*British Journal of Psychiatry* (1985), **146**, 91–95

# *Correspondence*

## AIDS-Panic: AIDS-Induced Psychogenic States

DEAR SIR,

We read with great interest the report of the syndrome of AIDS panic in New York, as described by Deuchar (*Journal*, December 1984, **145**, 612–619), and wish to report two cases of psychogenic states in British subjects, in which concern about AIDS was the principal precipitant.

*Case 1*: A 32-year-old married man was admitted to a general hospital in Newcastle with a sudden onset of paralysis of the left arm, left leg, and left side of the face, with anaesthesia in these areas. The attending physicians felt that the most likely diagnosis was of a conversion state, and he was therefore referred to the liason psychiatry service. He improved rapidly with simple relaxation, reassurance and support, accompanied by physiotherapy, regaining full power over a period of 72 hours. The illness had developed after a 'flu-like illness he had had eight weeks earlier. At the time the media were seized with frenzied headlines about AIDS. A friend had also said to him, in jest, that he had heard that AIDS would lead him to be paralysed down one side of his body. He became filled with terror and preoccupation about AIDS, and he also developed ideas of guilt concerning an extra-marital affair he had had recently, and the effect on his wife of transmitting AIDS to her. At the time of admission he was deluded in that he felt he had sinned before God and was therefore being punished with AIDS for his marital infidelity. This delusion rapidly resolved along with his rapid physical recovery. It was relevant that he had four years earlier developed difficulty in swallowing, with hypochondriasis that cancer was causing his dysphagia; his symptoms had been the result of an anxiety state which had developed when a plane flight had to be cancelled, delaying departure on holiday. There was no history of homosexuality, nor of any sexual problems, nor any history of psychiatric illness.

*Case 2*: A 36-year-old married woman, who has low factor VIII, and who has an 11-year-old haemophiliac son, presented with a two months history of increasing feelings of worthlessness and inability to cope, progressing to retardation and being frankly unable to do her housework. Over this period feelings of guilt were prominent for having given birth to a haemophiliac son, and having placed him in danger of contracting AIDS. This had occurred in the wake of local concern about AIDS, following the death of a haemophiliac from infusion of factor VIII received from America. Tricyclic medication and psychotherapy with a cognitive approach was not successful in her case. She became profoundly depressed and suicidal, requiring ECT, with good effect. She had had a mild neurotic depressive episode which resolved with no antidepressant medication after the birth of her now nine-year-old daughter—in that illness also, guilt over her son's haemophilia had been important. There was no history of homosexuality, nor of any family psychiatric illness.

Comment: AIDS panic is described (Schwartz, 1983) as "demanding AIDS testing at the first appearance of some cutaneous lesion or persistent cough": it is said to be more common in individuals whose personalities have prominent obsessional and paranoid features. In both of our cases, florid psychiatric symptomatology has occurred through a psychogenic mechanism in individuals who illustrate a variant of the obsessional features cited by Deuchar; namely, a concern for health, in these cases against a background of physical illness factors. This took the form of a 'flu-like illness in Case 1, and of haemophilia-associated problems in Case 2. Their concern about AIDS reached them through different mechanisms, the end point being illnesses with certain similar features, in particular delusions of guilt, which Deuchar cited as being common amongst AIDS victims.

We thank Dr. S. P. Tyrer for allowing us access to Case 2 in this report.

G. O'BRIEN
F. HASSANYEH

*Royal Victoria Infirmary,*
*Newcastle upon Tyne NE1 4LP*

### Reference

SCHWARTZ, R. (1983) AIDS-Panic. *Psychiatry News*, August 17.

## Contraceptives without Consent?

DEAR SIR,

I have recently been asked by a local general practitioner whether a depot contraceptive injection could be used to prevent recurring pregnancies in a 22-year-old girl with simple schizophrenia.

The patient's five year borderline psychosis has never really remitted. Her first pregnancy 2½ years ago resulted in a post-partum exacerbation of symptoms and compulsory admission. The baby was temporarily fostered but returned to the patient under supervision when she was discharged. A slow deterioration in her mental state resulted in a further three month compulsory admission, this time with the eight-month-old baby. Since then she has lived with an approved family and then in her own flat, with Social Services supervision of the baby and

regular depot neuroleptics. In spite of being fitted with an I.U.C.D. shortly after delivery, she managed to become pregnant again by a casual boyfriend. She declined further neuroleptic injections because of the pregnancy, in spite of reassurance and persuasion to the contrary. She now has a four-week-old baby (who is being fostered short-term) and her two-year-old child (who is with the patient's mother) and has returned to her flat alone. Her mental state is slowly deteriorating, as happened following her first pregnancy, and I have no doubt we shall shortly be admitting her compulsorily again.

The overall management of such a case includes the desirability of preventing further pregnancies, for psychiatric as well as social reasons. In view of the failure of other contraceptive methods, would one be entitled to give her a depot contraceptive injection, even against her wishes? Enclosure to DDL (84) 4 from the Mental Health Act Commission "Guidance to Responsible Medical Officers on Consent to Treatment" states that the R.M.O. must decide whether a particular form of treatment, including medicines, falls within the requirements of Section 58 of the Mental Health Act (1983). Drugs prescribed solely for treatment of physical illness do not come within the scope of Section 58. As the law stands, if Section 58 is considered to apply to the administration of a depot contraceptive injection—because preventing a further pregnancy will significantly benefit the patient's future mental health—the first injection (which lasts three months) could presumably be given without further formalities and against the patient's wishes if necessary. Thereafter, Section 58 requires that the Mental Health Act Commission's independent doctor should certify that despite the patient's refusing consent, the treatment is likely to alleviate or prevent deterioration of the patient's condition and should continue to be given. I think this is a point of view which could be argued quite strongly by the R.M.O. in such a case.

The more general point is that such cases must arise all the time throughout the country in young women suffering chronic or recurrent mental illness and/or mental handicap (both equally "mentally impaired" in the writer's opinion, but not according to the Mental Health Act). If an increasing number of such cases come to the attention of the Mental Health Act Commission, one wonders whether depot contraceptive injections will be considered to be in the same category as surgical implantation of hormones to reduce male sexual drive, and therefore be made the subject of Section 57 provisions in due course. A final point is that surgical sterilisation procedures, which may be equally relevant to the long term mental health of such patients, are also procedures for which a case could be made for inclusion within Section 57 of the Mental Health Act.

FABIAN HAGGIS

*The Old Manor Hospital,*
*Wilton Road,*
*Salisbury SP2 7EP*

**The PSE in the Transcultural Setting**

DEAR SIR,

The paper by Swartz *et al* (*Journal*, April 1985, **146**, 391–394) raised questions concerning the strengths and limitations of the Present State Examination (PSE) in a multi-cultural setting and examined the assumptions implicit in the design of the instrument.

I wish to draw attention to issues raised by the method of translation. The accepted method is that the original English version of the PSE is translated into a local language and then back-translated into English by another person. The back-translation is assessed by an English-speaking psychiatrist who compares this translation with the original, and inconsistencies are removed (Leff, 1973). This method is designed to maintain the congruence of the instrument across languages, and therefore, its validity.

However, it is apparent that as cultural and conceptual differences increase, it becomes difficult to achieve linguistic equivalence (i.e. equivalence of meaning). This is especially so when the translation is across language groups, e.g. from Indo-European into non Indo-European languages. Translations from English into Yoruba (a West African language) and vice-versa pose different problems respectively. 'Depression' can be translated into a number of Yoruba words: *ibanuje, irewesi, ironu* or *idori-kodo*: Whereas '*ibanuje*' would be strictly translated into the 'spoiling of one's insides', its equivalent would be 'depression'. The decision of which translation to render would be determined by the context, the understanding which the translator has of the use to which the instrument would be put, and the familiarity of the translator with colloquial UK English as opposed to African English.

The current method of translation has an explicit dependence on the original English version, to a degree which imposes limitations on the validity of the translation. In addition, the method does not provide operational guidelines designed to assist the technical translators in making appropriate choices