the consultant (psychiatrist) remains the dominant leader and in this context he quotes the Royal College of Psychiatrists' (1977) warning against decision-making in multidisciplinary teams. With only one fifty-minute staff meeting a week it is clear that shared (multidisciplinary) decision-making must be largely unattainable. If we add to this the fact that only the nurses attend the patient group meetings, it is hard to see how the psychiatrist can have much contact with the patient culture. His statement that, "Reorganization of a ward undoubtedly needs single-minded leadership if new objectives are to be imposed", goes contrary to social systems theory (Chris Argyris, 1970) and organizational development theory (Warren Bennis, 1969). Supervision by a more experienced colleague may have its value provided it does not stifle creativity, but the need for conformity to established clinical practices was stressed more than learning from new concepts of organization.

Having spent twelve years at Henderson (1947 to 1959) and seven years at Dingleton (1962 to 1969) with a major interest in systems theory and change, I feel frustrated by the conservatism characteristic of clinical practice in both the U.K. and the U.S.

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References

ARGYRIS, CHRIS (1970) *Intervention Theory and Method.* Reading, Massachusetts: Addison-Wesley.

BENNIS, WARREN (1969) *Organizational Development.* Reading, Massachusetts: Addison-Wesley.

ROYAL COLLEGE OF PSYCHIATRISTS (1977) The responsibilities of consultants within the NHS. *Bulletin*, September, pp 4–7.

A CASE OF ANOREXIA NERVOSA AND DIABETES MELLITUS

DEAR SIR,

I would like to report a study of a patient with both these diseases. The patient's menarche occurred at the age of 11, and she was diagnosed as having diabetes mellitus when she was 14. This was controlled by soluble insulin. At the age of 17 she was transferred to the Department of Mental Health from the metabolic ward with severe weight loss and amenorrhoea of one year's duration for which no organic cause could be found.

On admission she had lost four stone in weight, was eating very little, but had intermittent bouts of bulimia and was taking large daily doses of a laxative. She was preoccupied with cooking, was overactive and obsessionally tidy. Her dieting appeared to be precipitated by a dislike of an obese aunt, and being called plump by her school friends. Severe and persistent vomiting followed a fall in which another person fell on top of her, on her 16th birthday. Body size studies, (Russell and Slade, 1973) showed that she grossly over-estimated her body size. She also expressed fear of adulthood, femininity and pregnancy.

She was diagnosed as having anorexia nervosa and was treated by a controlled diet, rest, phenothiazines and psychotherapy. There was a steady increase in her weight and her insulin was adjusted accordingly.

The case raised at least two interesting possibilities. Did the two conditions exist independently or are they inter-related? That they exist independently is supported by the fact that the patient secretly but systematically reduced her insulin as she lost weight. During the year of severe dieting before admission her diabetes did not get noticeably out of control. Against that is a report by Crisp (1965) which stated that a number of patients with anorexia nervosa had an abnormally long insulin response to an intravenous injection of glucose and the suggestion that diabetes mellitus and anorexia nervosa are inter-related.

Another possibility is that she used her diabetes to help her lose weight. She may have found that by taking less insulin she could reduce her intake of food and so lose weight. Bruch (1952) stated that patients with anorexia nervosa seek to gain control over their body growth and development. This patient had a very effective method of doing this. Crisp (1965) suggested that patients develop anorexia nervosa as a defence against adulthood and sexuality. By reducing her body weight and with the associated amenorrhoea this patient effectively prevented the onset of her adult reproductive life. The fall she had on her 16th birthday was of great importance to her, and could have had sexually symbolic overtones.

The answers to some of these questions may be available at a later date as the patient is still in psychotherapy.

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References

BRUCH, HILDE (1952) *Eating Disorders.* London: Routledge & Kegan Paul.

CRISP, A. H. (1965) *Proceedings of the Royal Society of Medicine*, **158**, 816.

RUSSELL, G. & SLADE, P. (1973) Awareness of body dimensions in anorexia nervosa, cross sectional and longitudinal studies. *Psychological Medicine*, **3**, 188–99.