NOONAN, J. P. A. & ANANTH, J. (1977) Compulsive water drinking and water intoxication. *Comprehensive Psychiatry*, **18**, 183–187.

Phobia and childhood parental loss

SIR: The recent report by Tweed *et al* (*Journal*, June 1989, **154**, 823–828) that agoraphobia with panic attacks and, to a lesser extent, simple phobia in an adult community sample are associated with parental loss or separation in childhood is an important contribution to our understanding of the aetiology of phobic disorders. However, certain limitations imposed by their method, particularly as they affect the interpretation of the negative results, should be noted.

Any interview procedure that screens for categorical cases will inevitably misclassify a proportion of borderline subjects. So long as there is no consistent bias in favour of over or under-diagnosis, this misclassification will not affect the estimation of prevalence rates for a disorder. However, the presence of false positives in the case group will confound the search for factors associated with the disorder in question, and studies of correlates based on unmodified survey data are likely to underestimate the significance of any associations. This problem can be overcome in two ways, either by excluding borderline subjects from studies of correlates (Robins, 1985), or else by verifying the subjects' case/non-case status according to particular rules in a follow-up case-control study. The advantage of the latter strategy is that it allows a more sensitive estimation of the significance of associations, particularly if there is pairwise matching of cases and controls.

The findings of Dr Tweed *et al* have been derived from a simple comparison of screen-positive and screen-negative survey subjects. This probably does not detract from the significance of the association reported between phobic disorders and childhood parental loss; indeed, a more rigorous approach might have demonstrated a stronger link. Where this study may have failed to do justice to the data is with regard to possible associations between childhood parental loss and other disorders such as social phobia and generalised anxiety disorder, and between anxiety disorders and specific maternal or paternal loss.

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ROBINS, L. N. (1985) Reflections on testing the validity of psychiatric interviews. *Archives of General Psychiatry*, **42**, 918–924.

Flaubert's complaint

SIR: I was interested to read in a recently published biography of Gustave Flaubert (Lottman, 1989) that he suffered from epilepsy, probably of temporal lobe origin (Gastaut & Gastaut, 1982). The biography also contains ample evidence of Flaubert's compulsive promiscuity and passion for writing, which be described as his "idée fixe". In a letter to one of his many female lovers he remarks, "I write a love letter to write, and not because I love". His great interest in religious matters is well known to any reader of his works, which include *Herodias*, *La Tentation de Saint Antoine*, and *Legend de Saint Julian Hospitalor*. Of himself he once said, "One must live as a bourgeois and think as a demi-god".

Several authors, including Trimble (1986), have drawn attention to a specific interictal syndrome associated with temporal lobe epilepsy and consisting of disorders of sexual function, hypergraphia, and hyperreligiosity. It seems probable that Flaubert suffered from this syndrome, but unlike many other fellow-sufferers, he was a genius able to turn his own pathology into art.

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References

GASTAUT, H. & GASTAUT, Y. (1982) La maladie de Gustave Flaubert. *Revue Neurologique*, **6–7**, 467.

LOTTMAN, H. (1989) *Flaubert*. London: Methuen.

TRIMBLE, M. R. (1986) Hypergraphia. In *Aspects of Epilepsy and Psychiatry* (eds M. R. Trimble & T. Bolwig), pp 75–87. Chichester: Wiley.

The damnation of benzodiazepines

SIR: The paper by Kraupl Taylor (*Journal*, May 1989, **154**, 697–704) is timely. His use of the term 'anxiety illness' applies to most of the multitude suffering from various forms of disabling and often chronic anxiety. A look back to the condition of such patients before benzodiazepines became available about 30 years ago reminds us of the very unsatisfactory medication (e.g. barbiturates and amphetamines) commonly prescribed, not to mention the physical treatments and even psychosurgery resorted to in desperation by those seeking relief from intolerable anxiety. With the benzodiazepines, the improvement for many by way of the relief of symptoms was impressive. They were able to live "tolerable and reasonably normal lives, taking fairly full advantage of their abilities". Many were able to go out alone,

travel, and hold down a job. Such patients were maintained for long periods on reasonable doses which did not need increasing. Disabling anxiety often returned if the dose was reduced, which is not surprising in patients suffering from those particular chronic illnesses.

Further distress is now occurring in this chronically anxious, and therefore vulnerable, group of patients as a result of the damnation chorus. While the benzodiazepines may be far from ideal, there is still a large population needing treatment for anxiety. This may have to be in the form of medication, even if only because the sheer weight of their numbers makes other forms of treatment unavailable.

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Compulsory HIV testing in psychiatry

SIR: The Royal College of Psychiatrists' guidelines for the management of HIV-related conditions in psychiatric practice were published recently (Catalan *et al*, 1989). The *British Medical Journal* commented that perhaps the most controversial point in the guidelines refers to the legality of testing without consent (*British Medical Journal*, 1989). The question, however, extends beyond the framework of the current legislation. The 1983 Mental Health Act was drawn up at a time when the HIV test was not yet available and the HIV epidemic was not a major issue on the British agenda. It would be wrong to use such legislation to support controversial clinical procedures which should be primarily driven by ethical, social, and clinical considerations. In the light of this *Journal's* coverage of these issues to date, I will concentrate on the points which merit further discussion.

1. Placing an emphasis on education and confidentiality when dealing with HIV in psychiatric practice is not an easy option, but is a challenge which could be met with alacrity. It is as well to ask how many psychiatric hospital wards give regular education programmes on AIDS-related risk behaviours to staff and patients, and how many provide ready access to condoms? In the face of staff prejudices, their knowledge of a patient's serostatus can lead to worse rather than better patient care (Cummings *et al*, 1986).

2. A difficult dilemma might arise in the future when AIDS-related dementia is suspected in a patient, now that treatment with zidovudine has become an experimental option (Schmitt *et al*, 1988). The evidence at present does not justify compulsory HIV testing and treatment with zidovudine in this condition.

3. I do not believe that HIV testing should be carried out without consent in patients showing aggressive or uninhibited behaviour. From the point of view of the patient, the financial, social, and occupational implications of an HIV test are enormous. Perhaps these need to be further spelt out to proponents of compulsory testing. It has been known in the past, for example, for an insurance company to penalise a candidate for having had an HIV test, whatever the result. From the point of view of staff safety, a negative result could "lull (them) into a false sense of security", as Dunn (1988) has already pointed out. A negative HIV Ab test can result not only from the sometimes lengthy period to seroconversion, but also from the finite specificity of the tests. It is important, therefore, to ensure staff safety by the provision of adequate numbers of trained staff and protective equipment.

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References

BRITISH MEDICAL JOURNAL (1989) HIV testing in psychiatry. *British Medical Journal*, **298**, 1600.

CATALAN, J., RICCIO, M. & THOMPSON, C. (1989) HIV disease and psychiatric practice. *Psychiatric Bulletin*, **13**, 316–332.

CUMMINGS, M. A., RAPAPORT, M. & CUMMINGS, K. (1986) A psychiatric staff response to acquired immune deficiency syndrome. *American Journal of Psychiatry*, **143**, 682.

DUNN, J. (1988) Screening for HIV. *British Journal of Psychiatry*, **153**, 568–569.

SCHMITT, F. A., BIGLEY, J. W., MCKINNIS, R., *et al* (1988) Neuropsychological outcome of zidovudine (AZT) treatment of patients with AIDS and AIDS-related complex. *New England Journal of Medicine*, **319**, 1573–1578.

Delusions of pregnancy in men

SIR: We read with interest Chaturvedi's report (*Journal*, May 1989, **154**, 716–718) of delusions of pregnancy in men. We describe below a patient with delusions of multiple pregnancy and multiple births where, unlike Dr Chaturvedi's case, no obvious organic pathology seemed to account for this symptom.

Case report: A never married, 31-year-old caucasian male with a 15-year history of chronic undifferentiated schizophrenia was admitted for in-patient evaluation after having failed to respond to adequate trials of three different neuroleptic drugs. He had also developed intolerable symptoms of akathisia and dystonia. All neuroleptic drugs had been discontinued one week prior to admission. Propranolol (80 mg/day) and lorazepam (1.5 mg/day) were discontinued over a period of 7 days after admission.