The book is certainly 'dated', both in its reluctance to cite any arguments after 1980, and in its cavalier treatment of local understanding (let alone the anti-colonial struggles). Sir Burton's own chapter on 'Traditional medicine' simply lists those local terms which can be glossed by approximately similar biomedical conceptualisations together with recipe lists of local plant remedies: local medicine is perceived in terms of 'malevolent spirits' or 'sorcery' without the reader gaining any understanding of what these terms might mean. Whether one wishes to call Tamarua and Burton-Bradley's critique of "the doctrine of cultural relativism" an attack or not is perhaps debatable; it certainly does not begin to deal with the issue of whether 'cultural relativism' (whatever that was) did indeed elide the evaluative and the descriptive. The volume's account of the theoretical issues stops short after a consideration of Rivers, Roheim, Benedict and the Malinowski-Jones debate of the 1920s.

There is, however, a considerable body of more recent work, central to the relevance of the development of Western medicine in Papua New Guinea, which deals with the relations between anthropological and biomedical theory. Given the limits of a short *Journal* review, it is a little strange that Sir Burton now complains of my omission there of his 1979 paper: his own volume with 23 pages of references does not cite the obvious general work (Lewis, 1975, Frankel, 1986; Frankel & Lewis, 1989), nor recent theoretical debates (Lewis, 1980; Brunton, 1989), let alone the influential if arguably flawed earlier work of Bateson, Mead and Fortune. One suspects that the book's progression through the publishing house was somewhat leisurely.

The development of psychiatry in Papua New Guinea has justifiably been regarded as a heroic achievement for which Professor Burton-Bradley has been rightly recognised. His volume, regrettably, does no justice to the complexity of the issues involved, nor to the life of its local inhabitants. Its subtitle is *Vignettes of an Earlier Period*: perhaps it was unfair of me to complain that it omitted certain questions; to claim that they are indeed there is however astonishing.

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Immigrants from the Indian sub-continent

SIR: Earlier this year I reported that a cohort of 86 first-generation immigrants from the Indian sub-continent spent a significantly lower proportion of a defined follow-up period as in-patients at the Bethlem Royal and Maudsley Hospitals ('Joint Hospital') than a matched group of indigenous English-born controls (Gupta, *Journal*, August 1991, **159**, 222–225). Subsequent analysis of follow-up data may shed some light on the reasons for this difference.

The average number of out-patient visits to the Joint Hospital during follow-up, and the proportion of patients who were seen exclusively in the Emergency Clinic, was very similar in both groups. Thus there does not appear to have been a compensatory increase in the use of non-in-patient psychiatric services by the immigrants. Nor was there any evidence, contrary to the findings of some previous studies (e.g. Pinto, 1970), that the migrant group were more likely to discharge themselves against medical advice, or to lapse from follow-up. A higher proportion of the immigrants were described as 'much improved', 'recovered' or 'well' at the time of their final contact with the Joint Hospital, but the difference failed to reach statistical significance.

Attempts were made to trace both groups through the hospital records and the NHS Central Register. The general practitioners of patients who were registered at the time of follow-up were sent a questionnaire, and 55 were able to provide some information about course and outcome (22 from the immigrant group, and 33 from the controls). There was no evidence that the migrants were more likely to have been seen at or admitted to psychiatric units elsewhere in the country. However, nearly twice as many of the immigrants either could not be traced to a general practitioner (GP) or family practitioner committee (FPC), or were traced but found to be no longer registered with the GP or FPC when direct inquiries were made. Thus, enhanced geographical mobility (either within or outside the UK) among the migrants remains a distinct possibility.

However, the lower rate of registration in general practice at time of follow-up may also reflect a failure of services at primary care level to maintain contact with immigrants with a prior history of psychiatric disorder. Among those who were still registered,

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.

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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