Correspondence

EDITED BY MATTHEW HOTOPF

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Towards a unitary theory of stigmatisation

I thank Crisp (2001) for his editorial on my paper and am pleased that he agrees with a range of propositions in the unitary theory of stigmatisation (Haghighat, 2001). Yet, his overemphasis on evolution as the foundation of stigmatisation raises a pivotal question. If stigmatisation is so biologically determined, what is the point of anti-stigmatising campaigns which essentially imply belief in the determining roles of cultural, political and socio-economic factors? Would this overemphasis not somehow respond to our despair in tackling stigmatisation, in that it allows its attribution primarily to something deeply ingrained?

Historically, the intensity of stigmatisation has varied in response to socio-economic and political contingencies – the genetic evolutionary machinery being inhibited or stimulated by these environmental factors. By analogy, milk is necessary for inducing the production of lactase but for this the genetic evolutionary machinery giving rise to lactase is not necessarily any more fundamental than the presence of milk in the environment.

As the title of my paper implies, one of its targets is to define routes to destigmatisation. Crisp questions why I distinguish constitutional from evolutionary factors. I do so to work towards this target. Constitutional factors involve rather ‘primitive’, ‘vegetative’ and ‘spontaneous’ responses less, or perhaps differently, amenable to anti-stigmatising interventions (if at all) while evolutionary factors involved in, for example, whether to let your sister marry someone with mental illness, are more amenable to conscious reflection and decision-making and are therefore subject to different types of anti-stigmatising interventions.

In finding the aetiology of stigmatisation one should not be misled by the form of a discourse but explore its raison d’être and motivating factors. Crisp seems to miss the fact that the same discourse can serve very different purposes for different social groups. The discourse of free will and self-infliction in addictions, when deployed by a conscientious doctor, social worker or family member, is likely to serve to induce feelings of responsibility in the patient. The same discourse used by the public is likely to have been primarily devised to allay their guilt faced with suggestions that they are stigmatisers. Patients with addiction, despite their indispensible relative responsibility in causing their condition, are attributed a wider range of imperfections than they deserve and are thus stigmatised. The discourse of self-infliction is an example of the ‘Just World hypothesis’ already discussed in my paper.

Crisp refers to Hughes’ (2000) consensual psychoanalytic proposition: people use projection as a defence against dysphoric mood. Yet, in order to remain evidence-based and not to refulgure those not dynamically oriented, my theory had to rely, as much as possible, on experimental facts of social psychology (e.g. Gibbons & Gerard, 1989). I agree with Crisp that the tendency to stigmatisate depends on robustness of the stigmatiser’s personality – those with high self-esteem are less likely to derogate others (Nunnally, 1961) and so gain psychologically – but it is, at the same time, likely to depend on the importance and self-interest value of what is at stake.

Crisp suggests that I have not considered links between psychological and socio-political factors seriously. Yet, in my paper I alert the reader that not all core issues related to stigmatisation could be discussed because of space limitations. Factors involved in stigmatisation are of course all interconnected. In a decision to reject a partner whose control of resources is poor, the mind may be weighting negative attributions more than positive ones – the allocation of ‘badness’ to another can yield psychological gain, the decision can prevent loss in socio-economic competition and finally the evolutionary need to distance poor reproductive bets can be satisfied. As another example, the choice of a certain political ideology favouring strict division between social groups, classes and persons is likely to respond to a psychological need to distance, dominate or control as opposed to a wish to share and to promote compassion, equality and interdependence. At the same time, this is likely to involve mind categorising and labelling and to profit the protagonists through a differential system of social privileges as well as responding to a primitive evolutionary urge.

Finally, Crisp observes that while I have taken a categorical approach I have ended up extolling a monistic philosophy. You can use different fields of enquiry to delve into the same phenomenon and endeavour to sum up the partial visions provided into the synthesis of a picture as the best possible approximation of reality. What I call constitutional or economic or other ‘origins’ are routes of enquiry into domains in which stigmatisation shows its face. If you asked what was the origin of the production of energy in the body, dietetics would refer mainly to food and calories, cellular biology primarily to mitochondria, biochemistry to the Krebs cycle or oxidative phosphorylation, physics to thermodynamics, etc., while these are all aspects of a single, ultimate mechanism. By the same token, all versions of the origin of stigmatisation, although divided and labelled by our brain as related to a distinct branch of knowledge, refer to a unitary, ultimate source: the pursuit of self-interest. When trying to understand stigmatisation we must not fall into the same trap that makes us stigmatisate. The paradigms of physics, chemistry, sociology, politics, etc., all have human dimensions, such as our tendency to divide, partition and parcel out – they are labels we have found to name the branches of what used to be called philosophy before we decided to carve it up into pieces. We did so because of our brains’ lack of capacity to cope with the extent and volume of the accumulated knowledge and now none of these branches can give us a global picture of reality. But we have the capacity to free ourselves from the same reductionism by recognising the limitations of our categorisations and by looking at the shared core of different versions of reality that these branches of knowledge present – where these versions overlap is likely to be the nearest to where we can reach in grasping the essence of reality.


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Author’s reply: Dr Haghighat’s response to my invited editorial comments (Crisp, 2001) upon his paper (Haghighat, 2001) adds to his overall discourse and may illuminate this matter for readers of these articles. I respect his proposition that self-interest is a basis of the stigmatisation process and all that flows from it. It advances thinking on the matter. Self-interest could be proposed as an explanatory hypothesis for much of human nature. Within the arena of stigmatisation of people with mental illness probably it can range across human experiential and ingrained biological needs, from its protective value for preservation of self-esteem through to selective mating subserving evolutionary purposes. He has emphasised cultural, political and socio-economic factors. I have suggested that greater emphasis is needed on our existential concerns and fears and the biological substrates to our personal survival strategies in the face of such perceived threats. All require our attention if we are to maximise our capacity to change.

He appears to despair of us changing our biologically driven nature and behaviours which, in this context, translate into crude defensive categorisations and labelling of those with mental illness, often leading to distancing rather than exploitation. I believe that the best chance of achieving such change is first to acknowledge the power of human biology. In civilised society we have usually striven then to shape and curb it by influencing attitudes and behaviour via moral, educative and legislative channels. We have sometimes succeeded. Importantly, we also need to address individual vulnerabilities and related triggers to such innate mechanisms. I reiterate that they probably importantly include the degrees of personal psychological fragility and related defensiveness, along with their social extensions and projections such as Haghighat emphasises. It may also benefit from clarification of the social handicaps and sometimes the advantages that can accompany some mental illness diatheses.

The College’s anti-stigma campaign is about to go public after 3 years of development and planning. Thoughtful input within contributions such as Haghighat’s paper, along with this welcome support from the Journal, are at its heart.


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Stigma caused by psychiatrists

Chaplin (2000) could have made an interesting read but unfortunately seemed to miss making any particular point. The effects of medication and Mental Health Act assessments can and do have powerful effects on both the ill person and his or her family. Alas, Chaplin failed to expand on a major issue – the attitudes some psychiatrists hold have far more devastating effects on their patients than either medication or the Mental Health Act.

I have written elsewhere (Corker, 2001) about the deeply harming effects that stigmatisation and discrimination by psychiatrists can have on people who may have suffered mental illness and may or may not have been their patients. While many articles have been written about the stigma of mental illness, too little has been said about the effect that the attitude of mental health professionals may have on patients.

For the patient the mental health professional must maintain a position of trust and also remember that they provide the building blocks for modelling at a point of extreme vulnerability in the life of the patient. As a mental health professional for 20 years, both in the National Health Service and private practice, I have also experienced the discrimination and stigma of being a patient during and following two major depressive illnesses. The experience of being ill has certainly changed my life and resulted in major losses; worse is the way in which the illnesses have been used by fellow professionals, both medical and non-medical, to stigmatisate and discriminate. I do admit to making mistakes as a result of illness but would have expected that this would be seen as the result of illness, where poor decision-making is acknowledged as one of the key signs.

I agree with Chaplin that psychiatrists “must be prepared to identify and challenge our own prejudices and attempt to modify our clinical practice”. First and foremost, this requires a sense of humility to examine a personal approach. Second, attitudes and practices that need to be changed must be identified. Third, the responsibility needed to make the change must be accepted.


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Cognitive therapy in schizophrenia

In the course of a favourable review of cognitive therapy in schizophrenia, Thornicroft & Susser (2001) cite the recent trial by Sensky et al (2000), but fail to mention that it had negative results. This 90-patient, 9-month randomised controlled trial, carried out under blind conditions, compared this form of treatment with a control intervention (befriending) and found no significant difference between the two. It is true that differences emerged 9 months after completion of treatment, but this latter part of the study was uncontrolled.

Of the other trials of cognitive therapy cited in their article, that of Drury et al (1996) did not use blind evaluations, and that of Kuipers et al (1997) employed neither blind evaluations nor a condition to control for the non-specific effects of intervention (the Hawthorne effect). Only one other published study (Tarrier et al, 1998) incorporated both these design features; this found a non-significant advantage of cognitive therapy over supportive counselling (Curtis, 1999).
Rather than being ready for an assessment of its effectiveness and cost-effectiveness in non-experimental settings, as Thornicroft & Susser argue, cognitive therapy may be in the process of meeting the fate of an earlier treatment for schizophrenia where advocacy preceded rigorous evaluation — insulin coma.


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No long-term benefit for cognitive therapy in acute psychosis: a type II error

Drury et al (2000) reported no significant difference in relapse rates, positive symptoms or insight between a cognitive therapy group and a recreational activities and support group of patients who had an acute episode of a non-affective psychosis. This 5-year outcome study assessed 34 out of an original cohort of 40 patients.

Working on the basis of small trials having a large type II error, the group size for each group can be estimated. If the anticipated mean response in one group is μ₁ and the standard deviation is σ, to show a significant result the mean relapse of one group can be estimated at 2 (μ₁) and the standard deviation can be estimated at 1.5 (σ). The estimated difference between the groups (δ) can be set at 0.5 (μ₃–μ₁). A formula to calculate the number (n) in each group (Pocock, 1983: 127–128) can be used as follows:

\[ n = \frac{2\sigma^2}{(μ₁ – μ₂)^2} \times f(α, β) \]

The α (type I error) is by convention set at 0.05, and the β (type II error) can be set at 0.2. The power of finding a true result (1 – β) will therefore be 0.8 or 80% and, by using a statistical table, f(α, β) is 7.9. Therefore, n can be calculated as

\[ \frac{2 \times 1.5^2}{0.3^2} \times 7.9 = 142 \]

patients in each group.

It would therefore take a very large sample to prove the null hypothesis in the above hypothetical estimate. In the study by Drury et al (2000), it would be misleading to extrapolate that there was no long-term benefit of using cognitive therapy in schizophrenia in terms of relapse. Larger studies are needed in this rapidly evolving area.


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Seasonal variation in suicides: hidden not vanished

Yip et al (2000) demonstrated that, in England, the seasonal variation in suicide rates in the 1980s and 1990s decreased considerably when compared with that in the 1960s and 1970s. From monthly suicide frequencies, they concluded that current data hardly show any seasonal effects on suicide rates, and they predicted that seasonal variation in suicide rates would disappear completely in the years to come.

Although we fully agree with Yip et al (and several other authors) that there is a global decline in the amplitude of seasonal variation in suicide rate, we do not agree with the conclusion that seasonal influences are beginning to fade away. We came to this conclusion by a recent study of train suicides (i.e. suicide by jumping before a moving train) in The Netherlands (van Houwelingen & Beersma, 2001). In this study (n=30) we confirmed the absence of a seasonal pattern in suicide rates as observed in 28-day intervals. We did, however, observe a strong seasonal influence on 24-hour patterns. Whereas the winter season showed two daily peaks in suicide rates, at around 9–11 am and 7–10 pm, the summer season revealed one major peak around 12–4 pm and a smaller peak shortly before midnight. The timing of the major summer peak is in the trough between the two winter peaks.

This more subtle influence of time of year on suicide rates adds a different dimension to what has been considered seasonality in suicidal behaviour and may generate new ideas concerning relevant factors involved. In train suicide data, seasonal influences are clearly present. This may also be true of other methods of suicide. In order to see this, time of day and time of year have to be taken into account simultaneously.


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Soviet-style psychiatry is alive and well in the People’s Republic

The involuntary committal to psychiatric institutions of political dissenters has long been associated with the abuses of psychiatric practice perpetrated in the former Soviet Union. The detention of dissenters may be based upon psychiatric judgement but political factors are relevant when such abuse becomes widespread. International concern has been growing following the decision of the Chinese Government to outlaw the practice of Falun Gong and forcibly to assign psychiatric treatment to practitioners of this meditative discipline. Falun Gong, also known as Falun Dafa,
Amnesty International is concerned that such forced incarceration will escalate as the authorities attempt to discredit Falun Gong and to brand its practitioners as ‘crazy’. The spurious diagnosis of ‘Qigong-induced mental disorder’ has even been described by some Chinese psychiatrists who claim obsessional symptoms, paranoid ideation, anxiety and depression as its core features. Other human rights violations, such as torture and ill treatment in custody, have resulted in a mounting death toll, currently standing at 77 according to Amnesty International (2001).

Attempts have been made this year by the American Psychiatric Association’s Committee on the Abuse of Psychiatry and Psychiatrists to encourage the World Psychiatric Association to undertake a review of these alleged wrongful detentions. The failure of even a proportion of Chinese psychiatrists to function within an articulated ethical framework along generally acknowledged international standards diminishes all of us practising in the arena of mental health.


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**One hundred years ago**

**The role of consanguinity in the etiology of epilepsy, hysteria, idiocy, and imbecility**

A contribution of interest on the above subject appears in a recent *Thèse de Paris* (1900) by Dr. Theophile Gillet of Paris, dealing with the results of consanguineous marriages in relation to certain neuroses and psychoses. Dr. Rilliet and Dr. Barthez in their classical “Treatise on the Diseases of Children” (1859) had stated that the results of consanguinity of parents were as follows. First, fewer births; secondly, more miscarriages and still births than the average; thirdly, weakness (physical and moral) of the surviving children; fourthly, a special tendency in the offspring to diseases of the nervous system, such as epilepsy, idiocy and imbecility, deaf-mutism, and local cerebral palsies; and lastly, a special proclivity in the offspring to tuberculous degeneracy. It has since been stated that among the more frequent results of consanguinity in the parents are such abnormalities as albinism, deaf-mutism, and retinitis pigmentosa in the offspring, even in cases where but one parent showed the specific morbid taint. The observations of Dr. Gillet were made at the Bicêtre during 11 years (from 1889 to 1900), during which period 1228 children were under care and treatment. Inquiries were also made into the histories of 425 girl patients at the Fondation Vallée, Paris, an institution for children suffering from nervous diseases. The total number of cases investigated was, therefore, 1653. Inquiries into the family histories of these patients elicited the fact that there were 45 instances of consanguineous marriage in the parents. These 45 families were minutely studied, with the result that the offspring of these families taken *en bloc* showed 19 cases of idiocy, 14 of epilepsy (idiopathic or symptomatic), eight of imbecility, three of hydrocephalus, one of chorea, and one of idiocy [sic], a total of 46 grave neuroses and cerebral defects. The relative degrees of consanguinity were as follows. In 28 instances the father and mother were first cousins, in seven instances they were cousins of the third, fourth, and fifth degree, and in one case uncle and niece. Inquiry into the condition of their children during infancy revealed the fact that convulsions and meningitis were notably prevalent, while idiocy or imbecility and chorea were also found to prevail in an abnormally high degree. Taking the total of all the surviving children of these consanguineous marriages it appeared that 2.7 per cent of them suffered from idiocy, epilepsy, imbecility, hysteria, or other grave cerebral disorders – a proportion very much larger than that generally present among the offspring of those in the same rank of life but who had not contracted consanguineous marriages.

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