References

BRAND, C. R. (1981) Personality and political attitudes. In *Dimensions of Personality* (ed. R. Lynn). Oxford: Pergamon.

CLARIDGE, G. (1985) *Origins of Mental Illness: Temperament, Deviance and Disorder*. Oxford: Blackwell.

EYSENCK, H. J. & EYSENCK, S. B. G. (1976) *Psychoticism as a Dimension of Personality*. London: Hodder & Stoughton.

—— & EYSENCK, M. W. (1985) *Personality and Individual Differences: A Natural Science Approach*. New York: Plenum.

Koro-Like States

SIR: We have under our care a 25-year-old male patient with complaints of penis and testicles shrinking into his abdomen.

Case report: This man, from a working-class English background, initially presented in 1983 at the age of 21, with an anxiety state and reactive depression for which he was admitted to hospital for further assessment. He had had both psychic and somatic anxiety symptoms. At that stage there was no evidence of a major affective or schizophrenic illness. Like the patient described by Modai *et al* (*Journal*, October 1986, **149**, 503–506), this young man was physically well-built but emotionally immature. He presented a poor self-image and usually responded to any threat to his ego by being verbally aggressive. His parents' marriage broke up when he was nine. He was left with his father, whom he always perceived as being a domineering man. He could not forgive his mother for leaving him and still harbours a strong feeling of rejection. He had a history of faecal soiling and repeated hospital admissions for successive eye-operations (following an accidental injury) around the age of ten. He first complained of his penis and testicles retracting into his abdomen while in hospital in 1983, coincidental with the break-up of his first serious relationship with a girlfriend. His mood subsequently deteriorated. He was treated with amitriptyline (50 mg/day) and stelazine (15 mg/day). The depression improved, but his belief about his genitalia remained unaltered. He was re-admitted a year later, and again in 1986, with clear-cut episodes of hypomania. His hypomania has now remitted, but during both these admissions he maintained his belief about his retracting genitalia. His concern is such that he avoids places where his genitalia may be exposed and he despairs of ever having a girlfriend again.

In contrast to classical koro, there does not appear to be a cultural factor in this case. Although koro is rare in the Western hemisphere, koro-like states may not be uncommon and may be under-reported.

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HIV and the Psychiatric Hospital

SIR: Most readers are aware of the controversy concerning the treatment of patients infected with the human immunodeficiency virus (HIV) presenting with various medical problems. There has been little discussion of the problems encountered when psychiatric disorder arises in these patients. Colleagues in virology and venereology assure us that the transmissibility of HIV by any route other than by sexual contact or transfusion is small. We may therefore rest assured that the aggressive self-mutilating or spitting patient presents little risk to staff or other patients provided that proper precautions are taken. I have been assured that needlestick injuries are ineffective in transmitting HIV, although I would still like to see some evidence of this, given the frequent need to sedate acutely psychotic and resistive patients by intramuscular injection.

The major problem in dealing with HIV-positive patients lies elsewhere, and has moral and practical dimensions. It is not uncommon for psychiatrically ill patients to be in a state of sexual hyperarousal, most often seen in mania. Equally, most long-stay facilities have a significant sexual sub-culture where intercourse is traded e.g. for the price of a few cigarettes. While staff try to prevent such activities, it is impossible to achieve 100% success. Introduction of HIV carriers to a psychiatric unit therefore poses the threat of transmission to patients whose judgement is impaired by virtue of mental illness.

Morally, detention of a patient under a section of the Mental Health Act implies a responsibility to guard that patient against the consequences of his or her impaired judgement. The sheer terror induced by being diagnosed as HIV positive, plus the profile of *some* high risk groups (promiscuous homosexuals and drug addicts), suggests that as the HIV epidemic continues, psychiatric hospitals will have a higher prevalence of HIV carriers than the population at large. Furthermore, HIV-associated dementia will probably require psychiatric placement, again increasing the prevalence. The moral question I would ask is: 'How can we defend detaining a patient who is at risk to his or herself by virtue of mental illness and whose condition entails a tendency to sexual promiscuity, in a facility where the prevalence of HIV carriers may be above that in the community?"

Practical problems abound. Closer supervision through augmented staff levels could, in theory, preclude the possibility of intercourse in hospital. If a middle line is taken and only those who are HIV positive are "specialed", we run into the problem of consent for screening. Also, it is a criminal offence to disclose the HIV status of a patient to unauthorised people (not the case with Australia Antigen).

I believe that the special problems faced in psychiatric units as a result of HIV merit urgent discussion by the College, the Mental Health Act Commission and the DHSS. In particular, I wonder whether Parliament needs to review the problem of consent for HIV screening when patients are to be admitted to psychiatric hospitals, and also the question of the degree to which the dissemination of their HIV status can be permitted. The use of 'high risk' categories in determining levels of surveillance, while still of use, cannot be considered adequate, given the spread of HIV into the heterosexual non-drug-abusing community.

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First Admissions of Native-Born and Immigrant Patients to Psychiatric Hospitals

SIR: In their study of first admissions of native-born and immigrant patients to mental hospitals in South-East England, Dean *et al* (*Journal*, 1981, **139**, 506–512) found increased rates of admission for most immigrant groups, particularly for illnesses diagnosed as schizophrenia.

However, their findings, which were based on routine data from the four Thames Regions, differed from more locally organised studies in showing substantially smaller excesses, particularly for Asians. For example, for all diagnoses for Indians Dean *et al* found a 50% excess of first admissions for men and a 20% increase for women. For immigrants from Pakistan and the rest of the Asian New Commonwealth they found a 40% deficit.

By contrast, for example, Carpenter & Brockington (*Journal*, 1980, **137**, 201–205) found, for all Asian groups combined, excesses of 200–500% at different age groups. The only exception was the 15–24 year-olds, who showed a 50% excess.

A possible explanation for the discrepancy is the notorious incompleteness of the data source Dean *et al* used (Mental Health Enquiry (MHE)). The authors attempted to address this problem by organising a campaign to improve completeness of recording. However suspicion must remain that while overall they achieved quite good results – 91% completion of the place of birth field – this success may have been patchy, giving rise to systematic distortion in their conclusions. A closer examination of the data for one of the four Regions they studied for 1976 suggests this is likely.

Dean's study excluded all but first admissions so as to avoid multiple counting of individuals. This meant that it depended not only on the birthplace field in each record, but also on the previous admissions question. Permitted responses to this include "not known", and people so coded are not included in first admission statistics. A survey in Newham Health Authority (Glover, 1985) found that about two-thirds of admissions so coded almost certainly were first admissions. Dean also excluded records with the birthplace omitted.

A study of N. W. Thames regional MHE data for 1976 by the Area Health Authority showed that the urban Areas had a higher proportion of first admission records with birthplace uncoded (ranging from 1.4% in Bedfordshire (Beds) to over 10% in Ealing, Hammersmith and Hounslow (EHH) and in Kensington, Chelsea and Westminster (KCW). Urban Areas also had a higher proportion of records with previous admission status "not known" (ranging from 2% in Beds to 16% in Brent and Harrow and 33% in KCW).

In general, but particularly in EHH, birthplace was more frequently missing from records with previous admission status "not known". The same urban areas had rather higher proportions of immigrants in their resident populations than the rural ones.

It seems reasonable to imagine that language difficulty is one obstacle records clerks may encounter in eliciting a patient's previous admission status. Clerks may also be unwilling to ask about some patient's birthplace if racial tension is prominent in the district served. The hospitals serving the Notting Hill Gate area, one of the more racially disturbed at the time, had particularly low rates of birthplace recording.

These findings suggest that the figures Dean *et al* produced are probably a serious underestimate and that the local studies should be considered to be more reliable. They particularly call into question the widely quoted idea that Asians make less use of psychiatric services. This view is based mainly on MHE studies, and runs counter to the impression of many psychiatrists who have worked in areas with large Asian populations.

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Reference

GLOVER, G. R. (1985) *Mental Hospital Admissions of Immigrants in Newham*. Unpublished report for Newham Health Authority. (Available from the author).