Understanding Capgras syndrome

SIR: In Anderson's comments (*Journal*, October 1990, **157**, 622–623) on Rastogi's article (*Journal*, June 1990, **156**, 883–884) he says that he is "disappointed to see once again the delusion of inanimate doubles explained away by psychological symbolism". I write to underline this view.

In his letter Dr Anderson also refers to my article (Lipkin, 1988). While I ended this by saying "it is the recommendation of the author that all patients presenting with a Capgras syndrome, whether obviously psychotic or not and whether there be evidence of early dementia or not, be investigated by electrophysiological and brain-imaging techniques", I should like to add a further comment. In my paper I noted that the patient discussed "was referred for second opinion by her consultant psychiatrist . . .". It is perhaps not insignificant that the referring consultant psychiatrist was a psychoanalyst. Important aspects of that particular patient's life gave some credence to the notion that her misidentification of her second husband was the manifestation of the psychological mechanism of 'denial'. Psychological treatment proved fruitless (not necessarily because 'denial' was not in operation), because the underlying problem was an organic one.

Therefore I share the view of many others, including Dr Anderson, that it is necessary to be aware that the Capgras syndrome and Capgras-like phenomena frequently have an organic base and that a preoccupation with putative psychodynamic formulations are not necessarily in the best interests of our patients.

BRON LIPKIN

Grovelands Priory Hospital
The Bourne
Southgate
London N14 6RA

Reference

LIPKIN, B. (1988) Capgras syndrome heralding the development of dementia. *British Journal of Psychiatry*, **153**, 117–118.

Eating disorder in Asian women

SIR: I read with interest the paper by Dolan *et al* (*Journal*, October 1990, **157**, 523–528) on the eating attitudes of British women from three different backgrounds (Caucasian, Afro-Caribbean and Asian). Despite their much lower referral rate for psychiatric treatment, Asian women were found to have significantly more disordered eating attitudes which, unlike Caucasian women, were not correlated with a similar degree of anxiety and depression. The paper demonstrated the different relationships between disordered eating attitudes (as shown by the English Eating Attitude Test; EAT) and anxiety and depression, and the implications on clinical presentation of eating disorders. However, a few points deserve mention.

Firstly, the mean age of the Asian sample is high (31.7 years) and not ideal for studying eating attitudes related to acculturation. No information was given as to whether the subjects were immigrants or second-generation British Asians. Previous studies (e.g. Mumford & Whitehouse, 1988) found disordered eating behaviour to be unexpectedly common in second-generation young British Asians (aged 14–16) who grew up with Western notions of slimness and dieting preoccupations. Social class, a known confounding variable in the EAT, is not mentioned.

Secondly, attitudes toward eating and body shape indeed vary greatly. Anorectic patients from different cultures may manifest different clinical patterns (Lee, 1989), and the use of Western instruments to assess eating attitude and body image in non-Western groups is fraught with controversies. More than 10% of the Asians did not attempt the questionnaire because of difficulty in reading English, and one wonders how many of the rest (43 of them, who constituted only 8.3% of the total sample and were understandably 'precious' subjects) had linguistic and conceptual problems (their education was not mentioned) which might lead to misinterpretations of the EAT and anomalous answers (King & Bhugra, 1989). This is especially relevant as Asian subjects did not have much anxiety and depression despite high EAT scores. The EAT has been factor-analysed to yield three subscales which may predict clinical patterns and outcome of eating disorders (Garner *et al*, 1982). It may be instructive for the authors to analyse accordingly for any meaningful (or chaotic) patterns instead of using the global score alone.

Thirdly, the lack of association of disordered eating attitudes with depression paralleled a recent Taiwan study of Chinese patients with eating disorders where, in contrast to Western findings, not one case of major depression was identified (Tseng *et al*, 1989). But the authors' assertion that "some degree of emotional distress is necessary to precipitate a request for help" is only right with respect to *mental health professionals*, as Chinese anorectic patients may seek help from physicians (for bloating and emaciation), gynaecologists (for amenorrhoea) or even herbalists (for energy imbalance). They rightly commented that doctors might not recognise eating disorders in non-white women, because the diagnosis of eating disorder involves the dialectical

process of illness negotiation between *both* the patient and the doctor (Swartz, 1987). In particular, doctors now in medical practice are likely to have been taught as medical students that eating disorder is a rare condition of the upper-class, white family. *Re-education* is obviously helpful, as this seems so inaccurate today.

SING LEE

Department of Psychiatry
Prince of Wales Hospital
Hong Kong

References

GARNER, D. M., OLMSTED, M. P., BOHR, Y., *et al* (1982) The eating attitudes test: psychometric features and clinical correlates. *Psychological Medicine*, **12**, 871–878.

KING, M. B. & BHUGRA, D. (1989) Eating disorders: lessons from a cross-cultural study. *Psychological Medicine*, **19**, 955–958.

LEE, S. (1989) Anorexia nervosa in Hong Kong – why not more in Chinese. *British Journal of Psychiatry*, **154**, 683–688.

MUMFORD, D. B. & WHITEHOUSE, A. M. (1988) Increased prevalence of bulimia nervosa among Asian schoolgirls. *British Medical Journal*, **297**, 718.

SWARTZ, L. (1987) Illness negotiation: the case of eating disorders. *Social Science and Medicine*, **24**, 613–618.

TSENG, M. C., LEE, M. B. & LEE, Y. J. (1989) A clinical study of Chinese patients with eating disorders. *Chinese Psychiatry*, **3**, 17–28.

Transsexualism

SIR: We wish to comment upon the two contributions to the literature on transsexualism (Mate-Kole *et al*, *Journal*, August 1990, **157**, 261–264; Burns *et al*, *Journal*, August 1990, **157**, 265–268). The first study is concerned with the outcome of gender reassignment and compares operated and waiting list patients. It is useful to present composite measures in terms of social activity and a self-assessment scale measuring neurotic symptoms. From these measures a generally improved quality of life may be discerned although the most important questions are left unanswered; these concern the patients' attitudes to the whole process of gender reassignment and the satisfaction, in retrospect, of having undergone the arduous procedures of approximation to the gender role requested. The matter of outcome assessment of this extraordinary intervention, conducted at the earnest request of the patient, requires greater attention than it has currently received, and assessments must be conducted by persons who are independent of the clinical team staff and 'neutral' in attitude toward the procedure of gender reassignment (Abramowitz, 1986; Snaith, 1987).

A small outcome study of our own, conducted with respect to these criteria, was reported briefly (Snaith, 1990). This gave us confidence to continue with the work but clearly more extensive studies are required to guide clinicians in these difficult decisions. We need to know more about the fate of those requesting gender reassignment whose requests are refused by gender identity clinic staff. At the time of rejection of application many patients appear to be very distraught but it may be that a number can later accept the grounds for refusal and lead more contented lives in pursuit of realistic aims.

The second study calls for further study of the phenomenology of transsexualism and the relation of these factors to outcome. This also is an important area of study. It is probable that whether or not the person fits the criteria of the DSM–III is of lesser importance than whether the person can live in the opposite gender role and be accepted in that role by family, friends and employers. The general stability of personality and ego strength are not assessed by the DSM but are vital factors in outcome. The care and pace at which a person is guided through a gender reassignment programme and the supervision of all aspects of this complicated procedure must certainly have a major effect upon the eventual outcome, relief of distress and improved quality of life which are the ultimate criteria on which reassignment procedures must be judged.

This close supervision can only be provided by a regional gender identity clinic team. The metropolitan centres at Charing Cross Hospital and the Maudsley Hospital offer a considerable service by accepting referrals without geographical restrictions but, for all their experience and excellence, they cannot provide the close social, psychological and endocrinological supervision to people living at a distance of some hundreds of miles; nor can they be immediately on hand to deal with the sometimes severe post-operative complications.

Although the nature of transsexualism remains elusive it is a human condition which is not likely to disappear and people will be requesting the services of experienced teams for many years to come. It is our experience that a satisfactory service can be established on a regional basis within the National Health Service. As regards private sector services these have the inherent danger that patients may purchase what they initially believe to be in their interests but which may end in disaster.

Transsexualism is listed in the classificatory systems as a psychiatric disorder. Whether or not this is correct may be debated but Gender Identity Clinics should be established under the supervision of psychiatrists who have the experience to assess stability of personality and to detect latent psychiatric disorder which would contraindicate gender reassignment. The Royal College of Psychiatrists should now