detailed case histories of these Indian patients should be provided for cross-cultural comparison. Besides, although the three Asian adolescents reported by Bhadrinath (1990) had "considerable fears of getting fat and body image disturbances" and met DSM–III–R criteria, it must be noted that they all came to the UK as a baby or as a child and thus grew up with Western notions of slimness and dietary preoccupations. This phenomenon of acculturation has been studied by Mumford & Whitehouse (1988), who found bulimia nervosa to be less common among white girls than second-generation young British Asians, who are quick to learn fashionable Western styles of reacting to stress.

Diagnostic criteria for AN need to be appreciated in the context of the attitudes to food, eating and body shape of a particular culture. It is vital that psychiatrists from other non-Western cultures do not apply DSM–III–R rigidly, and report on any atypicality in the AN patients they see. This will contribute to important cross-cultural data and a more culture-free understanding of abnormal female fasting, which has a long history, and in Western countries has happened to be defined in 'atheoretical' diagnostic manuals as the AN which most of us recognise today. There is really a difference between 'culture-bound' and 'concept-bound' entities.

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SIR: The recent surge of interest by professionals in eating disorders among Asian people is long overdue. Bhadrinath's highlighting of the condition (*Journal*, April 1990, **156**, 565–568) described an important phenomenon which is probably far more common than has so far been reported. Certainly the EAT score data of Dolan *et al* (*Journal*, October 1990, **157**, 523–528) would suggest this to be so.

From our own recent experience in treating a 13-year-old Asian girl, who fulfilled DSM–III–R criteria for anorexia nervosa, there was evidence to suggest that the condition was precipitated and maintained by features associated with problems relating to cultural conflict. The increased sensitivity to body appearance, common during adolescence, was heightened by the cultural conflict she experienced while negotiating the task of being Asian in the United Kingdom.

One of her main reasons for not eating was the desire to look and dress like 'white models' in fashion magazines and in this way feel more part of western culture at the same time as differentiating herself from that of her parents.

Further work is needed to explore the epidemiology of eating disorders among Asians and the hypothesis that the pursuit of 'westernness' contributes to the aetiology needs to be investigated.

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SIR: I read with interest the comments of Khandelwal & Saxena (*Journal*, November 1990, **157**, 784) in response to Badrinath's article (*Journal*, April 1990, **156**, 565–568).

The variance of anorexia nervosa described by Drs Khandelwal & Saxena highlights an important deficit in the diagnostic practice which fails to distinguish genuine anorexia nervosa from the atypical one. The young female described by them with decreased appetite, excessive weight loss and amenorrhoea, but no clear body image disturbance or fear of becoming fat, may have something else but not 'genuine' anorexia nervosa. Such differentiation becomes more important when we try to understand this disorder in the cross-cultural context.

The concept of anorexia nervosa suggests that the weight loss, emaciation and other characteristics are secondary to a relentless pursuit of thinness which appears to be the primary preoccupation in these patients. Mixing the concepts of genuine anorexia nervosa and the one which is not characterised by this preoccupation about thinness defeats the very purpose of understanding it conceptually and culturally.

When Simmonds (1914), a pathologist, reported a destructive lesion in the pituitary gland, every case of malnutrition was explained as caused by some endocrine pathology (Brusch, 1975). Over the next two decades genuine anorexia nervosa was filtered away from Simmonds disease. Now, when the understanding of its psychopathogenesis and evolution is becoming clearer, it will be a backward step not to

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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.

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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.

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