can be used to explain all phenomena that relate to temperament – it would be highly suspect if it did. On the other hand, the hypothesis is certainly not disconfirmed by differential responses to temperamental characteristics in boys and girls.

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SIR: I am sorry that Graham & Stevenson feel that my use of the term 'mini-disorder' does not represent their concept of temperament. Nevertheless, it does seem in keeping with their argument in the earlier paper I cited (Stevenson & Graham, 1982). With respect to the observed association between temperament and the later development of behaviour disorder, they stated: "in fact we are merely observing a mild (or not-so-mild) problem turning into a larger one".

Their letter is helpful in clarifying their theoretical position, but let me comment briefly on the implications of the view that "much" child psychiatric disorder constitutes extremes of temperament. Firstly, the notion that psychiatric disorder implies more than just the extreme of a single behavioural trait is not just mine. The criteria for most psychiatric disorders in both ICD–9 and DSM–III require patterns of multiple symptomatology and social impairment. Moreover, as noted in my paper (Rutter, 1987), many *common* disorders are defined in terms of types of behaviour that are not part of any concept of temperament. That is obviously the case with problems such as enuresis or encopresis, but it is also so with many conditions, such as phobic states, that have a closer connection with temperamental features. The development of, say, school phobia or agoraphobia involves something different from a general escalation in anxiety; that is why they are differentiated from anxiety states.

Secondly, with acute disorders there is the need to account for onset and remission. It does not seem likely that this is accountable for in terms of accentuations and reductions in temperamental features. Nevertheless, I agree that evidence both for and against is lacking. Also, it is common for psychiatric disorders in childhood to exhibit considerable situation-specificity. This phenomenon requires a form of explanation that does not fit readily into a concept of extremes of temperament.

Thirdly, with pervasive chronic disorders there is the assumption of continuity between normal variations in the temperamental feature and its apparent equivalent in the pathological condition. Again, the empirical evidence is sparse, but it seems likely that often this is not the case. For example, Graham's demonstration that some cases of the hyperkinetic syndrome respond to an oligoantigenic diet (Egger *et al*, 1985) suggests that the disorder is not just the manifestation of a high level of temperamental activity.

Fourthly, I appreciate that the Graham & Stevenson view by no means excludes circular processes involving interactions with environmental influences. However, what it surely finds more difficult to encompass are processes that have results that involve the emergence of types of behaviour that are different from accentuations or diminutions of temperamental features.

Finally, there is the most basic point of all: the assumption that, if psychiatric disorder is just an extreme of temperament, both should share the same set of correlates. But is that so? Certainly there is a lack of supporting evidence. The implication, for example, is that the genetic basis of the two is the same and that the environmental features associated with psychiatric disorder should apply similarly to temperament.

I chose to discuss Graham & Stevenson's concept because of my high respect for their research and I would like to take the opportunity of publicly thanking them for their courtesy and helpfulness in letting me see and comment on their paper in advance of its publication. Our views on temperament differ in crucial respects but we are entirely at one in the view that empirical evidence will decide between our concepts. Such evidence is being obtained by them (as well as by other investigators), and I await their findings with great interest.

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Huntington's Chorea

SIR: Martindale (*Journal*, March 1987, **150**, 319–323) has raised an important issue that is relevant not only to Huntington's chorea but also to child psychiatry. It is well known that parents often have difficulty in recognising depression in their children. Professional responses to child psychiatric difficulties are less often discussed, and it seems worth drawing attention to a suggestion recently put forward by Emde *et al* (1986). Childhood depression was described many years ago, but it took a long time to gain general acceptance both by clinicians and by research workers. Emde *et al* hypothesised that this might be because depressed children threaten to arouse painful feelings in the professionals with whom they come into contact, and this may lead the professionals to fail to recognise the condition.

We are all familiar with 'observer effects' in research and these often seem to be regarded as contaminations which prevent us from discerning the truth. Both Martindale and Emde *et al* seem to suggest that this is only partially true and that some emotional responses (such as denial) will blind us to the truth, but others, such as the ability to tolerate feelings of hopelessness, helplessness and sadness in ourselves, may enable us to make a diagnosis which would otherwise elude us.

If this is correct it would seem to have several implications. Firstly, regarding teaching, perhaps we should spend more time helping our trainees to be more aware of their emotional responses to their patients; and secondly, as regards research, it would at least seem worth recording the emotional reactions of the interviewer to the patient.

My clinical impression is that patients often evoke similar emotional responses in a large number of professionals, and it could be that we should be taking more notice of this.

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Anorexia and Antidepressants

SIR: We wish to take up and extend Crisp's theme (*Journal*, March 1987, **150**, 355–358) regarding the mode of action of antidepressant drugs in patients with anorexia nervosa. We have recently studied a group of four male patients with eating disorder, depressive symptoms, and obsessional behaviour.

All four have several features in common, including early age of onset (13–15 years), dietary restriction with consequent weight loss, and obsessional, repetitive exercise routines. One patient exercises with such force that he has sustained several muscle injuries. Three of the patients have been admitted to hospital in the past with transient weight gain. All patients have experienced marked anxiety in relation to loss of control of body weight. This has occurred, for example, when exercise was disrupted by injury or infection, and has led to anticipatory ruminations about the risk of contracting illness and losing control over body weight or body 'fat content'.

In all four, obsessional behaviour has extended beyond the spheres of diet, preparation of food, and preoccupation with exercise to the extent that they are unable to make simple decisions – almost amounting to 'folie de doute'. Three of the four patients are high-achievers academically, pursuing courses in tertiary education; the fourth has been sufficiently ill to interrupt his schooling, although he was regarded premorbidly as being of above average potential. Their academic success has been jeopardised by their obsessional insistence on studying every subject in excessive detail, which leads to their falling behind in their study schedules, causing anxiety and precipitating further ruminations.

All four are currently improved in their academic and social functioning (but not in their core anorexic psychopathology) following the administration of drugs which block 5HT re-uptake with varying degrees of specificity (e.g. fluvoxamine or clomipramine).

Crisp justifies the use of clomipramine by drawing attention to the possible primary phobic and secondary avoidance behaviour and obsessional features within anorexia nervosa. We concur with the view that in some anorexic patients obsessional features play an important role (Dally, 1969), particularly in male patients (Beumont, 1972), and such symptoms contributed significantly to the difficulties encountered by our patients. Taking Crisp's argument that tricyclic drugs have an immediate effect on drive behaviour further, we suggest that in addition they reduce repetitive, 'stereotyped' behaviour as manifested in impaired decision-making seen in these patients.