

training and commitment. The spectre of a dilute, meaningless grouping practising everything from psychoanalysis to dianetics must surely be dismissed ere long.

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#### Screening for HIV

SIR: I am astonished that an academic psychiatrist such as Dr Goodwin (*Journal*, March 1988, 152, 426–427) should find difficulty in accepting the need to determine the HIV status of a patient in which HIV encephalopathy forms part of the differential diagnosis.

The psychiatric syndromes accompanying HIV encephalopathy remain undefined, and it is only with reports such as that of Thomas & Szabardi (*Journal*, November 1988, 151, 693–695), backed up with post-mortem studies, that an adequate nosology of the condition can be developed. Our predecessors did not quibble over the justification for determining whether infection with *treponema pallidum* was present in their patients, and I can see no reason why the position should be any different for HIV. Dr Goodwin appears to assert that, because an effective treatment is, as yet, unavailable for AIDS, we should refrain from studying the syndromes that HIV may cause (how can they be studied if the HIV status is unknown?). The consequences of such a position extended to non-AIDS psychiatric disorder would be, quite simply, stagnation.

Dr Goodwin's dismissal of the nursing management issue is, in my opinion, trite. HIV infection poses quite specific problems where behavioural disturbance occurs. Nurses on acute admission wards are able to receive immunisation against hepatitis B and I believe this should be *de rigueur*. No such immunisation exists against HIV. The conventional wisdom that HIV transmission is limited to sexual intercourse and the injection of large quantities of body fluids is gradually giving way to a realisation that quite minor insults can lead to seroconversion (a review of this is in preparation) and that needlestick accidents and blood spillage may represent very real hazards to staff. When a patient becomes acutely disturbed, there is a natural reaction to respond to the problem immediately; in the case of HIV positive patients who not infrequently spit and spray blood when disturbed, intervention by staff without adequate protection may well result in infection with the virus. To place staff at needless risk of contracting a lethal condition because of the dubious niceties

accorded to HIV infection (as opposed to any other transmissible agent) is quite unacceptable.

It is my view that patients who are to be admitted to a psychiatric unit, when behavioural disturbance may be likely, should be routinely screened for HIV carrier status. In the case of informal patients, where consent for screening is not forthcoming, consideration should be given as to the appropriateness of admission. In the case of those detained under the Mental Health Act, I am sure that 'assessment' may be taken to include dangerousness from HIV carriage as well as other parameters.

I am still unable to fathom why there is so much furor about HIV. A raised mean corpuscular volume may label a patient as an alcoholic (in the absence of B<sub>12</sub> and folate deficiency) – should we have to obtain specific consent for a full blood count? Why is AIDS accorded this unprecedented protection from investigation?

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#### Therapeutic Factors in In-patient Psychotherapy Groups

SIR: It was encouraging to see a report of a British study on therapeutic factors within in-patient psychotherapy groups (Kapur *et al*, *Journal*, February 1988, 152, 229–233): published research in this area tends to originate largely in the US.

In order to obtain their in-patient sample, Dr Kapur *et al* collected data from 3 groups operating in 3 separate units. Even then the sample is quite small ( $n = 22$ ). This raises the question of how widely group psychotherapy is available to in-patients in contemporary acute admission units. Our own findings suggest that such groups are only available to a very low percentage of in-patients (Mushet & Whalan, 1987).

The study also raises the question of how much psychotherapeutic work can be done with in-patients. Dr Kapur *et al* report that the group therapy offered followed Yalom's (1983) interactional framework. It is not clear from the data, however, that patients were able to respond to this focus, as the value of factors such as altruism and cohesiveness is mainly stressed in the results. Our research findings suggest that such morale-boosting factors are very important to in-patients but that, when an interactional framework is used, patients place particular