and whose GP was able to provide information on outcome, there were no significant differences in psychiatric status between the two groups (although there was a trend for the GPs to report a history of significant physical illness more commonly in the migrants). The absence of information about the fate of the remainder is, nevertheless, a cause for concern.

PINTO, R. T. (1970) *A study of psychiatric illness among Asians in the Camberwell area*. Unpublished M.Phil. Thesis, University of London

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Case report criticism

SIR: I am a psychiatric trainee in a large teaching hospital. In common with many of my colleagues throughout the UK, time spent away from clinical work to indulge in training, preparing for examinations etc., is at a premium. The reading of selected articles in the *British Journal of Psychiatry* and other journals is a useful way of keeping up to date with current thinking in the art. However, after reading the case report "Suspicion of somatoform disorder in undiagnosed tabes dorsalis" (*Journal*, October 1991, **159,** 573–575), I found myself puzzled as to what I should have learnt from it.

Tabes dorsalis is adequately described in most of the standard textbooks, and the fact that a psychiatric assessment was solicited before the investigation had confirmed the diagnosis, seems a curious reason for a case report, particularly such a long one.

Good case reports are instructive and illuminating. Could I make a plea that, in view of the burgeoning numbers of case reports, only those which present truly novel observations be selected for publication?

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EDITOR'S REPLY: Case reports have not "burgeoned" recently; they form part of the Brief Reports Section, whose size has not changed for a number of years. All Brief Reports have passed through the *Journal*'s normal peer review process and have competed successfully with many others for the limited space available. In the case referred to, the referees felt that there were sufficient "novel observations" to recommend its acceptance with a high rating.

Is Dhat culture bound?

SIR: Dhat syndrome is increasingly being referred to as a "true culture-bound sex neurosis" commonly found in India (*Journal*, November 1991, **159,** 691–695). Its origins are considered to be in the early Hindu belief that semen is derived from blood and its loss leads to physical and mental disabilities.

The idea that semen is derived from blood and is a vital body fluid has existed in many cultures. In China, semen has been considered the essence of the sexual Yang, and its loss is a waste of the vital male Yang essence (Tannahill, 1980). In the Victorian era, semen was described as 'the essential oil of animal liquours", "the purest of the body humours", "the spirituous part of the animal frame" and "the most ethereal or subtilized portion of the blood, a highly rectified and refined distillation from every part of the system, particularly the brain and spinal marrow" (Haller & Haller, 1974).

Almost every conceivable form of physical and mental illness was once attributed to seminal loss, mainly by masturbation. However, something quite akin to Dhat syndrome was described as spermatorrhoea, with similar symptoms including multiple somatic complaints, anxiety, depression and sexual difficulties (Dangerfield, 1843). The treatment involved widely diverse measures like cauterisation of the urethra, an electric alarm triggered by nocturnal erection, and the insertion of wooden blocks, the size of pigeon's eggs, into the rectum, to be kept there day and night to compress the prostate and force the semen back into the bladder (Haller & Haller, 1974).

The *Lancet* carried an editorial in 1840 on the physical debility, mental impairment and moral degradation caused by seminal loss. Physicians believed that virtuous young men absorbed the spermatic fluid which enriched the blood and vitalised the brain. Sir Isaac Newton was supposed to have said that he never lost a drop of seminal fluid (Haller & Haller, 1974). Thus there was consensual validation between the patient's and the doctor's view of such problems, quite like the one now between the traditional village healer and the native Indian.

In the western world, accumulating medical knowledge about sexual matters has accompanied increasing public awareness and permissiveness. The idea that semen is a precious body fluid and its loss is deleterious to health has been dispelled from medical and lay minds simultaneously. The modern notion of sexuality is a historical construct of the past few decades, and is largely due to changing power structures in society (Foucault, 1979). Along with

scientific knowledge, the change in sexual attitudes has resulted from a wide variety of factors: changes in kinship and family system; economic, social and political changes; and the changing form of social regulations (Weeks, 1981).

India is still a largely non-permissive society where ignorance about sexual matters is widely prevalent. A large majority of the population does not receive any kind of sex education, and discussing sexuality openly is a taboo. Ignorance thus breeds more ignorance, with quacks and self-appointed 'sexologists' perpetuating erroneous views, just as happened in the West earlier. Dhat syndrome thus appears to be a variation of the centuries-old false beliefs and ignorance. It is 'culture-bound' only in the sense that it represents the immense 'cultural' difference between the scientifically aware medical population and the myth-orientated native population.

DANGERFIELD, G. N. (1843) The symptoms, pathology, causes and treatment of spermatorrhoea. *Lancet, i*, 211–216.
FOUCAULT, M. (1979) *The History of Sexuality, Vol. I.* London: Allen Lane.
HALLER, J. S. & HALLER, R. M. (1974) *The Physician and Sexuality in Victorian America*. Chicago: University of Illinois Press.
TANNAHILL, R. (1980) *Sex in History*. London: Hamish Hamilton.
WEEKS, J. (1981) *Sex, Politics and Society*. London: Longman.

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Stability of negative symptoms of schizophrenia

SIR: Ring and colleagues (*Journal*, October 1991, **159,** 495–499) reported the negative association between the illness variables and negative symptoms in schizophrenia and the stability of negative symptoms.

The negative symptoms in the 20 long-stay chronic schizophrenic patients reported by Mathai & Gopinath (1986) were reassessed by the same investigators after a period of two and a half years. The sample included 17 females and 3 males. The mean age was 42.35 years (s.d. 9.34) at the time of the initial assessment. The mean durations of illness and hospital admission were 16.84 years (s.d. 5.95) and 13.94 years (s.d. 7.20) respectively. The variables believed to affect negative symptoms, i.e. the wards the patients were admitted to, the occupational therapy units where they worked, the amount of activity, social stimulation, and medications, were maintained the same as at the initial assessment. The negative symptoms were assessed using the SANS (Andreasen, 1981) based on direct observation and interview, and nurses' and occupational therapists' reports. Except for a significant ($P<0.001$) increase in attentional impairment in 15% of the patients, the scores in all subscales and the total scores remained stable. Our findings were comparable to those of Ring *et al*, i.e. in general the negative symptoms were stable over time and neither the initial scores nor the change at the reassessment could be correlated to any demographic, clinical or treatment variable. It is interesting to note that this study was conducted in a patient population different in ethnic, demographic and clinical characteristics, over an extended period of 30 months.

ANDREASEN, N. C. (1981) *Scale for Assessment of Negative Symptoms (SANS)*. Iowa City: University of Iowa.
MATHAI, P. J. & GOPINATH, P. S. (1986) Deficits of chronic schizophrenia in relation to long term hospitalisation. *British Journal of Psychiatry*, **148,** 509–516.

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Problem drinking in women

SIR: The rise in female admissions for alcohol problems to psychiatric hospitals is disproportionate to the number of male admissions although men comprise the majority of such referrals (Madden, 1984). We were thus surprised when we noticed more female than male referrals to our hospital. In order to gain a better understanding of this, we undertook a study to identify differences between men and women being referred.

Our hospital keeps a case register listing in-patient admissions and their diagnosis by ICD–9 criteria. Patients eligible for our study had been admitted between January 1987 and December 1989, and ascribed an ICD–9 diagnosis of alcohol dependency syndrome (303.0). All patients came from the catchment area of a general psychiatric hospital in Birmingham.

Our study is a retrospective case note review of patients meeting the inclusion criteria. Of 19 patients who fulfilled this, 11 were women (mean (s.d.)