in the number of patients referred to psychiatric hospitals who fulfil diagnostic criteria for the syndrome bulimia nervosa. Until recently such referrals seem to have been relatively uncommon. Russell (1979), when originally describing the condition, reported that it had taken him six and a half years (1972–8) to collect 30 cases; and Greenberg and Marks (*Journal,* August 1982, **141,** 148–53) report that out of over 800 patients treated between 1972 and 1980 at the behavioural clinic at the Bethlem and Maudsley Hospitals only six had bulimia nervosa.

Our experience in the course of conducting a treatment study suggests that patients with bulimia nervosa are no longer uncommon. Over the past six months we have been referred 18 such patients, none of whom had previously received treatment. In addition, over the same period seven other patients with this diagnosis have been seen elsewhere in the hospital. All 25 patients came from the Oxford area. From our contact with psychiatrists practising elsewhere in Britain, we have gained the impression that there has been a similar increase in referrals to other centres.

Why should this upsurge have occurred? The explanation may be related to the publicity the disorder has recently received in the media. This began with a television documentary early in 1981 and has included at least five national radio programmes and six articles in major newspapers. Whilst it is possible that the publicity may have engendered new cases by suggesting that self-induced vomiting is an effective means of weight control, we do not think this is the prime cause of the increase in referrals. Most of our patients started binge-eating and vomiting in the seventies. The same is true of 499 women who appeared to fulfil diagnostic criteria for bulimia nervosa whom we identified in 1980 with the help of a popular magazine; their average duration of binge-eating and self-induced vomiting was 5.2 (sd = 4.7) and 4.5 (sd = 4.0) years respectively (Fairburn and Cooper, 1982).

We suspect that the publicity may have resulted in people with bulimia nervosa being more willing to seek help. Of the 499 people identified in the 1980 magazine study, less than a third had ever mentioned their eating difficulty to a doctor, and the majority had kept it secret from their family and friends. These women reported that their secrecy arose from shame and guilt about their eating habits, and the belief that they were the only one with the problem. Many of them expressed surprise and relief at learning that others ate in 'binges' and practised self-induced vomiting. Assuming that such attitudes were widespread, we think that, by lessening their sense of isolation and shame, the recent publicity may have helped people with bulimia nervosa to divulge their eating problems to doctors. In addition, doctors may have been alerted to the fact that people with a normal body weight may nevertheless have an eating disorder which requires specialized help.,

If this explanation is correct, the upsurge in referrals may be a short-lived phenomenon during which existing cases of varying duration will come to attention. Thereafter we would expect the referral rate to reflect more accurately the incidence of the condition.

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PSYCHIATRIC SYMPTOMS IN CHRONIC EPILEPTICS

DEAR SIR,

In their paper on Psychiatric Symptom Patterns of Chronic Epileptics attending a Neurological Clinic (*Journal,* March 1982, **140,** 236–43) Kogeorgos *et al* referred to the bulk of their epileptic patients as suffering from "focal, mainly temporal lobe seizures". They do not specify how many patients had simple partial seizures, how many had focal non-temporal lobe epilepsy, and how many had generalized seizures in association with their temporal lobe epilepsy. All these factors have been shown to have a significant influence on the rate of psychiatric pathology in epileptic patients (Stevens, 1975; Stevens and Herman, 1981) and the relative number of patients in each category may have bearing on the significance that can be attached to the differences in psychopathology found between the focal and generalized epileptic groups in this study.

They also do not indicate how many patients in the focal epileptic group had left, right or bilateral ictal foci. The psychopathology in patients with epilepsy has been shown to vary with the laterality of focus (Bear and Fedio, 1977) and those with right temporal lobe foci tend to underestimate the severity of their psychopathology and those with left temporal lobe foci to overestimate their psychopathology, when rating themselves in comparison to observer ratings (Bear and Fedio, 1977). This degree of bias will be less

evident in this paper due to the fact that all ratings were made only by the subjects themselves.

As the laterality of foci is not stated it is difficult to see how the findings can be regarded as support for an association between psychopathology and a left temporal lobe focus, though this is stated in the discussion.

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—— & HERMAN, B. P. (1981) Temporal lobe epilepsy, psychopathology, and violence: The state of the evidence. *Neurology,* **31,** 1127–32.

DEAR SIR,

We would like to reply briefly to Dr Roberts' 3 basic points. Firstly, complex seizures were a feature in all our patients with focal epilepsy, although, as we state in our paper, not all seizures were of temporal origin. Unlike Dr Roberts, we do not think that the available evidence, including the two review papers that he cites (Stevens, 1975; Stevens and Hermann, 1981), suggest significant differences in interictal psychopathology between patients with temporal and non-temporal seizures, if other factors, especially major cerebral pathology are excluded. Additional generalized seizures can be an aggravating factor, but as these were present in only 6 of the 47 patients with focal epilepsy, it is unlikely that they could have substantially affected the mean score of this subgroup of patients. Secondly, the study by Bear and Fedio (1977) is an interesting one, but based on a rather small number of patients (a total of 27) who were furthermore selected without regard to their psychiatric history—always a potential major complicating factor. Their finding of differences in psychopathology and response-style in temporal lobe epileptics related to laterality of the focus remains unconfirmed. Thirdly, we nowhere claim to have assessed laterality effects. The sentence in the discussion concerning the effect of a left temporal lobe focus merely refers to an additional finding in the study by Stores (1978), which we cited.

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AMITRIPTYLINE FOR DEPRESSED WOMEN WITH YOUNG CHILDREN IN GENERAL PRACTICE

DEAR SIR,

We feel that your readers would be interested to hear the results of a small controlled trial of amitriptyline in women who were identified as suffering from minor psychiatric illness in a general practice survey carried out in Harrogate, North Yorkshire. Symptoms of depression and anxiety which commonly affect women in the general population are related to adverse social factors (Moss and Plewis, 1977; Brown and Harris, 1978; Richman, 1978). Perhaps this is why it is often assumed that counselling of some sort is the most appropriate form of management in this sort of disturbance. However, we have some evidence that amitriptyline can reduce depressive symptoms under these circumstances and that improvement is still present after a year.

All the patients on the general practice list of one of us (J.H.) who were women with children aged two to 15 were approached and asked to complete the Leeds Scales (Snaith *et al,* 1976; Forrest and Berg, 1982) with a view to identifying those who had minor psychiatric illness. About 80 per cent responded. High scorers (scores of 7 or more) were interviewed a few weeks later and were offered treatment in a double-blind, randomly-allocated, placebo-controlled trial of a slow release amitriptyline preparation if the family doctor considered them sufficiently disturbed and there was no likelihood of pregnancy or severe physical illness. Twenty-five women, about a third of those interviewed, were included and successfully completed the trial. Progress was monitored using the Leeds Scales. The doctor made his own rating of symptoms and did not know what the questionnaire scores were. In retrospect it was found that his assessments of depression, apathy and diurnal vartiation of symptoms were significantly associated with Leeds D Scale scores ($P < .05$). The active drug group received 25 mg of amitriptyline for a week and then 50 mg in one evening dose. Blood levels of drug were estimated at four and