Japan in 1956 from the original descriptions (*Vershrobenheit* 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 Organization, 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 stigmatise people with schizophrenia and such an unbecoming attitude may not be limited to a particular country.

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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 stigmatise, 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.

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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

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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.

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