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# Correspondence

## Responding to stigma

Dear Sirs

The detailed response to my article 'Whatever Happened to Stigma?' (*Bulletin*, January 1986, **10**, 8–9) has shown the concern that many psychiatrists, and others, feel about this topic. King (*Bulletin*, April 1986, **10**, 83) has pointed to the unpredictability and uncertainty attached to psychotic patients, noting the layman's view that such illness is 'not real' and 'weird'. Stafford-Clark (same page), in a generous and constructive letter, has stressed the need for psychiatrists to set an example to their colleagues and to see patients (sufferers) rather than clients (customers). Davidson (*Bulletin*, June 1986, **10**, 155) provided data supporting my own, pointed to the urgent need to ensure appropriate services 'to reduce the build up of negative attitudes', and suggested that the College should be at the forefront of research in this field.

Perhaps the most detailed response was that of Spicker (*Bulletin*, September 1986, **10**, 250–251) who suggested that it was beliefs about behaviour and the users of psychiatric services, rather than the services or status of psychiatry itself, that led to stigma. He quoted American research suggesting that more specific definitions of illness created a focus of rejection. The paradox of a precise science seems to be that a 'cure' is expected. None of which I disagree with, but there still seems to be a need for internal action, within the medical profession. There is no prospect of eradicating the superstitious/irrational basis for stigmatising madness, not least because of the 'sense of personal threat' that the condition involves. But until the image of the psychiatrist—the popular versions of TV, books, the cinema—is co-equal with that of the heart surgeon or trusted GP, any attempt by psychiatrists to change opinion will necessarily backfire.

Snide comments about alienists have been around a long time. Ernest Jones quotes a colleague, 'I suppose they read papers on an improved variety of Chubb lock',[1] from the early 1900s. Vincenti (*Bulletin*, September 1986, **10**, 249) quotes a 1984 article by Fink[2] entitled 'You are the only sane psychiatrist I know'. Given the student attitudes elicited by Davidson and myself, and that they can be changed,[3] this is something that the College should be working on. Not only must they insist on retaining a significant slot in the student curriculum for psychiatry, but the teaching therein should be coherent and forceful. Ideally there should be some infiltration into the general medical teaching, so that the psychological problems of hospitalisation and serious physical illness are considered alongside the obvious physical signs.

Of course, the real need is for post-graduate psychiatric experience to be incorporated into the routine training of any general physician. Most GP rotating training schemes include a psychiatric attachment, to everyone's benefit, but will the guardians of the MRCP grasp such a nettle? That should be one of the College's aims, if, like the American Psychiatric Association (Vincenti, *Bulletin*, September 1986, **10**, 249), they are prepared to regard stigma as a priority issue.

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## Mental Health Act 1983

Dear Sirs

As a newly approved member under Section 12(2) of the Mental Health Act (1983) and in response to Dr Aznonye's letter (*Bulletin*, August 1986, **10**, 211), I should like to point out that a sufficient working knowledge of the Mental Health Act is achieved during the course of psychiatric training and for the Membership examinations. In the post-Griffith era, therefore, where we are confronted with limited resources, administrative costs, cost-effectiveness, etc., I should think that the considerable overlap between the above and the oral test suggested by Dr Aznonye would make the latter an expensive and unnecessary exercise. Furthermore, I am sure that passing the Membership examination is an adequate test for the 'experience in the diagnosis and treatment of mental disorders'.

J. S. Bamrah

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