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BODY IMAGE DISTURBANCE IN ANOREXIA NERVOSA

DEAR SIR,

The denial of thinness in the face of severe emaciation is a striking, clinical observation of many patients with anorexia nervosa. This observation has led to a series of ingenious and careful studies which have attempted to demonstrate, empirically, a disturbance of body image in this disorder. These experiments have held out the hope that here is an important piece of psychopathology which can be investigated objectively, even measured with an interval scale.

Unfortunately, the straightforward results of the initial study of Slade and Russell (1973) have not been consistently replicated. It has become recognized that a host of variables (e.g. age, weight, the apparatus used, the instructions given) may influence the results (Garner & Garfinkel, 1981). Now Touyz *et al* (1984) have shown that with their group of patients and with their techniques, patients with anorexia nervosa as a group differed from the controls in the extent of variability of their body size estimates.

When doing research, investigators go to great lengths to ensure that their measurements are reliable and valid. Blind ratings are attempted and it is sometimes crucial that raters have no knowledge of the hypothesis being tested. We appear, however, to be rather lax in applying similar standards for patients when this might be necessary. It may be particularly important when patients suffer from a condition like anorexia nervosa which is reputed to be associated with denial and inconsistency. Patients with anorexia nervosa are usually intelligent and well read and it is a reasonable assumption that most would be aware of the hypothesis being tested when they are subjected to body image experiments. What sort of confidence can be placed in their ratings? Perhaps these ratings bear a closer relationship to their attitudes to treatment or the experimenter than to their perception of their bodies. Some patients like to please, others are less well disposed. Factors like these could explain the extent of variability noted.

Body image experiments in anorexia nervosa are probably a good example of how confusing the results can be when the object being examined happens also to be a subject who knows what is being examined and why. Progress in this field must be limited unless this difficulty is taken into account.

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AGORAPHOBIA AND HYPERTHYROIDISM

DEAR SIR,

A twenty-eight year old West Indian female patient presented with severe agoraphobia. Systemic enquiry and physical examination indicated probable hyperthyroidism. Appropriate serum samples were sent for biochemical analysis, but the results were within the normal range. The tests were repeated and the original results confirmed. The patient was then successfully treated with a combination of behaviour therapy, psychotherapy and a monoamine oxidase inhibitor. Eleven months later the patient deteriorated psychiatrically and demonstrated unequivocal signs of excess thyroid activity, which were amply confirmed on biochemical tests. Successful treatment of the hyperthyroidism again led to an abatement of the psychological symptoms. The initial failure of the biochemical indices to confirm the history and physical findings presumably arose because the normal values encompass a small proportion of false negatives.

Non-specific anxiety, irritability and emotional

lability are common in hyperthyroidism (Wayne, 1954; Williams, 1964). The case is interesting because it demonstrates the temporary success of conventional psychiatric treatments in a neurotic syndrome, which in this case was underpinned by an occult endocrine disorder. The potential danger of treating psychiatric disturbances without adequate medical screening is also indicated.

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A DIMENSIONAL CONCEPTUALIZATION OF ANXIETY

DEAR SIR,

The paper by Tyrer (*The British Journal of Psychiatry*, January 1984, **144**, 78–83) nicely discussed the current classification of anxiety. Tyrer pointed out the decline of the use of the anxiety neurosis diagnosis and the incorporation of its former territory into other diagnostic entities. Both the diversity of diagnostic practices with respect to anxiety and their change become apparent from his fine article.

The present authors here propose a conceptualization of anxiety that is an alternative to discrete anxiety entities. Specifically, it is suggested that any anxiety case be plotted on three dimensions—stimulus specificity versus non-specificity, sometimes versus always present, and cognitive versus somatic components.

The matters of stimulus specificity and pervasiveness have long been dealt with by clinicians and by all of the DSM manuals. The phobia is obviously most stimulus specific. The phobia and the panic states are by definition not manifested all the time. Generalized anxiety disorder and the obsessive compulsive states are. Freud spoke of "free floating anxiety", and Wolpe, "pervasive anxiety". The cognitive versus somatic component of anxiety has been described recently by Freedman, Dornbush, and Shapiro (1981) in connection with differential treatment of the various anxiety disorders, and by earlier authors (Salzman, 1978; Weekes, 1978; Beck, 1976; and Schachter & Singer, 1962). The obsessive compulsive disorder would appear to have the highest cognitive component.

One potential advantage of this three dimensional conceptualization over the traditional disease entity based classification is that most anxiety cases do not fall neatly into the pure types. Phobics tend to be generally more anxious than the average person. Patients with a generalized anxiety disorder are not equally anxious at all times and in all circumstances. The presently proposed formulation perhaps especially facilitates the understanding of the DSM III categories of phobias in relationship to each other and to the other anxiety disorders. The simple phobias are the most circumscribed with respect to stimulus and respect to time. Agoraphobia is the least circumscribed and resembles the generalized anxiety disorder. The social phobia occupies an intermediate position.

Therapeutic implications from the three dimensional classifications seem possible. In the previously cited article of Freedman, Dornbush & Shapiro (1981), tricyclic antidepressants and MAO inhibitors were recommended for high cognitive and high somatic symptoms, beta-blockers for low cognitive and high somatic symptoms, psychotherapy for high cognitive and low somatic symptoms, and reassurance for low cognitive and low somatic symptoms. There are a variety of psychotherapeutic, behavioral, and drug treatments for all the anxiety disorders. It is conceivable that eventually a logically formulated and empirically determined system of treatment planning could be based upon scores in three dimension, e.g., 6–2–6 indicates tricyclic antidepressants and behavioural therapy.

This conceptualization not only permits more precision within the realm of anxiety disorders, but allows for greater compatibility with diagnoses in other domains. A person could receive a schizophrenic or personality disorder or depressive diagnosis and yet the nature of his/her anxiety could be specified.

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