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CORRESPONDENCE

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To the Editor:
I would like to make a belated comment on two aspects of the important article by First (2005) entitled 'Desire for amputation of a limb: paraphilia, psychosis, or a new type of identity disorder'.

Firstly, I applaud his method of using the internet and telephone interviews to overcome the problems of reporting bias and false inferences that may result from the examination of small numbers of case histories. However, his method could be enhanced if patients were asked to nominate a medical practitioner who could supply some corroborative history. The doctors could be identified through their medical registration details and the patient's anonymity would be preserved.

Secondly, although Professor First's paper and other publications about body identity disorder refer to patients who actually self-amputate their own limbs (Bayne & Levy, 2005; First, 2005) I could not find a single case of deliberate self-inflicted lower-limb amputation published in the medical literature. Moreover, there are only two cases of self-inflicted upper limb amputation by non-psychotic patients. One was a middle-aged man who had a medical amputation of a lower limb and later self-amputated a hand (Sorene *et al*. 2006). The second case involved a woman who amputated because she believed her hand had done 'bad things' (Brenner, 1999). The other cases of self-amputation cited in the introduction in Professor First's paper were reported to suffer from psychosis (Schlozman, 1998; Tavcar *et al*. 1999).

Therefore, excluding a small number of cases that were anonymously assessed via telephone, only one patient in the medical literature with body identity disorder actually self-amputated a limb. When considering if an elective amputation should be performed to prevent self-amputation in cases of body identity disorder the extreme rarity of this complication should be considered.

Declaration of Interest

None.

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The Author replies:
Although most individuals with body integrity identity disorder (BIID) are not at serious risk for self-amputation of a limb, according to the 2005 study, a significant minority are at risk: 12% reported self-amputation of a limb, 10% reported that they had amputated one or more fingers, and 6% reported having made an unsuccessful attempt. In his letter, Dr Large seems to doubt the credibility of these reports based primarily on the paucity of published case reports in the medical literature. While the study's methodology of relying solely on subject

self-report inevitably raises questions about the veracity of the reports, given the secretive nature of individuals with this condition, the absence of case reports in the medical literature is not at all surprising.

Individuals with BIID are not psychotic, being fully aware that other people are likely to consider their desires for amputation to be 'crazy'. Consequently, many individuals who attempt self-amputation try to stage it to look accidental. For example, as reported in the documentary film 'Whole', a middle-aged man became a LAK (left above knee) amputee by shooting his left knee at close range with a shotgun, and then claimed it was the result of a hunting accident. Thus, attempts to self-amputate may have appeared to medical personnel to be accidental rather than intentional and hardly worthy as the subject of a case report. Any doubt that some individuals with BIID become desperate enough to resort to self-amputation is dispelled by the case studies included in the various documentaries and television news programmes (e.g. 'Whole', ABC News Primetime Live, BBC Horizon) that have examined this intriguing but unfortunate condition.

Declaration of Interest

None.

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Research Letter

Mental health systems in Latin American and Caribbean countries: a change in the making

Latin American and Caribbean countries (LAC) are diverse both culturally (e.g. sixteen countries are Spanish-speaking; eight English-speaking; and one each Portuguese-, French- and Dutch-speaking), and economically [fifteen have been classified as low-and-medium-income countries (LMIC), and twelve as high-and-medium-income countries (HMIC)]. In contrast, they are united by a shared past, stained by conquest and exploitation, and by their present struggle to better their populations' wellbeing.

In recent decades, many countries moved from military to democratic regimes. This process was accompanied by socio-cultural movements that included the struggle against human rights' violations of institutionalized psychiatric patients. Indeed, throughout the region mental health care was often delivered by anachronistic custodial institutions, where human conditions were extremely precarious. Today, the mental health policy for the region is based on the Caracas Declaration adopted in 1990 (Levav *et al.* 1994) and reaffirmed more recently by the Brasilia Conference of 2005. Their guiding principles are in common, to protect human rights, to deliver mental health care within the primary health system, to transfer in-patient psychiatric care from mental to general hospitals, and to build up a community network of options of care for people with mental disorders.

However, despite major progress made since 1990, mental health care does not receive the priority it deserves. Indeed, we find worrisome facts in the Mental Health Atlas (WHO, 2005). Some examples of these facts are: (1) In four countries the rate of psychiatrists was higher than 5·0/100 000 inhabitants, while in eighteen countries the rate was less than 2·0/100 000. Moreover, with the exception of Cuba, most of these highly trained professionals practice partially or exclusively in the private sector. (2) Seven countries lacked a mental health policy, five did not have a mental health programme, and six had no legislation. (3) The rate of psychiatric beds was uneven, from a low of 0·34/10 000 in Nicaragua to a high of 10·8/10000 in Grenada. (4) Inequity is present throughout; most of the out-patient units are located in the capital and urban centres, with limited access for the rural population. (5) In eight countries the investment in direct mental health care represented less than 1·0% of the total health budget. Even in HMIC countries, like Argentina,