to me to have been a questionable step to take. There was no evidence that this assisted the treatment of the patient in any way. He was not treated with AZT (zidovudine). His management from the staff's point of view was no doubt vigilent with a view to the risk of viral infection, but this should have been so in any case. I cannot see the merits of determining HIV status in the patient described, and I would be interested to know whether he was able to consent to the procedure.

Whatever the merits in an individual case, there are no grounds for extending the idea of HIV screening in paranoid psychoses. The issue of consent in initiating this examination is paramount and the obtaining of consent in a deluded patient must be highly contentious. It may indeed be correct that a diagnosis of HIV infection should be entertained in a case of paranoid psychosis where a previous history of drug abuse or sexual exposure to the virus is suspected. However, the testing of patients in order to gratify one's desire to make a diagnosis must be resisted. The practical guidelines recommended by the BMA (at least its official guise) emphasise that consent must be sought to HIV testing, and while the legal position may be unclear, the ethical issues demand caution at the very least. Psychiatrists should be especially sensitive to these issues, and it is disappointing to find insensitive recommendations expressed in this way and published without restraint being imposed by the referees or editor.

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SIR: We thank Drs Johnson and Goodwin for their careful reading of our case report. We agree with Dr Johnson that multiple drug abuse may be associated with paranoid psychosis. Our patient had a history not only of taking heroin, but also of abusing diazepam and chlordiazepoxide. There was no history of abuse of amphetamine, cocaine, psilocybin, or LSD. No drugs were abused by the patient during the three weeks prior to admission when he was receiving methadone detoxification, and urine screening at this stage detected only methadone. Therefore, there seems to be little evidence that we were dealing with a drug-induced paranoid state in this case.

Dr Goodwin takes exception to our recommendation that "in every patient presenting with a psychosis of unknown origin and a history of intravenous drug abuse, AIDS should be suspected and the test for HTLV III antibodies performed". He raises the question of consent by the patient to have the blood test performed. In the case of our patient, whose psychosis showed a fluctuating course, written consent was obtained at a time when the patient had reasonably good rapport with reality, and he was also appropriately counselled. However, we are aware of the problem of the validity of consent given by a psychotic patient (Thomas, 1987). It should be noted that this is an area where medico-legal opinions and recommendations shift quickly (Dyer, 1987), and it seems to us premature to take up an entrenched position regarding the ethical rights and wrongs for testing for HIV infection.

The current BMA guidelines say that all patients should give informed consent and that the justification for testing an unconscious or desperately ill person is open to doubt (Sherrard & Gatt, 1987). No comment is made about what procedure to adopt should the person be psychotic and unable to give informed consent. It is to be expected that guidelines will be drawn up in the future concerning HIV testing in psychotic patients; possibilities might be additional consent from a relative, opinions of two independent clinicians, or the use of the appropriate section of the Mental Health Act.

We have to take issue with Dr Goodwin's point concerning the clinical need to determine the HIV status of a psychotic patient from a high-risk group. There can be little justification for advocating ignorance when a simple test can shed light on the diagnosis. The fact that currently available treatments of HIV infection are only palliative should not absolve the clinician from the responsibility to pursue the diagnosis: if the test is positive, rational treatments can be instituted, and if the result is negative, the clinician has the duty to search for alternative causes of the psychosis. The establishment of the diagnosis has bearing not only on treatment but also on prognosis, of which the patient, and with his agreement his family, have the right to be informed, and appropriate counselling should be undertaken. The need for HIV testing in psychiatric patients has been further emphasised by recent reports that HIV infection may present clinically with psychiatric or neurological illness without the clinical features of AIDS (Navia & Price, 1987).

Finally, when dealing with a new disease, it is essential to map out the clinical picture and the natural history of the condition: it would be virtually impossible to institute treatment strategies without this information.

Thus, in our view, the pursuit of diagnosis in a psychotic patient from a high-risk group with a simple blood test cannot be labelled "insensitive", and the opposite course of action may be paramount

to negligence. We accept full responsibility for our recommendation and stand by it: it would be deplorable if the *Journal* succumbed to pressure to exercise the type of censorship advocated by Dr Goodwin.

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Ganser Syndrome

SIR: Carney *et al* (*Journal*, November 1987, **151**, 697–700) quoted Professor Whitlock's finding that Ganser syndrome is not confined to prisoners. In the Western world the number of people claiming compensation for health problems following somatic or emotional trauma in industry or traffic is increasing at a rapid pace; hence the proportion of patients presenting with this disorder (which I place on a hysterical-malingering dimension) has risen.

In 1956 I published my observations on a series of patients claiming disability pensions and presenting with the clinical picture of Ganser (Tyndel, 1956). In 1973 I coined the term 'nomogenic disorder', in analogy with the notion of iatrogenic disorders, defined as psychopathological disorders in whose development or maintenance the law and its implementation play a significant role (Tyndel, 1977). Ganser is listed as one of the paradigms of nomogenic disorders.

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Age of Onset of Schizophrenia

SIR: Verghese *et al* (*Journal*, November 1987, **151**, 707) suggest that age of onset of schizophrenia is not later in women in India. Our experience is different.

In a retrospective study conducted at the out-patient psychiatric unit of the All India Institute of Medical Sciences, New Delhi, 539 patients with schizophrenia were studied regarding sex differences in age of onset during a two-year period (1981–83). Of these, 328 were males and 211 were females. The diagnosis of schizophrenia was made clinically using ICD–9 guidelines; however, controversial sub-types (simple, latent, and schizoaffective) were excluded. The age at which immediate family members noticed psychotic symptoms for the first time was considered to determine the age of onset of schizophrenia. The age of the patient at the time of consultation was documented in each chart by a junior research officer who was specifically deputed to record the socio-demographic variables of psychiatric out-patients. The age at first treatment and the age at first admission were not considered. The mean age at onset for males was 23.39 years (s.d. = 6.92) and that for females was 25.77 years (s.d. = 7.97) giving a gender gap of 2.4 years. The results were statistically significant ($t = 3.56$, $P < 0.001$). The sex difference persisted when the patients were divided into paranoid and non-paranoid sub-groups.

We are not able to offer any explanation as to why there is such a difference in findings from the same country.

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Anthropology and Psychiatry

SIR: Kleinman (*Journal*, October 1987, **151**, 447–454) raises some important questions concerning the validity of diagnosis and the search for "accurate representation" in contemporary psychiatric research. While various diagnostic instruments have no doubt achieved a degree of success in the area of reliability, Professor Kleinman's argument is a timely reminder that this does not imply that their validity is assured. One senses that many