Correspondence

EDITED BY KIRIAKOS XENITIDIS and COLIN CAMPBELL

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Zero tolerance of violence

Behr et al (2005) raise important concerns about the relationship of mental health services with the government’s Zero Tolerance Campaign against violence towards National Health Service staff. They argue that the suggested blanket exclusion of those with mental illness from this policy is stigmatising and may appear to condone violence towards staff by patients with mental illness. Clearly this would be a bad thing.

However, I have concerns about further justifications for excluding difficult patients from mental health services, this time under the guise of ‘capacity’. We already have a variety of time-honoured procedures for doing this, such as geography (‘not my catchment area’) and diagnoses (‘personality disorder’ or ‘drug-induced psychosis’). The authors seem to imply that patients either have or do not have capacity, failing to reflect the complexity of the law and the notion of capacity as a phenomenon that varies from situation to situation (in other words, with the gravity of the issue in question) and from time to time. It is not a static property of people, nor is it categorical.

Violent behaviour is often a symptom of mental disorder and may require intervention from mental health services. These individuals already have difficulty accessing services. I would argue that what they need is more not less. Clearly it is not acceptable for mental health professionals to be fearful for their own safety at work, and there need to be appropriate resources and settings in which to safely care for such patients. There is, however, undoubtedly an element of risk in working in such settings, which must be acknowledged and safely managed without being condoned. The criminal law applies equally to psychiatric patients, who should be prosecuted if they break the law, just as any other citizen. Perhaps in the world proposed by Behr et al police officers will be able to refuse to arrest violent people and prison officers refuse to attend to violent prisoners.


S. Wilson Maudsley Hospital, Denmark Hill, London SE5 8AZ, UK.
E-mail: SimonWilson@slam.nhs.uk

Authors’ reply: We are unsure whether Dr Wilson is suggesting that zero tolerance guidelines should not be applied to people who have a mental disorder or whether they should be abandoned altogether.

If the former, he perpetuates the stigma of mental illness and the public perception that psychiatrists are responsible for all actions of people receiving psychiatric treatment. Public attitude may affect people’s volitional capacity (Mele, 2004). The view that all violent behaviour by users of mental health services is a manifestation of illness may therefore be anti-therapeutic by leading people to minimise their own sense of agency. If Dr Wilson is suggesting that the policy should be abandoned altogether, he is perpetuating the notion that people have unfettered rights to receive services. Our view is that this is not the case and that the rights of competent adults should be upheld in association with their observance of their duties.

Although we share Dr Wilson’s concerns about the complexities of capacity assessments, ultimately it is these dichotomous judgements that determine whether people can consent to treatment, be allowed to take the consequences of self-harm or drug addiction and whether they go to jail or hospital for crimes they commit. If we reject the determinist stance that all actions by people with mental illness are undertaken because of their mental illness, it is hard to imagine a better way than by the assessment of their capacity to take responsibility for those actions in question.

Mental health workers, like prison officers, inevitably have to work with people who are aggressive and violent. It is appropriate that violence by prisoners should result in their freedom being further restricted. We believe that in addition to criminal prosecution, limiting or withdrawal of services may provide a similarly appropriate response to violence by capacious users of mental health services.


G. M. Behr Paterson Centre for Mental Health, 20 South Wharf Road, London W2 IPD, UK.
E-mail: graham.behr@nhs.net

J. P. Ruddock Central and North West London Mental Health NHS Trust, London, UK

M. J. Crawford Department of Psychological Medicine, Imperial College, London, UK

Domestic violence and female mental health in developing countries

We read with interest the article by Kumar et al (2005). In developing countries, where families are closely knit and cohesive, domestic violence was thought to be uncommon. However, studies of domestic violence in developing countries show a similar prevalence to that in developed countries. In Sri Lanka a survey at the outpatient department of the North Colombo Teaching Hospital in Ragama, a semi-urban area in the suburbs of Colombo, found that 40.7% of women had been abused by their partners (further information available from the authors on request). The abuse was physical as well as verbal, emotional and sexual and most women reacted in a submissive manner: 79% of those abused have stayed in their marriages for more than 10 years. This submissive behaviour could be because Sri Lankan women usually lack the means to leave their husbands and live independently and the fact that society looks down upon such women.

In a study in eastern Sri Lanka, Subramaniam & Sivayogan (2001) reported that most women, regardless of their level of education and their employment
status, cited the welfare of their children as a prime reason for staying in an abusive relationship.

Parental separation is considered a risk factor for poor mental health in the offspring. Therefore parents staying together in marriage may protect their children from mental health problems. However, in our study children of 31% of the victims had witnessed the abuse. It has been demonstrated that emotional abuse in childhood has a major impact on adult mental health (Edwards et al, 2003). Kumar et al found that 56% of women who had been abused had poor mental health. Since parental mental disorder has been shown to be associated with psychological problems in the offspring (Rutter, 1966), it is doubtful whether staying in an abusive marriage is beneficial for the children.

Studies in developing countries repeatedly confirm that domestic violence is a problem that cannot be ignored and will significantly affect the mental health of future generations. We appreciate the efforts of Kumar et al in highlighting this issue and we consider the time has come to prevent this form of abuse in developing countries.


K. A. L. A. Kuruppuarachchi Department of Psychiatry, Faculty of Medicine, University of Kelaniya, Ragama, Sri Lanka.

L. T. Wijeratne Department of Psychiatry, University of Kelaniya, Ragama, Sri Lanka.

Epidemiological approach to predicting psychiatric risk in the military

The warlike events resulting from terrorism in London on 7 July 2005 have again shown the importance of enhancing human resilience and give special relevance to June’s issue of the Journal. In a marvellous overview, Professor Wessely (2005) gave us his thoughts concerning psychological trauma, modern psychiatric trauma concepts, and the emergence of new syndromes, especially in military settings.

Contrary to Professor Wessely, we are convinced that longitudinal selection provides considerable advantages for psychiatric risk management. Despite the unsatisfactory American experience with personality testing during the Second World War (Jones et al, 2003) our main field of activities is cohort-based psychometric screening and prediction models. In 2002, the Swiss Armed Forces assigned us to investigate new methods to predict psychiatric disorders in servicemen. At first we were sceptical that such a task could be fulfilled. However, we found prediction models to forecast outcome in emergency patients in the medical literature (Tuhrim et al, 1988). Furthermore, personality seemed to play some part in the outcome of somatic disorders (Eysenck, 1988) and suicide seemed predictable from demographic variables (Holinger et al, 1988). Consequently we investigated how these techniques could be transferred to psychiatry.

In a small preliminary (2002) study we screened 3000 recruits on their first day of basic training and followed their medical records for psychiatric problems. Based on clinical–epidemiological knowledge, logistic regression helped us to create a robust multivariable model. Since 2003 the model has been used by the Swiss Armed Forces for recruitment. The model compares each conscript with about 30 000 servicemen. As a result, subsequent psychiatric discharge on the grounds of receiving an ICD–10 (World Health Organization, 1992) diagnosis was significantly lowered by a factor of 3 (or 72%) compared with unscreened recruits. The personality trait of the conscripts did not have any impact.

We are convinced that our prediction model can be successfully adapted to any military service model and operational setting. Therefore, we believe it is too early to bid farewell to psychiatric screening systems in medical risk management.


S. Vetter Centre for Disaster and Military Psychiatry, University of Zurich, Birchstrasse 3, CH-8057 Zurich, Switzerland.

E-mail: stefan.vetter@access.unizh.ch

Author’s reply: I thank Dr Vetter for his cordial letter. The question at issue is not whether or not it is possible to create a statistical model that can predict psychiatric breakdown in military recruits – that is certainly possible, as the experiences of the Second World War psychiatrists showed. The question is with what accuracy one can make such a prediction and what are the consequences for those both correctly identified and, even more importantly, those who have been incorrectly identified (the false positives). Dr Vetter does not provide sufficient information for us to make that judgement. What is needed is the sensitivity, specificity and most importantly the positive predictive value of whatever collection of variables he and his colleagues are using to determine the risk of future illness. It is this statistic that enables us to assess the utility of the proposed model.

Furthermore, we do not know what were the consequences of being labelled as at risk of psychiatric breakdown. Were these people denied military service? Switzerland is one of the increasingly few countries that still has compulsory military service. Serving in the Armed Forces is a fundamental part of the life of every Swiss citizen and enables a person to form social networks that operate for many years. Are people disadvantaged from being denied that opportunity? Given that the Swiss are also famed for their neutrality, the fall in psychiatric morbidity as a result of screening is not likely to be because those denied military service are not exposed to the risks of the battlefield. Instead it may be that their subsequent breakdown merely happens in another sector of Swiss life. Without data from a randomised controlled
trial, it is impossible to decide whether any public health benefit has resulted from introducing psychiatric screening. Given the weakness of the individual predictor variables, the timing of screening (at the end of adolescence) and the fact that to date no programme of psychiatric screening for events that have yet to happen (i.e. future breakdown) has been shown to be effective in a randomised controlled trial, I think that I am entitled to stay with my conclusions that psychiatric screening to detect vulnerability to future breakdown remains unproven and continues to have the potential to do more harm than good. Until such evidence is forthcoming, it may be more useful to devote resources to increasing resilience through support and training, and providing better and more acceptable services to help those who do succumb to the rigours of military life.

Declaration of interest

S.W. is Honorary Civilian Advisor in Psychiatry (unpaid) to the British Army Medical Services.

S. Wessely King’s Centre for Military Health Research, Department of Psychological Medicine, Institute of Psychiatry, London SE5 9RJ, UK. E-mail: s.wessely@iop.kcl.ac.uk

Is gestational week at birth a predictor of schizophrenia?

We read with great interest the article by Isohanni et al (2005), which investigated subtle motor, emotional, cognitive and behavioural abnormalities as predictors of schizophrenia. The authors concluded that these are not useful predictors of illness. However, Isohanni et al did not investigate gestational age as a predictor of psychological abnormalities in later life. This has recently been used as a predictor in some cohort studies (Thompson et al, 2001; Gale & Martyn, 2004; Wiles et al, 2005), and is obstetrically one of the most important predictors of childhood outcomes that are also related to psychological abnormalities in later life (Thompson, 2001; Gale & Martyn, 2004; Cunningham et al, 2005). We feel strongly that birth cohort studies of psychological abnormalities in later life should include gestational week at birth. The study of Isohanni et al would have benefited from inclusion of this variable.

Authors’ reply: We welcome the comments of Shukunami et al but it is important to realise the basic theoretical and practical difference between a risk factor and prediction of illness in the premorbid phase. When exposures are common (as are many obstetric complications) but incidence ratios of the illness are not high and outcomes fairly rare (as is schizophrenia), prediction of future disease is difficult.

Abnormal gestational age may or may not be a subtle risk factor for schizophrenia. This has been analysed in a recent meta-analysis (Cannon et al, 2002) of eight prospective population-based studies of the association between obstetric complications and schizophrenia. Gestational age under 37 weeks was weakly associated with schizophrenia (odds ratio = 1.22, 95% CI 0.90–1.65). The results within the Northern Finland 1966 Birth Cohort were similar (Jones et al, 1998).

Our review mentioned abnormal foetal growth and development as a potential risk factor for schizophrenia, as did Cannon et al, but the predictive power of abnormal foetal growth is weak as it is a rather common phenomenon. Prediction in this situation is not easy at the population level. Our aim was to describe the best known risk factors for schizophrenia, which is why we did not conduct a detailed analysis of gestational age.

The references included in the letter of Shukunami et al suggest that the association of gestational age with other mental disorders may be stronger than for schizophrenia.


M. Isohanni Department of Psychiatry, University of Oulu, PO Box 5000, Finland. E-mail: matti.isohanni@oulu.fi

K. Molanen Department of Psychiatry, University of Oulu, Finland

Stigmatisation of people with schizophrenia in Japan

Lee et al (2005) reported that in Hong Kong individuals with schizophrenia experience stigma even from family members. This stigma as well as public attitudes towards mental illnesses are serious issues. Mental health professionals are expected to take a supportive stance against such stigmatisation. However, is this always the case?

Practising clinicians may have unconsciously been partly responsible for assigning prejudice to the condition. The terminology routinely used in Japanese clinical practice to describe the characteristics of schizophrenia is somewhat derogatory, e.g. the term jinkaku suijin no teika (a decline in the level of personality) is often used to describe a feature ascribed to the larger domain of negative symptoms. The symptoms checklist used in the official mandatory evaluation of long-term inpatients includes one item regarding ‘the morbid state of personality’, apathy and abulia are assigned the label of ‘residual personality changes’, and no other items are assigned to the category of negative symptoms. These descriptions imply that the affected person’s personality has decayed and, consequently, that the process is irreversible.

There are other expressions often used in Japanese clinical practice that may encourage prejudice: these include jigiteki sokai kan (silly or childish cheerfulness), kekkon jotai (a defective state), hinekure (perverseness) and omoi agari (conceited). The latter two terms were introduced in...
Japan in 1956 from the original descriptions (Verschobenheit and Verstiegenheit, respectively) of L.Binswanger (1881–1966) and are still in use. Demands to eradicate the stigmatisation of people with mental illnesses have never been higher in modern psychiatry (Porter, 1998; Crisp et al, 2000; Corrigan et al, 2001). Caregivers need to be alert to the intrinsic problems that may exist in daily practice. The disclosure of medical records is still uncommon in Japan (Takei, 2001) and standardised diagnostic systems such as the ICD–10 (World Health Organisation, 1992) have not been widely used. These practices have fostered reliance on subjective judgement and the use of rather undesirable terminology in clinical practice. Mental health professionals may themselves stigmatisate people with schizophrenia and such an unbecoming attitude may not be limited to a particular country.


Experience of social stigma by people with schizophrenia. Public treatment-related stigmatisations situates, treatment-related stigmatisation exhibits two features that render its impact on patients particularly poignant. First, whereas patients can conceal their illness from friends, colleagues or even family members, total secrecy within the psychiatric treatment system is nearly impossible. Nor can they distance themselves from psychiatric treatment without running the risks of being labelled as ‘non-compliant’ or ‘lacking insight’, and having a relapse of illness. Second, patients often experience unconscious stigmatisation by mental health staff. Instances such as those described by Takei et al frequently occur in the course of routine clinical management by psychiatrists and nurses. However, even when there is no conscious intent to stigmatisate, certain institutional practices in psychiatry that cause stigma are examples of structural discrimination (Pincus, 1996). This arises less from personal prejudice than a combination of causes such as poor quality of health services, inadequate budget allocation and neglected rights of patients.

Psychiatrists have routinely blamed negative social attitudes for the stigmatisation of people with schizophrenia. Public health campaigns have sought to reduce the stigma associated with mental illness by increasing public knowledge. Without doubting the benefit of attitudinal shifts among the general population, we believe that programmes aimed at reducing stigma must be informed as well as evaluated by patients’ lived experience of psychiatric treatment. Tackling structural discrimination and the resulting power difference is at the root of such a change.


N. Takei Department of Psychiatry and Neurology, Hamamatsu University School of Medicine, Hamamatsu, Shizuoka 431–3192, Japan, and Section of General Psychiatry, Division of Psychological Medicine, Institute of Psychiatry, London, U.K. E-mail: ntakei@hama-med.ac.jp

S. Takei, N. Mori Department of Psychiatry and Neurology, Hamamatsu University School of Medicine, Hamamatsu, Japan

Authors’ reply: Takei et al give salient examples of how psychiatrists and psychiatric treatment contribute to the stigmatisation of individuals with schizophrenia in Japan. We discuss similar and other related instances of such treatment-related stigma in a separate paper (Lee et al, in press).

Compared with stigma in most social situations, treatment-related stigmatisation exhibits two features that render its impact on patients particularly poignant. First, whereas patients can conceal their illness from friends, colleagues or even family members, total secrecy within the psychiatric treatment system is nearly impossible. Nor can they distance themselves from psychiatric treatment without running the risks of being labelled as ‘non-compliant’ or ‘lacking insight’, and having a relapse of illness. Second, patients often experience unconscious stigmatisation by mental health staff. Instances such as those described by Takei et al frequently occur in the course of routine clinical management by psychiatrists and nurses. However, even when there is no conscious intent to stigmatisate, certain institutional practices in psychiatry that cause stigma are examples of structural discrimination (Pincus, 1996). This arises less from personal prejudice than a combination of causes such as poor quality of health services, inadequate budget allocation and neglected rights of patients.

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S. Lee Hong Kong Mood Disorders Centre, The Chinese University of Hong Kong, Prince of Wales Hospital, Sha Tin, Hong Kong. E-mail: singlee@cuhk.edu.hk

A. Tsang Hong Kong Mood Disorders Centre, The Chinese University of Hong Kong, Hong Kong

A. Kleinman Department of Anthropology, Harvard University, USA

One hundred years ago

Criminality in the feeble minded

The weak-minded criminals of the type which we have indicated are, Dr. Smalley tells us, for the most part recidivists. Beginning their penal career at a relatively early age, generally about the period of adolescence, when they are forced to enter on the struggle for existence for which they are so heavily handicapped by their defective organisation, they continue through the rest of their lives to oscillate between the prison, the asylum, and the workhouse, with brief intervals of freedom, during which they can be more actively noxious. Ordinarily the offences which they commit are of a relatively trivial character, being indeed, very often rather sins of social omission than acts really meriting the name of crime. This general rule, however, is subject to many and grave exceptions. The feebleness of mind which renders these defectives incapable of sustained effort and of due adaptation to environment drives them to parasitic ways of life, while it involves a lack of self-control which leaves their conduct at the mercy of every casual impulse of unusual intensity. An outburst of lust will provoke them to rape or bestiality, or an exaggerated sense of injury aroused by some trivial incident will impel them to wreak their vengeance in murder or arson.

The number of the criminal defectives of this lowest class is not, it would appear from the available records, very large. The official figures for the last three years put

590
it at 1090, and this would probably include some instances in which the same individual was counted more than once. When it is further borne in mind that a not inconsiderable share of this total is made up of cases of senile and alcoholic dementia and other forms of enfeeblement which are rather inert and helpless than actively mischievous, it will be seen that the group may be reduced to even more moderate proportions. On this fact of their relatively small number, taken in conjunction with the extent and variety of their anti-social activities, Dr. SMALLEY is able to found a convincing argument in favour of dealing with these weak-minded offenders on special lines. The expense that would be incurred by their permanent detention in a suitable institution would, he points out, be covered, at least in part, by the saving of the cost now involved in repeatedly prosecuting them and maintaining them in prison. Moreover, it is possible that under a course of continuous and appropriate training which would develop whatever manual aptitudes they possess—and in many cases these aptitudes are considerable—they could be made to contribute in some measure to their own support. In any circumstances there can be no question as to the advantage that would accrue to the community from the substitution of such a scheme as Dr. SMALLEY suggests for the present system, which is not only expensive and cumbrous but which falls completely to secure what should be its first aim, the adequate protection of society.

REFERENCE


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