

A Place for Bromides?

From Stephen Howard (Norfolk)

SIR—Nearly 30 years ago I was confronted with a problem of a man addicted to Sodium Amylbarbitone. He was taking 18 grains a day, and any attempt at withdrawing the drug slowly produced acute physical and psychological problems. Ultimately I filled him with large doses of potassium bromide, making him somewhat drowsy, but enabling him to discontinue the sodium amylbarbitone. When the bromide was stopped, there was no recurrence of the barbiturate withdrawal symptoms.

I have searched the *Index Medicus* for any reference to the use of bromides in the treatment of drug dependence, but have found none. I wonder, therefore, whether my experience (from an age when drug dependence was not widespread) might not be significant. I have wanted to pass it on, but (being retired, and out of medical circles), have not known to whom. In retrospect, I feel that bromides, when used with caution, were of more use and safer than many of the more recently introduced alternatives.

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Exercise Dependence

From Paul-Allan Dewsnap (West Kent Postgraduate Medical Centre)

SIR—I read with interest the well referenced review by Dr de Coverley Veale¹ formulating an unhealthy commitment to physical activity in terms of 'exercise dependence'. The model is both plausible and elegant, but can nonetheless be criticized. Having made the point that it is necessary to distinguish between a primary form of exercise dependence and that which is secondary to an eating disorder, he then fails to show convincingly that such a distinction is possible.

Acknowledging the considerable overlap in terms of both phenomenology and the associated endocrinopathy, he goes on to look at the distinction in terms of psychopathology, but then employs some rather circular reasoning to make his point. For example, he states that a study on the eating attitudes of the primary exercise dependent has not been done, then confidently predicts that no abnor-

mality would be found since, according to his model, the discovery of abnormal attitudes would exclude the diagnosis of primary exercise dependence.

He does cite the results of some studies on normal, by which I presume he means unselected, runners and concludes that they show none of the characteristic psychopathology of anorexia nervosa. It is true that Goldfarb & Plante² found a low-normal mean fear of fat for their sample of 200 runners, but the significance of this result is perhaps diminished somewhat when it is appreciated that the Goldfarb Fear of Fat Scale³ which they employed is a new assessment device and the norms published so far are for female populations only, while the group of 200 runners included 136 males. More importantly, however, it must not be overlooked that 29 of those 200 runners (14.5%) did have a high fear of fat. While these fear of fat scores did not correlate with running zeal in terms of such measures as distances covered, neither is there clear evidence elsewhere to suggest that they correlate with dieting zeal among groups of anorexics.

His final conclusion that the distinction can be made in terms of the ultimate aim of the exercising seems spurious. Reluctant patients such as anorexics may not be frank about their aims which therefore have to be inferred. Aim can be considered at various levels of abstraction. In considering exercise as an end in itself in primary exercise dependence but as a means to an end in anorexia nervosa, he chooses to select a level of abstraction which fits best with his model. Equally plausible would be the contention that in both conditions physical exercise is a means used to achieve a sense of personal effectiveness.

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1. DE COVERLEY VEALE, D. M. W. (1987) Exercise dependence, *British Journal of Addiction*, 82, pp. 735-740.
2. GOLDFARB, L. A. & PLANTE, T. G. (1984) Fear of fat in runners: an examination of the connection between anorexia nervosa and distance running, *Psychological Reports*, 55, p. 296.
3. GOLDFARB, L. A., DYKENS, E. M. & GERRARD, M. (1985) The Goldfarb Fear of Fat Scale, *Journal of Personality Assessment*, 49, pp. 329-332.

Reply to Dewsnap

From D. M. W. de Coverley Veale (Royal Free Hospital School of Medicine, London)

SIR—I thank Dr Dewsnap for his criticism (Dewsnap, 1987) of the model of primary and secondary exercise dependence (Veale, 1987). The distinction is proposed in the spirit of a working hypothesis, as I am currently performing a survey of subjects who are exercise dependent to try to clarify the relationship. Some of these subjects will also fulfill the diagnostic criteria for an eating disorder whilst most will probably not. Most authorities would regard the former as a more extreme form of the excessive exercise which is seen to varying degrees in many eating disorders, and would regard it as a secondary feature—as a means of losing weight. The distinction between primary and secondary exercise dependence has an inherent circular reasoning because the model is hierarchical and diagnostic classifications are categorical and do not allow for sub-clinical features. Some of the primary exercise dependent subjects may have sub-clinical features of an eating disorder and show mildly abnormal attitudes towards eating and this is something we hope to clarify. I would accept that we shall need a more sophisticated analysis of the aim of the exercise in primary exercise dependence and striving for more personal effectiveness is one very plausible hypothesis.

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DE COVERLEY VEALE, D. M. W. (1987) Exercise dependence, *British Journal of Addiction*, 82, pp. 735-740.

The University College Drug Dependence Unit From Roger Farmer (University College Hospital, London)

SIR—I would like to point out that current assessment and treatment procedures at University College Hospital Drug Dependency Unit are rather different from those in operation when Emmanuelle Daviaud and her colleagues¹ carried out their study.

The Unit continues to attempt to maximize the attractiveness and effectiveness of its services and