BINGES, VOMITING AND GUILT

DEAR SIR,

Episodes of gross over-eating followed by self-induced vomiting may occur in a number of different settings. Patients presenting with anorexia nervosa may complain of such bulimic episodes (Garfinkel *et al*, 1980) and they may occur in subjects who are of normal weight or obese (Russell 1979, Stunkard 1959). Under these circumstances the episodes of bulima usually occur in secret and are accompanied by guilt and dysphoria. The ancient Romans are reported to have indulged in superficially similar practices during Bacchanalian orgies, descriptions of which suggest that they were lacking in the dysphoric symptoms which are characteristic of clinical bulimic episodes. The two patterns of behaviour appear therefore to be distinct. We report a case in which a period of apparently 'hedonistic bingeing' preceded the development of overt anorexia nervosa.

The patient is a 25 year old woman who developed anorexia nervosa at the age of 19, losing weight from 54 kgs, her premorbid weight, to 35 kgs. For the last 2½ years when forced by social necessity to dine with friends she has subsequently induced vomiting. Since coming off the 'pill' 1 year ago she has been amenorrhoeic.

At the age of 17 she attended a small tutorial college in Cambridge. Amongst the other pupils was a clique of 4 girls who were tall and very slim and all engaged in modelling assignments at weekends. She was flattered to be invited to join this exclusive group for 'tea parties' held weekly in their lodgings. Each guest would bring cakes and biscuits and large quantities of bread and doughnuts were provided. In an atmosphere of considerable merriment the participants consumed the food together with cold milk containing chocolate powder. During the course of the feast each girl would adjourn to the bathroom and induce vomiting using a feather to irritate the fauces. On her return she would resume eating.

The gatherings had an exclusive quality but were discussed openly without obvious guilt and were a source of amusement to male and female friends. The patient notes that 3 of the 4 original members of the circle subsequently developed anorexia nervosa, 2 requiring hospitalisation. She also reports that during her anorexic illness she was able easily to reinstitute the method of induction of vomiting that she had learnt during the tea parties.

The prevalence of the behaviour described by our patient is unknown, as is its relationship to the later development of anorexia nervosa. It is possible that it represented an early symptom of the disorder in which case the convivial nature of the eating episodes and the lack of associated secrecy and guilt distinguish them from bulimic episodes as previously described (Russell 1979). Moreover the absence of episodes of bulimia complicating the patient's subsequent illness suggests that the 2 phases were discontinuous. Whether the experience of these 'social binges' played an aetiological role in our patient's anorexia nervosa is uncertain although the expertise gained during them was effectively used as a means of weight control during the phase of overt illness.

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MEASUREMENT OF BODY IMAGE IN ANOREXIA NERVOSA

DEAR SIR,

A disturbance of body image was regarded by Bruch as pathognomic of anorexia nervosa and is included in some of the formal diagnostic criteria of the disorder. However, the phenomenon has proved difficult to study empirically and the literature is replete with contradictory findings. Touyz *et al* (1984) have recently reported the results of a study which used a new and promising technique of assessing the estimation of body size. This involved projecting a photographic image of the subject on to a monitor via a video comera. The camera had a zoom lens attachment which allowed subjects to alter the magnitude of the image horizontally. The principal finding was that patients with anorexia nervosa tended to differ from controls in terms of the variability of the estimates of their body size.

Szmukler (1984) has recently suggested that the findings of the Touyz *et al* study could reflect patients' preconceptions about the nature of the experiment rather than the actual perception of their body size. There is another difficulty which further complicates interpreting the findings of this study. The photographic examples presented in the paper demonstrate variable contrast and poorly defined image edges. These problems arise because

varying the width of the image results in a change in illumination, and the wider the image the poorer the contrast and the less clear the image definition. These two problems are by no means trivial. Perception of size is influenced by contrast between foreground and background (Goldstein, 1980), and clarity of outline in turn affects contrast. Clearly these factors need to be properly controlled in research concerned with perception of body size.

It is likely that the method of assessment reported by Touyz and colleagues will be adopted by other researchers in this field. Should this be the case, equipment should be employed which is not susceptible to the illumination problems highlighted. We have found also that the problem can be overcome electronically be coupling the image control to a source of illumination so that contrast and definition remain constant.

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DISORDERS WITH OVERVALUED IDEAS

DEAR SIR,

McKenna's review article (*Journal,* December 1984, **145,** 579–585) with the above title contributes some useful points towards defining the nature of the belief, in dysmorphophobia, although he omits to state that the excessive concern with unsightly appearance occurs in a person of normal appearance.

The nature of the belief is rightly described as an overvalued idea. But many of the past studies he mentions fail to specify this view (Thomas, 1984), so that in such series the belief could be a delusion-like idea or a primary delusion (Jaspers, 1946). The latter is said to be diagnostic of schizophrenia and the former occurs in all types of psychoses (Fish, 1967), so it comes as no surprise to find high rates of schizophrenia. depression, personality disorder and severe neurosis in these populations.

The view that dysmorphophobia may be a symptom of an underlying disease is indisputable on clinical grounds, but 40% of the patients do not have underlying classifiable psychiatric illness (Thomas, 1984). I suggest that the term dysmorphophobia be reserved for such patients and that secondary or symptomatic dysmorphophobia should be used when other mental illness is responsible.

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MOOD CHANGES AFTER CHILD BIRTH

DEAR SIR,

With regard to the paper by Kendell *et al* (*Journal,* December 1984, **145,** 620–625), I note that those components of mood likely to cause distress to the patient in the first two weeks after childbirth which were measured in this study included depression, irritability, tearfulness and anxiety. In out study of 42 women during the first week after childbirth, using a modified form of P.S.E. (Cooper *et al,* 1977), we found the major features of mood disturbance to be: anxiety, depression, tension and worries, with other less important but significant variables being obsessionalism, less of concentration and listlessness. In this series of publications we have drawn attention to the close correlation between platelet MAO activity (George & Wilson, 1980), serum prolactin (George *et al,* 1980) and maternal B-endorphin/B-lipotrophin (George & Wilson, 1982) and these specific mood variables. These studies emphasise the importance of biochemical mediators in the presentation of early puerperal mood disturbance and offer a biochemical template in studying the puerperal specificity of these mood changes as discussed in Kendell's paper.

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