Obsessive-Compulsive Rituals

SIR: Marks *et al* (*Journal*, April 1988, **152,** 522–534) have recently reported on the effects of clomipramine and various modalities of behavioural therapy in a double-blind trial involving 49 ritualising obsessive-compulsive patients. We feel that the review of literature and the interpretation of findings provided by the authors may not be fully correct.

The authors suggest that no studies support the therapeutic superiority of clomipramine in comparison with other tricyclic drugs in treating obsessive-compulsive disorder (OCD). This statement overlooks a recent comparative study by Zohar & Insel (1987). A counterbalanced within-subjects crossover comparison of clomipramine and desipramine found clomipramine to be therapeutically superior to desipramine in treating OCD. We feel that several further comments are justified regarding the methods and conclusions of the study. Findings of clomipramine v. placebo are described in the following manner: "... 26 weeks of clomipramine compared with placebo yielded limited and transient benefit in the first eight weeks only". It is only fair to point out that any effects beyond week 8 are confounded by virtually asymptotic performance of the clomipramine and placebo groups, and a concomitant change in methods. The interested reader is referred to the paper of Kasvikis & Marks (1988), which discusses this trial's methodology further, and notes that therapist-assisted exposure was added following week 8.

Thus, only the initial 8 weeks of this trial offer a relatively unbiased estimate of the therapeutic effect of clomipramine v. placebo. Indeed, inspection of Table 2 and Fig. 2 of the study in fact indicates a significant therapeutic effect of clomipramine in comparison with placebo for the period in question, with respect to target rituals time, global rituals time, target rituals discomfort, level of depression, and social leisure adjustment. As noted, findings do not appear to be transient, as witnessed by the essentially flat slopes of all functions graphed in Fig. 2 beyond week 8. Thus, it remains somewhat unclear what would be adequate in the authors' minds to consider a drug v. placebo difference as clinically significant or durable.

The authors describe clomipramine as having "a limited adjuvant role". It is noteworthy that another aspect of the design of the initial 8-week phase of this study may have masked any more direct role. During the initial period of assessment (weeks 1–8) all patients were preselected to ensure that they would be responsive to behavioural intervention, and all patients except those in group Cé (i.e. the antiexposure group) were required to undergo up to 3 hours of self-exposure therapy each day. It is unlikely that any other treatment would have much effect, or for that matter could have much effect, given this magnitude of exposure.

The method used for the trial makes it unfit to hierarchise the therapeutic factors. The claim that self-exposure comes first, followed by clomipramine and by therapist-aided exposure is not warranted, as the design was indeed set up as a comparative study of the adjuvants to exposure. Thus, it merely shows that clomipramine is the best ancillary therapeutic factor once the decision was made to use exposure as the axis of the treatment.

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Depersonalisation and Self-Perception

SIR: I share with Dr O'Shea (*Journal*, November 1988, **153,** 709) the belief handed down by Mayer-Gross (1935) that depersonalisation is attributable to a "preformed functional response of the brain". My argument is teleological. Why does this response exist? What is its purpose? The answer lies, I believe, in its occurrence in life-threatening situations (Noyes & Kletti, 1977), in which it probably has significant survival value. The victims of such situations experience emotional, cognitive, and somatic detachment; a dissociation between the observing and participating 'self'. Thus, they are able to take action that enhances their chance of survival at a time when they might be expected to be paralysed by fear. While this form of depersonalisation appears to be beneficial, this experience also occurs in otherwise normal subjects under certain conditions when it is innocuous or at most a minor inconvenience. The question of the relationship between these benign manifestations and the disabling depersonalisation experienced by psychiatric patients I cannot presume to answer, except at a descriptive level. The difference is that

psychiatric patients experience severe dysphoria and are preoccupied with the experience of experiencing depersonalisation.

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Globus Hystericus

SIR: I suppose that if any group of psychiatrists was asked to define globus hystericus, the majority would agree with Wilson *et al* (*Journal*, September 1988, **153**, 336–339) and say that it is the sensation of a lump in the throat causing difficulty in swallowing. Modern textbooks of psychiatry, e.g. Gelder *et al* (1983), confirm this usage. However, before this venerable term sinks irrecoverably into misuse I would recall its origin, since a great part of the history of concepts of psychiatric disorder is bound up with it. Those who would recall the history in more detail should read the brilliant account by Veith (1965).

The origin of the concept of globus is the sensation of a swelling rising from the epigastrium toward the throat, accompanied by a sense of churning and fear; this is the epigastric aura of the temporal lobe fit. In ancient times, predating Greek medicine, this was attributed to the uterus taking leave of its moorings in the pelvis and led to the concept of the 'wandering womb' and to the term 'hysteria' itself. The idea that unsatisfied sexual urge is related to emotional disorder, especially in women, runs through the whole history of psychological medicine. Shakespeare expressed it in *King Lear*:

> O, how this mother swells up toward my heart
> *Hysterica passio*, down thou climbing sorrow,
> Thy element's below.

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The Mind-Body Problem

SIR: Benjamin (*Journal*, July 1988, **153**, 123–124) contends that the 'mind-body problem' is essentially a philosophical one. He also acknowledges the influence of philosophy on everyday psychiatric theory and practice. His argument for a place for philosophy in the medical curriculum deserves support. He correctly points out that most psychiatrists use philosophical arguments to justify their approach without fully working out the consequences for their clinical and research practice.

I take issue with Dr Benjamin, however, on a point of philosophy. The "hard-line behaviourist or materialist" who rejects the proposition that the human mind is a spiritual thing would not necessarily "discover that there is a great deal which he must either ignore or violently corrupt". There is room for a materialist approach which recognises the dynamic nature of matter and the myriad processes of interaction which occur within it. It is quite clear that this philosophy cannot, at this moment, explain all of the complexities of the 'mind-body problem'. The importance of this dynamic or dialectical materialism is that it provides a philosophical framework for the scientific investigation of the problem.

The philosophy of dialectical materialism can be explained simply as follows. The human mind and spirit cannot exist without a human brain. That individual human mind and spirit together cease to exist when the material of that human brain ceases to exist in the particular form which constitutes a human brain. Other human beings may continue to recognise that individual's mind and spirit as perceived by their own human brain if they have experienced direct or even indirect interaction with that individual.

Thus dialectical materialism does not recognise a dichotomy between mind and body. It requires of theories purporting to explain the complexity of the human mind to show that they are based on material facts and that the conclusions offered can be tested. It accepts that our present level of knowledge and current methods of investigation are not yet capable of explaining everything about the human mind. It poses the question, how can we explain this or that phenomenon? It is thus a spur to research. This philosophical approach allows room for all clinical findings, not just those that fit a rigid conceptual scheme as suggested by Dr Benjamin.

Dialectical materialism was the philosophical method pioneered by Karl Marx and Frederick Engels to investigate the economic, social, and political relations of man in a scientific manner. It is also the, often unspoken, philosophy that underscores scientific investigation in any field.