view anorexia nervosa and atypical eating disorder as distinct disorders.

The syndrome seen rarely in the Indian subcontinent is the one characterised by body image disturbance and preoccupation with weight reduction. In that sense anorexia nervosa may be a culture-bound syndrome of the West, influenced by the western cultural norms and practices.

Whereas traditionally in the Indian culture fullness of the body has been regarded as a sign of a well nourished, healthy, affluent and beautiful lady, western beliefs, values, perception and behaviour regard the pursuit of thinness as a perfectly logical concept of beauty. Thus it will not be wrong to suggest that the western socioculture itself dictates this particular behaviour.

Until there is significant weight loss and emaciation, psychiatrists in the West fail to recognise this impairment in judgement and deficient insight about her condition in an anorexia nervosa patient. That is probably also the reason why the classificatory system, which is entirely 'western', places more emphasis on measuring physical parameters for making a diagnosis of anorexia nervosa, than on recognising the overvalued idea or even a delusion of being obese as primary psychopathology.

Solitary cases of this disorder seen in the children of Asian migrants to the West only substantiates the fact that it is the western culture which influences this disorder. As the Indian subcontinent becomes more 'westernised' and adopts the value systems of the West, it will be surprising if this culture-bound syndrome of the West does not percolate to the East.

DINESH K. ARYA

Pastures Hospital
Mickleover
Derby DE3 5DQ

References

BRUSCH, H. (1975) Anorexia nervosa. In *American Handbook of Psychiatry, Vol IV* (ed. S. Arieti), p. 788.

SIMMONDS, M. (1914) Uber emlodische Prozesse in der Hypophysis. *Archives of Pathol. Anat.* **217**, 226.

Anorexia nervosa in the elderly

SIR: We read with interest the report of Gowers & Crisp of an 80-year-old woman with anorexia nervosa (*Journal*, November 1990, **157**, 754–757). Although anorexia nervosa is considered to be rare in the elderly it is perhaps unsurprising that such cases exist given the significant incidence in young people and the high rate of chronicity associated with the disorder.

Among schoolgirls, Crisp has previously shown an incidence of one severe case in every 200 over the age of 11 years, rising to one in every 100 over the age of 16 years (Crisp *et al*, 1976). This may still be an underestimate given the rate of body-shape dissatisfaction among British comprehensive schoolgirls found by Salmons *et al* (1988). In their survey some 25% to 30% of girls aged 16 to 18 years admitted to being only rarely satisfied with their bodyweight, and 'usually' or 'always' terrified of gaining weight.

A multitude of studies on the outcome of anorexia nervosa have demonstrated a high rate of chronicity. Hsu (1980) and Schwartz & Thompson (1981), reviewing the more rigorous studies which had appeared over the preceding 15 years, found a general recognition that some 50% of cases showed continued abnormal eating behaviour at follow-up, which extended in some surveys up to 35 years after the time of first diagnosis. Even if this is an overestimate, the implication is that many people who suffer from anorexia nervosa in their youth maintain their abnormal eating attitudes throughout their lives, and it is perhaps surprising that anorexia nervosa is not described more frequently in the elderly.

We have recently treated a 73-year-old woman with features similar to the woman described by Gowers & Crisp (Cosford & Arnold, 1990). She suffered an episode of anorexia nervosa following a bereavement at the age of 23 years. This was characterised by marked weight loss, extreme behaviour to avoid food intake, an expressed fear of gaining weight, and secondary amenorrhoea. She recovered after nine months of in-patient treatment and subsequently maintained an adequate weight for some 50 years afterwards. She recently suffered a relapse, with severe weight loss, a distorted body image and a fear of becoming fat. Her eating behaviour again became markedly abnormal, and multiple investigations failed to reveal a physical cause for her weight loss. She responded to a strict dietary regime and was discharged five months after admission having regained her former weight, which she has subsequently maintained during out-patient follow-up.

We would suggest that anorexia nervosa is probably underdiagnosed in the elderly, and would support the assertion that it should be included in the differential diagnosis of unexplained weight loss in this age group.

PAUL COSFORD

St Mary's Hospital
London W2

ELAINE ARNOLD

Central Middlesex Hospital
London NW10

References

COSFORD, P. A. & ARNOLD, A. E. (1990) Anorexia nervosa in the elderly. In preparation.

CRISP, A. H., PALMER, R. L. & KALUCY, R. S. (1976) How common is anorexia nervosa? A prevalence study. *British Journal of Psychiatry*, **128**, 549–554.

HSU, L. K. G. (1980) Outcome of anorexia nervosa. *Archives of General Psychiatry*, **37**, 1041–1046.

SALMONS, P. H., LEWIS, V. J., ROGERS, P. *et al* (1988) Body-shape dissatisfaction in school-children. *British Journal of Psychiatry*, **153** (suppl. 2), 27–31.

SCHWARTZ, D. M. & THOMPSON, M. G. (1981) Do anorectics get well? Current research and future needs. *American Journal of Psychiatry*, **138**, 319–323.

Psychological sequelae of torture

SIR: I was grateful to read your annotation on psychological sequelae of torture by Turner & Gorst-Unsworth (*Journal*, October 1990, **157**, 475–480).

Torture has been a widespread experience in the 20th century. Most probably there has never been a time when institutionalised torture has been so widely inflicted on large masses of people in all continents. After the military coup of 1980 in Turkey, I witnessed large numbers of victims of torture in Metris Military Prison, Istanbul, where I was imprisoned for one year (1982–1983). I would agree with the authors that torture has a wide variety of psychological effects on the victims, their families and friends. But psychological sequelae of torture cannot be limited to them, but should be extended to the large group of torturers who have been especially trained to torture.

The situation where individuals first have been forced, then slowly taught, to obey and then to enjoy human suffering, and to become professionally trained systematic torturers must be considered. Having had the opportunity to observe torturers, one cannot help feeling for those who have most probably in their turn been psychologically and physically abused. In Turkey, many turturers warrant diagnoses of psychiatric syndromes which have never been diagnosed or treated. Suicide rate, deliberate self-harm, alcohol dependency and possibly other drug misuse appears to be much higher in those individuals trained to be involved in torture. Different forms of psychotic episodes are commonplace and homicide rates among torturers are much higher than in the general population.

Torture has wide implications upon the whole society where its practice takes place. The society as a whole gets enmeshed into the idea of its existence, and fear and degradation is extended to all aspects of life. Now in Turkey torture has become a major theme in short stories, poetry, films, pictures and songs. In the last ten years there have been hundreds of poetry books, short stories, paintings and films on the tortured, the torturers and their circumstances. It has become part of the language and culture and almost a way of communicating. Its existence transcends all boundaries and makes itself felt in all aspects of life.

In my out-patient clinic at the Charing Cross Hospital, Turkish immigrants who have never experienced torture come with stories of ill-treatment as their psychological complaints. Both neuroses and psychoses in these people are flavoured with stories of torture, sufferings and horror. The idea of torture, even if they know little about it, has become an expression of their persecutions, anxieties, racist and sexist experiences. It is a component of their guilt, self-pity and hopelessness. The individual and the whole society has been marred by the psychological effects of torture.

DORA KOHEN

Charing Cross and Westminster Medical School
London W6 8RP

British and Australian depression revisited

SIR: Two recent long-term outcome studies of depression, from Sydney (Kiloh *et al*, 1988; Andrews *et al*, 1990) and London (Lee & Murray, 1988; Duggan *et al*, 1990), have shown similar results. The initial diagnosis often heralded a very poor long-term outcome, and personality disturbance was one part of the explanation for this. However, there are important differences between the Sydney and London findings which we wish to highlight.

The first of these concerns the neuroticism (N) subscale of the Eysenck Personality Inventory (EPI). The EPI N now has an excellent pedigree as a predictor of outcome in depression, but Professor Andrews *et al* found its predictive power to be confined to their subgroup of 'neurotic' depressives. This may encourage readers to re-identify raised N with a diagnosis of 'neurotic' depression, which would be unwise. In both series, N scores do not differ between 'neurotic' and 'endogenous' subtypes, so that whatever separates the 'neurotic' from the 'endogenous' depressive, it is not the degree of neuroticism. In London, unlike Sydney, we found that EPI N predicted chronicity particularly in the 'endogenous' (melancholic) subgroup. We therefore propose that the relationship between high N scores, diagnostic subgroup, and outcome should remain open to further investigation.

A second difference concerns the influence of depressed mood on the assessment of personality. Andrews *et al* apologise that their patients were assessed when they still had symptoms, and argue that 'recovered' personality has the more significant