

Bangladeshi family. We also came across some problems with fasting at Ramadan. We agree with Dr Bhandrinath that there is a need for a better understanding of attitudes to body shape and food within different subcultures. We are frequently reminded that the second generation of children from ethnic minority families do not necessarily follow the views and values of their parents nor indeed that of the host culture in which they presently live. Although work has been done at looking at anorexia nervosa in black populations (Buchan & Gregory, 1984; Holden & Robinson, 1988), it would be interesting to look at the occurrence of anorexia nervosa and bulimia nervosa in British-born Asian patients.

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SIR: We read with interest the article by Badrinath (*Journal*, April 1990, **156**, 565–568), and wish to make some comments based on our experience with eating disorders in India. Although published literature is lacking, it is likely that these disorders are far less prevalent in India than in developed countries. However, more interesting is the finding that the presentation of eating disorders encountered in India also varies from the typical description of anorexia nervosa. Our patients are also young females showing decreased appetite, excessive weight loss and amenorrhoea. But a clear body image disturbance or fear of becoming fat is hardly ever seen. Hyperactivity, abnormal food handling and bulimic symptoms are also very uncommon. On the other hand, vomiting is a frequent symptom, often contributing significantly to the weight loss. Sometimes this presentation is accompanied by other functional or clear conversion symptoms (e.g. localised pain, aphonia, hysterical seizures). Most of these patients do not satisfy the necessary criteria of anorexia nervosa according to the classification systems like the DSM–III–R, although they share the central feature of refusal to maintain body weight over a minimum normal weight for age and height. Often these patients are placed

in the residual category of eating disorders not otherwise specified.

The lesser prevalence as well as variation in presentation are both perhaps related to socio-cultural factors. As Badrinath mentions, traditional Indian culture does not emphasise thinness as a must for feminine beauty. Neither is the concern with body image as much as that in the West. In contrast to anorexia nervosa, hysterical symptoms are commonly encountered in India (Saxena *et al*, 1986), while they have become rare in developed countries. It may be relevant here to refer to Bemporad *et al* (1988), who have discussed the similarities between anorexia nervosa and hysteria. They postulate that both these seem to be expressions of age-specific conflicts intensified by constrictive cultural ideas. This may explain the inverse relationship between the prevalences of anorexia nervosa and hysteria in the developed and the developing countries. From this viewpoint, the occurrence of hysterical symptoms in Indian patients with anorexia nervosa may also not be entirely coincidental.

Indian culture is increasingly coming under the influence of Western norms and values. It will be interesting to observe whether anorexia nervosa becomes more prevalent as well as more typical in presentation in the coming years.

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#### Temporal lobe in schizophrenia

SIR: The role of abnormalities of temporal structure in schizophrenia (*Journal*, May 1990, **156**, 615–619) is supported by reports of temporal atrophy in schizophrenics evaluated by computerised tomography (Yates *et al*, 1990), right temporoparietal inefficiency in schizophrenics assessed during a continuous performance test by positron emission tomography (*Journal*, February 1990, **156**, 216–227), and reduction in the total volume of the gray matter in the left temporal lobe in the brains of monozygotic twins discordant for schizophrenia (Suddath *et al*, 1990).