

and includes a wide range of phenomena following bereavement, including withdrawal, tearfulness, weight loss, obsession with death, health problems, increase in fits, faecal incontinence and regressive behaviour. Carers reported the continuing effects of bereavement. For example, one man, who had had a close but difficult relationship with his father, was still working through the bereavement with a psychologist, and taking psychoactive medication, some five years after his father's death. Another man, after a similar period of time, still cried out for his mother when something went wrong; Miss F is said still to break down easily, crying "My mother's dead!", illustrating the immediacy that a bereavement can have even after a number of years.

The work we reported adds to the growing body of evidence that bereavement can cause psychological distress and behavioural symptoms, which may well be overlooked or misinterpreted.

S. Hollins Department of Psychiatry of Disability, St George's Hospital Medical School, Jenner Wing, Cranmer Terrace, London SW17 0RE

Maternal eating disorder and mother-child conflict

Stein *et al*'s study (1999) provides essential reading for clinicians involved in treating anorexia nervosa or bulimia. However, in light of recent research concerning pregnancy and eating disorders (Morgan *et al*, 1999), three further areas of investigation seem to have been unexplored.

First, we have demonstrated that a third of women with bulimia developed postnatal depression, rising to two-thirds in women with previous anorexia nervosa. Second, Stein *et al* treat 'eating disorders' with unwarranted homogeneity; we found profound differences between pregnant women with bulimia and those with previous anorexia nervosa. The latter predicted postnatal depression, absence of breast-feeding and postpartum relapse into eating disorder. The most striking differences were apparent at a descriptive level, where women with previous anorexia nervosa appeared highly alienated from their infants. Third, the majority of pregnancies described in our study (Morgan *et al*, 1999) were unplanned due to mistaken beliefs regarding fertility.

It would be interesting if Stein *et al* were able to re-examine their data with reference to specific eating disorder diagnoses, presence of affective disorder and

planning of pregnancy, all of which might generate maladaptive responses to the antecedents of conflict.

Stein, A., Woolley, H. & McPherson, K. (1999) Conflict between mothers with eating disorders and their infants during mealtimes. *British Journal of Psychiatry*, **175**, 455–461.

Morgan, J. F., Lacey, J. H. & Sedgwick, P. M. (1999) Impact of pregnancy on bulimia nervosa. *British Journal of Psychiatry*, **174**, 135–140.

J. F. Morgan Department of General Psychiatry, St George's Hospital Medical School, London SW17 0RE

Authors' reply: Dr Morgan makes some interesting points in the light of his own study concerning factors which might influence the nature of the relationship between mothers with eating disorders and their infants. However, the purpose of our paper was to examine the evolution of conflict between mothers with eating disorders and their infants using detailed observations of sequences of interactions. In particular, we wanted to establish whether the way in which mothers and infants responded to different situations during mealtimes influenced development of conflict. We found that whether or not the mothers responded to the infants' cues determined whether or not conflict arose. In addition, the infants' behaviour also contributed to the evolution of conflict in some circumstances. The elucidation of these features of interaction, which was only possible through sequential observations and analyses, offers the potential for intervention irrespective of which background factors influence interaction. In particular, it is critical to help mothers to recognise the positive aspects of their infants' communications and cues during mealtimes in order to facilitate this interaction.

Obviously, we are very interested in the other factors in the mother's history or mental state which might influence the course of these interactions, such as those detailed in the Morgan *et al* paper cited above. However, in order to carry out the analysis of sequential interactions as we have done, and to determine the relative influence of a variety of other factors on the course of these interactions, a much larger study would be required. This would be valuable but well beyond the scope of our paper.

A. Stein, H. Woolley Leopold Muller University Department, Royal Free and University College

Medical School, University College London, Royal Free Campus, Rowland Hill Street, London NW3 2PF

K. McPherson School of Hygiene and Tropical Medicine, Keppel Street, London WC1E 7HT

Compulsory treatment in anorexia nervosa

I read with interest the paper by Ramsay *et al* (1999).

The matter of compulsory treatment in anorexia nervosa is clinically important. The lifetime risk of women developing this disease is 0.5%, that is half the lifetime risk of schizophrenia. The mortality rate is unacceptably high, reaching nearly 20% at 20-year follow-up. This would suggest the need for compulsory treatment in certain circumstances. However, there is disagreement between authorities about the issue, and in relation to the right of anorexic patients to receive life-saving treatment if they are unable to consent to it by reason of their mental disturbance. Various viewpoints have been presented in a recent multi-authored book (Vandereycken & Beaumont, 1999). As Ramsay *et al* point out, the only other empirical study attempted in this area was by Griffiths *et al* (1997) in New South Wales. The situation in New South Wales at the time of the latter publication was rather different from that in the UK inasmuch as anorexia nervosa is not considered a mental illness as defined in the Mental Health Act of this State. On that ground, Mr Justice Powell of the Supreme Court of New South Wales ordered the discharge of a severely ill patient with anorexia nervosa in 1986, setting a precedent that persisted until 1999. Incidentally, the patient in question died some time after her discharge.

In the absence of suitable mental health legislation in this area, the management of severely ill patients with anorexia nervosa who refused treatment became an issue for the Guardianship Board. Unfortunately, no new provisions were inserted into the Guardianship Act to deal precisely with this responsibility. Consequently, the treatment of patients has often been severely impeded, the public guardian demanding formal requests at each stage of treatment, and hence causing a considerable delay, and sometimes refusing treatment on grounds which appear ridiculous, for example refusing a cognitive-behavioural programme because it was not 'medical' treatment.