Understanding Capgras syndrome

SIR: In Anderson’s comments (Journal, October 1990, 157, 622–623) on Rastogi’s article (Journal, June 1990, 156, 883–884) he says that he is “disappointed to see once again the delusion of inanimate doubles explained away by psychological symbolism”. I write to underline this view.

In his letter Dr Anderson also refers to my article (Lipkin, 1988). While I ended this by saying “it is the recommendation of the author that all patients presenting with a Capgras syndrome, whether obviously psychotic or not and whether there be evidence of early dementia or not, be investigated by electrophysiological and brain-imaging techniques”, I should like to add a further comment. In my paper I noted that the patient discussed “was referred for second opinion by her consultant psychiatrist . . .”. It is perhaps not insignificant that the referring consultant psychiatrist was a psychoanalyst. Important aspects of that particular patient’s life gave some credence to the notion that her misidentification of her second husband was the manifestation of the psychological mechanism of ‘denial’. Psychological treatment proved fruitless (not necessarily because ‘denial’ was not in operation), because the underlying problem was an organic one.

Therefore I share the view of many others, including Dr Anderson, that it is necessary to be aware that the Capgras syndrome and Capgras-like phenomena frequently have an organic base and that a preoccupation with putative psychodynamic formulations are not necessarily in the best interests of our patients.

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Reference


Eating disorder in Asian women

SIR: I read with interest the paper by Dolan et al (Journal, October 1990, 157, 523–528) on the eating attitudes of British women from three different backgrounds (Caucasian, Afro-Caribbean and Asian). Despite their much lower referral rate for psychiatric treatment, Asian women were found to have significantly more disordered eating attitudes which, unlike Caucasian women, were not correlated with a similar degree of anxiety and depression. The paper demonstrated the different relationships between disordered eating attitudes (as shown by the Eating Attitude Test; EAT) and anxiety and depression, and the implications on clinical presentation of eating disorders. However, a few points deserve mention.

Firstly, the mean age of the Asian sample is high (31.7 years) and not ideal for studying eating attitudes related to acculturation. No information was given as to whether the subjects were immigrants or second-generation British Asians. Previous studies (e.g. Mumford & Whitehouse, 1988) found disordered eating behaviour to be unexpectedly common in second-generation young British Asians (aged 14–16) who grew up with Western notions of slimness and dieting preoccupations. Social class, a known confounding variable in the EAT, is not mentioned.

Secondly, attitudes toward eating and body shape indeed vary greatly. Anorectic patients from different cultures may manifest different clinical patterns (Lee, 1989), and the use of Western instruments to assess eating attitude and body image in non-Western groups is fraught with controversies. More than 10% of the Asians did not attempt the questionnaire because of difficulty in reading English, and one wonders how many of the rest (43 of them, who constituted only 8.3% of the total sample and were understandably ‘precious’ subjects) had linguistic and conceptual problems (their education was not mentioned) which might lead to misinterpretations of the EAT and anomalous answers (King & Bhugra, 1989). This is especially relevant as Asian subjects did not have much anxiety and depression despite high EAT scores. The EAT has been factor-analysed to yield three subscales which may predict clinical patterns and outcome of eating disorders (Garner et al, 1982). It may be instructive for the authors to analyse accordingly for any meaningful (or chaotic) patterns instead of using the global score alone.

Thirdly, the lack of association of disordered eating attitudes with depression paralleled a recent Taiwan study of Chinese patients with eating disorders where, in contrast to Western findings, not one case of major depression was identified (Tseng et al, 1989). But the authors’ assertion that “some degree of emotional distress is necessary to precipitate a request for help” is only right with respect to mental health professionals, as Chinese anorectic patients may seek help from physicians (for bloating and emaciation), gynaecologists (for amenorrhoea) or even herbalists (for energy imbalance). They rightly commented that doctors might not recognise eating disorders in non-white women, because the diagnosis of eating disorder involves the dialectical
CORRESPONDENCE

Sir: We wish to comment upon the two contributions to the literature on transsexualism (Mate-Kole et al, Journal, August 1990, 157, 261-264; Burns et al, Journal, August 1990, 157, 265-268). The first study is concerned with the outcome of gender reassignment and compares operated and waiting list patients. It is useful to present composite measures in terms of social activity and a self-assessment scale measuring neurotic symptoms. From these measures a generally improved quality of life may be discerned although the most important questions are left unanswered; these concern the patients' attitudes to the whole process of gender reassignment and the satisfaction, in retrospect, of having undergone the arduous procedures of approximation to the gender role requested. The matter of outcome assessment of this extraordinary intervention, conducted at the Maudsley Hospital offer a considerable service by accepting referrals without geographical restrictions but, for all their experience and excellence, they cannot provide the close social, psychological and endocrinological supervision to people living at a distance of some hundreds of miles; nor can they be immediately on hand to deal with the sometimes severe post-operative complications.

Although the nature of transsexualism remains elusive it is a human condition which is not likely to disappear and people will be requesting the services of experienced teams for many years to come. It is our experience that a satisfactory service can be established on a regional basis within the National Health Service. As regards private sector services these have the inherent danger that patients may purchase what they initially believe to be in their interests but which may end in disaster.

Transsexualism is listed in the classificatory systems as a psychiatric disorder. Whether or not this is correct may be debated but Gender Identity Clinics should be established under the supervision of psychiatrists who have the experience to assess stability of personality and to detect latent psychiatric disorder which would contraindicate gender reassignment. The Royal College of Psychiatrists should now

References


Transsexualism

process of illness negotiation between both the patient and the doctor (Swartz, 1987). In particular, doctors now in medical practice are likely to have been taught as medical students that eating disorder is a rare condition of the upper-class, white family. Re-education is obviously helpful, as this seems so inaccurate today.

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