analytical therapy. Many persons are suitable for supportive analytical therapy who are relatively emotionally healthy, but who can not or will not co-operate with the demands of analytical therapy. For example, we have suggested elsewhere that cognitive style affects the decision of what kind of therapy is potentially most useful (Weiner & Crowder, 1986). Following an extensive cognitive evaluation of patients seen at a large public hospital, we concluded that a supportive therapy was

the indicated treatment in our clinic, a population in which the average full scale IQ is 83 and the average patient cannot grasp the simile and metaphor needed to operate in an analytical mode (Weiner & Lovitt, 1984).

We commend Dr Holmes for speaking out on behalf of supportive psychotherapy. We assert that it is a full sibling of analytical therapy and not an impoverished distant relative. A dynamic understanding of patients is just as important in supportive therapy. Therapists use that understanding to help foster adequate coping by direct means, through various teaching techniques, modelling and advice-giving. These are not non-specific aspects of psychotherapy: they have their specific indications and contraindications. As noted above, supportive therapists must also be cognisant of transference and the other manifestations of unconscious mental process; not to bring them to the patients' consciousness, but to use that awareness to shape the therapeutic interaction for the patient's greatest benefit.

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Calcium and Extrapyrimal symptoms

SIR: It has been suggested that serum calcium ion levels may predict both the onset and occurrence of extrapyramidal symptoms (EPS) (Alexander *et al.*, 1979; El-Defrawi & Craig, 1984) and more recently Fernando & Manchanda (*Journal*, May 1988, **152**, 722–723) reported on their successful treatment of EPS with calcium in two patients. We wish to report the findings of an investigation into the relationship between severity of EPS and serum calcium levels in a population of patients on neuroleptic medication.

We studied all patients admitted into an acute psychiatric ward over a six-month period, who in addition had been on a neuroleptic agent for at least

three weeks. We also included patients attending a depot clinic at a day centre serving the same geographical area as the acute psychiatric ward. All subjects were rated on the Simpson-Angus Neurological Rating Score (Simpson & Angus, 1970) and blood was obtained for calcium estimation at the same time.

Forty-nine subjects were studied, comprising 21 females and 28 males. The mean age was 44.0 years (s.d. = 16.0 years). The mean total duration of neuroleptic use was 81.79 months (s.d. = 66.40 months) and mean current duration of neuroleptic use 28.64 months (s.d. = 43.82 months). The mean current daily neuroleptic dose (chlorpromazine equivalent) was 338.29 mg (s.d. = 512.31 mg). Twenty patients were on both neuroleptic and anti-cholinergic agents. Thirty-six (73.5%) patients had the diagnosis of schizophrenia. The Kendall rank correlation coefficient between calcium levels and scores on the Simpson-Angus scale was -0.10 ($P=0.28$).

In this study, no significant relationship between calcium levels and severity of EPS was demonstrated. It may well be that no simple direct relationship exists. El-Defrawi & Craig (1984) suggested that it was the relative changes in the levels of calcium in the individual patient that predicted EPS, i.e. that decreasing calcium levels in the presence of neuroleptics predicted onset of EPS. There is an obvious need for further work to clarify their report.

The occurrence of EPS depends, among other things, on the pharmacological structure and dosage of administered neuroleptics and also on the concomitant use of anticholinergic agents. In addition, age, sex, and individual predisposition are all factors of importance. Thus these factors would have to be accounted for in any future studies.

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