local health authorities." This is a problem not so much of the special hospitals but more of the NHS hospitals that have lost the skills of dealing with potentially difficult patients. But a problem that does belong with special hospitals is their lack of skill in rehabilitation, and the report praises the rehabilitative endeavours of Balderton Hospital on behalf of Rampton and suggests that all the special hospitals establish such a unit.

The second major principle for special hospitals should be to try to make these abnormal places as normal as possible. Security is obviously important, but as the Boynton report on Rampton said it is wrong to subject patients to a higher degree of security than is clinically necessary.[2] A secure perimeter is enough for most patients, and seclusion should be kept to a minimum.[3] Within the hospitals patients should be allowed free movement, to wear their own clothes, to have access to outside media, and to receive and send uncensored letters, and the sexes should be able to mix. Another of the report's recommendations that will help to normalise the special hospitals is that general practitioners from outside should provide for the physical care of the patients.

A third principle that goes together with normalising the special hospitals is that they should be as open as possible. Staff should not be required to sign the Official Secrets Act, and, as well as local doctors coming in to treat the patients, the local community should be involved with the hospital, and local dignitaries might take part in its management. Links with academic institutions should be encouraged, and the Mental Health Act Commission, which will be established under the Mental Health Act 1983 to protect detained patients, should be welcomed. Journalists, too, should be encouraged to visit the special hospitals not just when somebody escapes, and they should help the public recognise that most people in the special hospitals are not dangerous while in them and that only a few of those released ever commit violent crimes. (One study has shown that in the last 18 years only 1% of those discharged from Broadmoor have committed homicide,[4] and another study of 180 patients subject to restriction orders showed that after release 84% had not reoffended in any way.[5])

A final principle that can be deduced from the report is that special hospitals should take only those patients who are thought to be treatable. If everybody who is mentally impaired is thought to be treatable then this should present no problem, but the very introduction of the word implies that some people are not treatable. These untreatable people are presumably to be left where they are to cope as they can, and the place that they are most likely to find themselves is in prison. Our unpleasant and grossly overcrowded prisons are no place for those who are mentally impaired but considered untreatable, and maybe the special hospitals should accept that they must be asylums as well as places of treatment. This asylum function need not conflict with the cardinal principle of keeping people out of special hospitals as much as possible.

The report says relatively little about the relations between the special hospitals and the prisons, except to note that in recent years prison medical officers have put forward fewer cases for consideration for transfer to the special hospitals. This may be happening, the report suggests, because the prison doctors are fed up with their cases not being accepted, but when this decline is put together with the fact that the proportion of patients being transferred to special hospitals rather than NHS hospitals is rising it can suggest only that there are more and more mentally ill people languishing in our prisons. A closer relationship between doctors in prisons and those in special hospitals, perhaps even to the extent of them being employed by the same authority, could only benefit the mentally ill in prison.

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Regular Review

Anorexia nervosa

A H CRISP

Those who have written extensively about anorexia nervosa over the past 50 years must be baffled by the present insistence that the condition is only now being truly discovered and that it has also become much more common. It was carefully described and reported in English works of over 300 years ago and given further credibility through the descriptions by Lasegue[1] and Gull.[2] The syndrome attracted attention in France at the turn of the century,[3,4] in Britain in the 1930s,[5,6] in the United States in the 1940s, and in Germany[7,8] and Scandinavia[9,10] in the 1950s and thereafter. Despite the scholarly report by Kaufman and Heiman[11] anorexia nervosa was neglected in the United States for two decades apart from the pioneering work of psychoanalysts such as Bruch[12,13] and Sours[14] and the remarkable collection of cases at the Mayo Clinic, first reported by Berkman[15] and now numbering several thousands. Bliss and Branch in 1960[16] wrote an admirably critical monograph on the condition but it may have impaired the recognition of anorexia nervosa in North America by its mistaken insistence that the disorder was no more than a syndrome of "nervous malnutrition."

Very little can be said about the prevalence of the condition, but from the limited information available there are at least

10 000 severely affected patients in Britain at any one time.[17] The outlook is poor, for about half remain chronically ill and the average length of the illness in those who eventually recover is about four years. About one in 20 people with such severe anorexia nervosa will die from it.

Diagnosis

The diagnosis may be difficult to make but in the absence of debilitating infection it is probably the most common cause of longlasting emaciation in the young adult. When such emaciation is coupled with furtive, defensive behaviour and an obvious preoccupation with food the diagnosis should always be brought to mind.

Difficulties in diagnosis stem mainly from the anorectic's need and ability to protect her state through secrecy. The disorder is not perceived as a disease, and in this respect it bears comparison with drug dependence and alcoholism. The anorectic's mind is dominated by the conflict imposed by the starving, foraging impulse on the one hand and the need to resist eating because of the terror of weight gain on the other. Weighing 35 kg or thereabouts, she may still be terrified of gaining weight. Paradoxically, the anorectic is obsessed with food, and her hoarding may spill over into frank theft, while her family may gain weight eating the food that she has prepared. Restlessness and poor sleep are usual, and early wakening, if identified, is likely to lead to the incorrect diagnosis of severe depression. Meanwhile, driven by a need to avoid a gain in weight and hence avoid eating at all costs, the anorectic's terrified manipulation of others, her rituals, and her avoidance of circumstances which she cannot control may get her labelled dismissively as hysterical. Attempts to resist and banish thoughts of food are unsuccessful and, unable to cope with life's challenges, patients may become increasingly depressed. The regressive qualities of anorexia nervosa, especially when chronic, will sooner or later have the effect of severing all relationships: her peers grow away from her, her parents die, and she is left isolated. Suicide is the most common cause of death.

The principal protective device is the denial of problems, especially those which surround the preoccupation with weight. Most patients realise that others will not comprehend or accept the nature of their fears, and so they insist that all is well, that they simply have a small appetite. In some cases food restriction gives way to bingeing, vomiting, and laxative abuse to prevent a gain in weight, although these stratagems may be strenuously denied. Such anorectics may take up to 50 or more Senokot tablets a day. These may cause profound metabolic disturbances and the patient may develop oedema and manifestations of potassium depletion bizarrely coupled or alternating with dehydration. Disorders of fluid balance may even precipitate an epileptiform seizure, which may encourage a further search for an organic lesion if the psychogenic and psychobiological basis of the disorder has not been appreciated. In such ways the differential diagnosis of anorexia nervosa can become one of the most complicated in medicine, and in the process various evident and sometimes peripheral elements of the syndrome become focused upon and raised to the status of independent syndromes.[18-20]

The definitive diagnosis depends not only on the recognition of the abnormal behaviour of the starving person but also on recognition of the underlying terror of weight gain. Further understanding of the nature of the disorder comes from the observation that the vast majority of patients are teenage girls from middle class families. It has been suggested that the anorectic's concern with her weight stems from its association with her pubertal "fatness" and it is the latter that she is avoiding. This concern with fatness has variously been called "pursuit of thinness,"[12] "fear of fatness,"[21] and "phobic avoidance of normal body weight,"[22] the last term carrying the implication that, for the woman, mature body weight demands the presence of that very "fatness" which is the basis of the anorectic's terror. Many claim that the final level of diagnosis concerns the experiential origins of this fear and that an examination of the problems of approaching maturity must be considered within the context of the family.

Aetiology

Theories of aetiology have swung increasingly towards the psychogenic pole with due recognition of certain constitutional factors—for example, gender, obesity, growth rate, and social class. The profound endocrine changes[23] are reversible with restoration of a more normal nutritional state, and this is always possible in the short term.[22] The fundamental basis of anorexia nervosa seems to be the adolescent girl's preoccupation with "fatness"—a fact emphatically mirrored in current fashion and teenage magazines. Most teenage girls, unlike teenage boys, are striving to lose fatness by intermittent dieting, usually with a singular lack of success. Their diet is often bizarre, a few hundred calories consumed one day and thousands the next.[24] Such sensitivity to fatness has its origins in the physical changes of puberty, though it may not be triggered until later. Equally it may be triggered by the initiation of puberty and well before the menarche.

The sexual basis, biological and social, of such fatness is of course peculiar to women. The main psychogenic theories have recognised this association. Psychoanalytic thinking has emphasised the sexual symbolism of food for the anorectic without attending adequately to its biological basis. As a consequence the theory focused on ideas and fears of oral impregnation as the basis for the condition which, while commonplace among teenagers are, in my view, insufficient to explain the development of anorexia nervosa. It is important to take into account the biological reality that food and reproduction are linked through growth and differentiation. Bruch[13] has expressed the view that "anorectics to be" were unable to differentiate between affective and visceral cues during childhood. Thus the anorectic, like the obese person, eats not so much in response to biological demand as to emotive cues, having their origins in the prospect of separation from the family and the challenges imposed by her peers, especially the sexual challenges of adolescence. To the anorectic the body, especially the adult body, is perceived as alien and threatening rather than owned.[22]

Such views not only fit with the characteristic onset of the condition in early biological adult life but also with its occasional later onset. An apparently robust adjustment to adolescent turmoil may be acutely decompensated in later life under the provocation of such events as marriage or the death of a parent. Others have emphasised the family interactional model.[22 25 26] Emerging physical maturity accompanied by and intensifying feelings of insecurity can be a threat within an enmeshed family fearful of sexuality. It may also threaten families and marriages which depend on the continued presence of children for their survival. Within such contexts many adolescents, beneath their bravura, seek for greater control and security. The testing out of limits in order to

identify them is a feature of youth, and in a society where institutionalised and moral limits are decreasing possibly the internal controls of the more conflict ridden adolescent need to become stronger.[22] For the teenage girl this might well include the curbing of "fatness," and all its implications, by dieting.

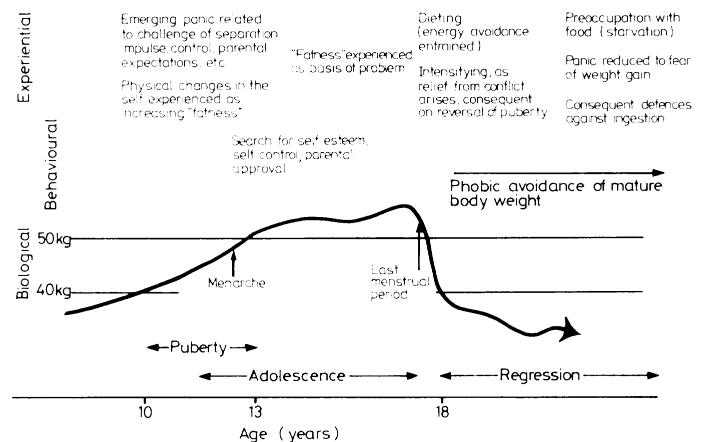
Bruch[13] and Garfinkel and Garner[27] and their colleagues emphasise that this process is the dominating mechanism within anorexia nervosa. I believe that in addition it is the biological regression triggered by the above processes that is the hallmark of the condition. Such a biological regression may be eschewed quite rapidly by restricting the intake of energy, in contrast to the more widespread features of protein-energy malnutrition usually found in natural starvation. Once the pubertal process has been effectively reversed, the individual will have succeeded in avoiding the maturational challenge of puberty. The figure shows some aspects of these various theories.

The experience of feeling fatter than one actually is, and the insistence on this being so, was once thought to be exclusively an anorectic characteristic, but it is now recognised as more widespread. Nevertheless, some anorectics do seem sublimely unaware of their extreme emaciation. This is perhaps less surprising, however, if the disorder is construed as adaptive to the individual's needs.[22] After all, the search for self control and mastery of the body at a normal body weight may be seen in those who pursue such activities as jogging,[28] athletics, gymnastics, and the ballet. Such concern can be pathological in its intensity and defensiveness, and possibly overlaps with anorexia nervosa, both within the individual and as behaviour characterising various members of afflicted families. When individuals whose personality deficits include an element of impulsivity find that such attempts at control are not effective, their sexual behaviour and eating habits may become chaotic. If this behaviour is accompanied by shame at, for instance, being fat, then defensive vomiting and purging will be incorporated into the syndrome at normal body weight. This syndrome has been variously called "dietary chaos,"[29] "bulimia nervosa,"[30] and "abnormal normal weight control."[31]

Treatment

Has such theorising helped at all in the treatment of anorexia nervosa? At a purely physiological level the threat to life posed by starvation can be corrected by refeeding. When an individual is in extremis tube feeding is preferable to intravenous "nutrition," since the exact metabolic deficit and need for replacement electrolytes, fluid, and energy are almost impossible to calculate. Enforced feeding may temporarily save life, but the fundamental task is to overcome the individual's resistance to eating. This requires the patient to contemplate a gain in weight with equanimity and without responding with overwhelming panic and reinforcement of her avoidance behaviour. Once this is done even the most emaciated and terminally ill anorectic can rapidly begin to eat normally.

It is probably naive to believe that psychoactive drugs can provide a permanent solution. Drugs which enhance the appetite such as insulin and the tricyclics may provoke panic in the anorectic and promote vomiting and purging. Major tranquillisers have been used in the past,[32 33] and these may be used to tide the patient over the immediate anxiety and reduce mobility, while good nursing care can promote an increased intake of food. Such treatment has the veneer of "compulsory detention" and has the additional flaw of being counterproductive in the long term, since it may reinforce the psychopathological state. Anorectics already see themselves as victims of an inhuman controlling power, and the condition itself may be described as a type of compulsory detention. Furthermore, in their search for relief anorectics—like other people with phobias—sometimes turn to sedatives such as alcohol and so there are risks of drug dependence. I think that it is unlikely that present claims for the value of endorphins or opiate antagonists in the treatment of anorexia nervosa will be sustained, but this remains to be systematically tested. The judicious use of small doses of phenothiazines or benzodiazepines during the process of gaining weight is the best guideline currently offered for treatment.



Typical evolution of anorexia nervosa.

More fundamental treatment requires an initial unravelling of the developmental psychopathological state. The initial goal will be enabling the anorectic to come to see the possibilities of an alternative life style. Subsequent psychotherapy will concentrate on encouraging the anorectic to leave behind her entrapped and childlike role. If this is to occur, personal growth must be promoted and be acceptable to parents and others, so that there is no rupture of primitive bonds or failure to sustain relationships. Such goals are not always possible and may be especially difficult for the anorectic and her family. The families of anorectics are often very caring but pathologically enmeshed and on the defensive against the outside world and its turmoil. "Conflict avoidance" (which is at the heart of anorexia nervosa itself) characterises these families and may find expression in syndromes such as alcoholism and agoraphobia. The middle class values which permit glib reference to the exercising of autonomy and freedom may be an additional risk factor. Such family dynamics are not specific to anorexia nervosa,[22 25 26] but they may be triggering factors for some individuals with over-determined views about the meaning and threat of bodily development—and the need to curb, overcontrol, and if necessary eliminate and thus avoid it.

Effective psychotherapy must be accompanied by a restoration of normal body weight. A behavioural approach to gain in weight may be possible. As puberty is rekindled

adolescent turmoil must be recognised and the patient will need intensive support. Without this support blind and often denied panic may occur and the anorectic will discharge herself from care and retreat more firmly than ever behind her defences. Family psychotherapy may require an examination of the parents' own adolescent periods with all that entails in terms of their attitudes to sex, their relationship, and to life in general. Improved self awareness will aid communication within the family and should reduce defensiveness and promote acceptance of and respect for individual needs. Sometimes a bereavement within the family can be seen as an historical turning point, and its persistent non-resolution may become a useful focus for relevant psychotherapy. Such treatment is time consuming and difficult but possible. There have been no controlled trials of the long term value of such treatment but it almost certainly helps many patients.[22] Controlled trials of training in social skills, grafted on to some treatment programmes, have not shown any long term effects,[34] but family psychotherapy itself has an effect one year later when provided as the principal form of treatment in outpatient care.[35] What is equally certain is that some anorectics cannot be helped in the long term. Intensive treatment leaves a residue of about a quarter of anorectics who remain severely crippled psychologically and physically (while untreated the figure is nearer half). With treatment fewer will die from the condition.

Prognostic indicators

There is general agreement on the factors which affect the long term prognosis, though inevitably there is some variability in reports.[9 36-38] Early onset is associated with a relatively benign outcome, and this may partly account for the claims of Minuchin *et al.*[25] Chronicity at presentation equally plausibly and in actuality bodes ill, though anorectics may nevertheless recover spontaneously or with treatment after 20 or more years of illness.[22] Premorbid obesity, together with a "bingeing-vomiting-purging" pattern of ingestion is associated with poor outcome, and is also more likely to be associated with similar behaviour at a normal body weight. A working class background seems to protect against developing anorexia nervosa but brings with it a poor prognosis in those who do develop the condition. Another factor associated with a poor outcome is an inability to secure peer relationships even during childhood. Finally, the family of those who binge and vomit often shows impulsive behaviour, which may be expressed as psychopathy, alcoholism, obesity, and so on. The father may be excessively rigid, and these factors together with evidence of neurosis in the parents or marital discord are all associated with a poor prognosis.

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