

Dr Harbinson's final comment about my victimising other psychiatrists is rather emotive. He/she is correct regarding the speculative nature of some aspects of my paper. This has been necessary because of the relative lack of research. However, I am certainly not intending that criticism be directed at colleagues, a number of whom have carried out valuable research while also carrying heavy clinical workloads. It remains my view that there is a need for a detailed epidemiological community study which specifically addresses the issue of trauma.

Curran, P. S. (1988) Psychiatric aspects of terrorist violence; Northern Ireland 1969–1987. *British Journal of Psychiatry*, **153**, 470–475.

Department of Health and Social Services (1998) *Living with the Trauma of the Troubles*. Belfast: Social Services Inspectorate, DHSS (NI).

Lyons, H. A. (1971) Psychiatric sequelae of the Belfast riots. *British Journal of Psychiatry*, **118**, 265–273.

Pollock, P. H. (1999) When the killer suffers: post-traumatic stress reactions following homicide. *Legal and Criminological Psychology*, **4**, 185–202.

Smyth, M. (1998) *Half the Battle: Understanding the Effects of the 'Troubles' on Children and Younger People in Northern Ireland*. Belfast: INCORE.

O. E. Daly Department of Psychiatry, Lagan Valley Hospital, Hillsborough Road, Lisburn, BT28 1JP

Studying grief in adults with learning disabilities

I read with interest the article by Bonell-Pascual *et al* (1999) and would agree that recognition of, and service provision for, the bereaved adult learning disability population is markedly deficient. However, their conclusion that learning disability is a significant predictor of future mental health problems following bereavement is not substantiated and should be interpreted with caution in view of the flawed research methodology.

The original cohort reported short-term psychopathological and behavioural outcomes following bereavement (Hollins & Esterhuyzen, 1997). This case-controlled study found an increase in aberrant behaviours and psychopathology in those bereaved compared with controls. Bonell-Pascual *et al* aimed to investigate whether the same outcomes had changed over a longer term (six to eight years). Unfortunately, the control cohort was not followed up, thereby making meaningful inferences impossible, as confounding life events are not controlled for. Also, more than half the study population had additional medical

disorders of likely prognostic significance. The authors recognise the limitations of their small sample size, but this is further compounded by incomplete follow-up of the original cohort, with greater than 15% of the original cohort excluded. Furthermore, follow-up data are missing from the analysis of psychopathology and aberrant behaviour.

In the classification of psychopathology, each sub-scale shows varied changes with no interpretable trends over time. Psychopathology identified in the original 1997 study had resolved in over 70%, although a few new cases were identified, especially in the adjustment and anxiety disorder sub-categories. However, we cannot attribute these new cases to underlying learning disability as confounding medical and life events may have played a significant role. Aberrant behaviour patterns were reported as showing a mean increase in each sub-scale over time. The individual change in aberrant behaviour patterns was, however, in both directions in all sub-scales (i.e. an improvement and deterioration in behaviour). The mean change quoted by the authors in such a small study sample with wide ranges of behaviour is, therefore, unreliable. Similarly, the one statistically 'significant' result, showing inappropriate speech to be more common, should also be treated with caution and taken in isolation is unlikely to be of clinical significance. Furthermore, the authors allude to problems with validation of the behavioural and psychopathological measures used in the significant proportion of the study population who were taking antipsychotic and antidepressant medication.

It is now recognised that people with learning disability do understand the permanence of death and consequently grieve (Harper & Wadsworth, 1993; Read, 1996). Bonell-Pascual *et al* highlight the need to better understand the general and specific needs of this vulnerable group of people and provide some useful insight into effective interventions. Future studies should be aimed at addressing these issues, be carried out prospectively and have adequate control groups to allow safe and meaningful conclusions to be drawn.

Bonell-Pascual, E., Huline-Dickens, S., Hollins, S., et al (1999) Bereavement and grief in adults with learning disabilities. A follow-up study. *British Journal of Psychiatry*, **175**, 348–350.

Harper, D. C. & Wadsworth, J. S. (1993) Grief in adults with mental retardation: preliminary findings. *Research in Developmental Disabilities*, **14**, 313–330.

Hollins, S. & Esterhuyzen, A. (1997) Bereavement and grief in adults with learning disabilities. *British Journal of Psychiatry*, **170**, 497–501.

Read, S. (1996) Helping people with learning disabilities to grieve. *British Journal of Nursing*, **5**, 91–95.

C. A. Lyons Department of Psychiatry of Learning Disability, Black Country Mental Health Trust, Heath Lane Hospital, West Bromwich

Author's reply: We have read Dr Lyons' letter with interest, and considered his/her comments with great care. It is encouraging that the letter also highlights the need for further research in this area, and we are happy to say that we have new research in progress.

We acknowledge that the methodology of the published report has limitations, but that does not mean that it is flawed. Dr Lyons does little more than amplify the limitations spelled out in what was, after all, only a short research report. It is perfectly acceptable to use data from the first study as longitudinal data in the follow-up study. Furthermore, although follow-up of the original control group might have yielded some useful material, it is more probable that it would have been unreliable, because of the likelihood that these individuals would have experienced bereavements themselves in the intervening time between the first and second study.

Dr Lyons suggests that new 'cases' at follow up cannot be attributed to the underlying learning disability as confounding medical and life events may have played a part. One of the key points made in both 1997 and 1999 papers is that the effects of bereavement are compounded by the increase in life events experienced by the client group at such a time.

With regard to the size of the second sample, the shortfall is not excessive: as stated in the paper, three of the missing individuals were dead, and three untraceable, possibly also dead. The true follow-up rate could thus be more accurately described as 41 out of 44, or 93%. Furthermore, two of the remaining three carers refused to help with the follow-up interviews because bereavement was too sensitive an issue for either the relative or the person with learning disability.

Dr Lyons suggests that the results of the study are not 'meaningful'. The original manuscript, which was cut in length at the request of the Editor, included qualitative material collected from carers at the same time as the quantitative data. This material supports the results of the quantitative data,

and includes a wide range of phenomena following bereavement, including withdrawal, tearfulness, weight loss, obsession with death, health problems, increase in fits, faecal incontinence and regressive behaviour. Carers reported the continuing effects of bereavement. For example, one man, who had had a close but difficult relationship with his father, was still working through the bereavement with a psychologist, and taking psychoactive medication, some five years after his father's death. Another man, after a similar period of time, still cried out for his mother when something went wrong; Miss F is said still to break down easily, crying "My mother's dead!", illustrating the immediacy that a bereavement can have even after a number of years.

The work we reported adds to the growing body of evidence that bereavement can cause psychological distress and behavioural symptoms, which may well be overlooked or misinterpreted.

S. Hollins Department of Psychiatry of Disability, St George's Hospital Medical School, Jenner Wing, Cranmer Terrace, London SW17 0RE

Maternal eating disorder and mother-child conflict

Stein *et al*'s study (1999) provides essential reading for clinicians involved in treating anorexia nervosa or bulimia. However, in light of recent research concerning pregnancy and eating disorders (Morgan *et al*, 1999), three further areas of investigation seem to have been unexplored.

First, we have demonstrated that a third of women with bulimia developed postnatal depression, rising to two-thirds in women with previous anorexia nervosa. Second, Stein *et al* treat 'eating disorders' with unwarranted homogeneity; we found profound differences between pregnant women with bulimia and those with previous anorexia nervosa. The latter predicted postnatal depression, absence of breast-feeding and postpartum relapse into eating disorder. The most striking differences were apparent at a descriptive level, where women with previous anorexia nervosa appeared highly alienated from their infants. Third, the majority of pregnancies described in our study (Morgan *et al*, 1999) were unplanned due to mistaken beliefs regarding fertility.

It would be interesting if Stein *et al* were able to re-examine their data with reference to specific eating disorder diagnoses, presence of affective disorder and

planning of pregnancy, all of which might generate maladaptive responses to the antecedents of conflict.

Stein, A., Woolley, H. & McPherson, K. (1999) Conflict between mothers with eating disorders and their infants during mealtimes. *British Journal of Psychiatry*, **175**, 455–461.

Morgan, J. F., Lacey, J. H. & Sedgwick, P. M. (1999) Impact of pregnancy on bulimia nervosa. *British Journal of Psychiatry*, **174**, 135–140.

J. F. Morgan Department of General Psychiatry, St George's Hospital Medical School, London SW17 0RE

Authors' reply: Dr Morgan makes some interesting points in the light of his own study concerning factors which might influence the nature of the relationship between mothers with eating disorders and their infants. However, the purpose of our paper was to examine the evolution of conflict between mothers with eating disorders and their infants using detailed observations of sequences of interactions. In particular, we wanted to establish whether the way in which mothers and infants responded to different situations during mealtimes influenced development of conflict. We found that whether or not the mothers responded to the infants' cues determined whether or not conflict arose. In addition, the infants' behaviour also contributed to the evolution of conflict in some circumstances. The elucidation of these features of interaction, which was only possible through sequential observations and analyses, offers the potential for intervention irrespective of which background factors influence interaction. In particular, it is critical to help mothers to recognise the positive aspects of their infants' communications and cues during mealtimes in order to facilitate this interaction.

Obviously, we are very interested in the other factors in the mother's history or mental state which might influence the course of these interactions, such as those detailed in the Morgan *et al* paper cited above. However, in order to carry out the analysis of sequential interactions as we have done, and to determine the relative influence of a variety of other factors on the course of these interactions, a much larger study would be required. This would be valuable but well beyond the scope of our paper.

A. Stein, H. Woolley Leopold Muller University Department, Royal Free and University College

Medical School, University College London, Royal Free Campus, Rowland Hill Street, London NW3 2PF

K. McPherson School of Hygiene and Tropical Medicine, Keppel Street, London WC1E 7HT

Compulsory treatment in anorexia nervosa

I read with interest the paper by Ramsay *et al* (1999).

The matter of compulsory treatment in anorexia nervosa is clinically important. The lifetime risk of women developing this disease is 0.5%, that is half the lifetime risk of schizophrenia. The mortality rate is unacceptably high, reaching nearly 20% at 20-year follow-up. This would suggest the need for compulsory treatment in certain circumstances. However, there is disagreement between authorities about the issue, and in relation to the right of anorexic patients to receive life-saving treatment if they are unable to consent to it by reason of their mental disturbance. Various viewpoints have been presented in a recent multi-authored book (Vandereycken & Beaumont, 1999). As Ramsay *et al* point out, the only other empirical study attempted in this area was by Griffiths *et al* (1997) in New South Wales. The situation in New South Wales at the time of the latter publication was rather different from that in the UK inasmuch as anorexia nervosa is not considered a mental illness as defined in the Mental Health Act of this State. On that ground, Mr Justice Powell of the Supreme Court of New South Wales ordered the discharge of a severely ill patient with anorexia nervosa in 1986, setting a precedent that persisted until 1999. Incidentally, the patient in question died some time after her discharge.

In the absence of suitable mental health legislation in this area, the management of severely ill patients with anorexia nervosa who refused treatment became an issue for the Guardianship Board. Unfortunately, no new provisions were inserted into the Guardianship Act to deal precisely with this responsibility. Consequently, the treatment of patients has often been severely impeded, the public guardian demanding formal requests at each stage of treatment, and hence causing a considerable delay, and sometimes refusing treatment on grounds which appear ridiculous, for example refusing a cognitive-behavioural programme because it was not 'medical' treatment.