

will prevent situations where trainers ask Part 1 candidates what essays they wrote in the examination!

MINDHAM, R. H. S. (1995) Arrangements for MRCPsych examinations. *Psychiatric Bulletin*, **19**, 448–449

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HoNOS, CPA CPGs & Co

Sir: I attended the meeting of the Royal College of Psychiatrists in Torquay and took part in one afternoon session looking at Health of the Nation Outcome Scales (HoNOS), Clinical Practice Guidelines (CPGs), and the Care Programme Approach (CPA).

Individually, each of these developments is difficult to fault, as will no doubt be those that follow. HoNOS perhaps has the potential for national audit and the examination of the effectiveness of treatment, CPGs may allow the standardisation of treatments/procedures which are generally felt to be the most beneficial, and the CPA presumably has the advantage of ensuring people are not forgotten or ignored. In spite of this I have reservations on all three.

The subjective element of HoNOS is open to considerable abuse if used nationally to sort out the best from the worst services (it is surely inevitable it will be used for this purpose). CPGs invite the unrealistic expectation of 'perfect' treatment at all times with the likelihood of legal repercussions in some cases. It would also seem likely a few patients will miss out on the benefit of a treatment that is felt by their doctor to be right but which isn't prescribed because it doesn't follow the particular CPG.

During the presentation on the CPA it was explained how a psychiatrist, assessing a person in an out-patient clinic, making a referral to a specialist counsellor, following up the patient at a subsequent clinic, and calling themselves the keyworker, could then document that they had followed the CPA for this particular individual and by implication be satisfied with their thorough approach. Since this would have been normal practice in any case, the exercise in this case seems pointless while creating additional paperwork.

Individually, none of these approaches is bad; however, each is something more to remember or consider, and I can't help wondering if they will be the last 'innovations'. They also seem to require the unrealistic expectation that doctors will be perfect at all times, i.e. perform at the standard of the best available (a similar argument might suppose we should all be able to run 100 metres

in 10 seconds, since this is the standard for optimum human achievement).

Perhaps the worst aspect is that in applying HoNOS, recalling all relevant CPGs, and successfully documenting CPAs, along with audit activity, business information and the rest that is currently demanded, there may be insufficient time to look at the clinical picture presented to us and consider properly how best to offer help.

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Schizophrenics, the unnameable?

Sir: Two fundamental problems in finding an acceptable way of describing 'an individual with schizophrenia' are the status of schizophrenia as an illness and the context in which the description is used. Haghghat & Littlewood (*Psychiatric Bulletin*, July 1995, **19**, 407–410) offer a valuable analysis of language, but are writing expressly in the medical model. The proviso, "if... people avoid certain linguistic forms... even when they accept that they have developed the corresponding illness..." avoids the issue. Whether one accepts the arguments against schizophrenia as a discrete entity or not, the 'safest' (least stigmatising? Most acceptable?) description may be, 'an individual with the diagnosis of schizophrenia'. This both allows for the medical model but begs the question of the existence of schizophrenia. The use of the word 'sufferer' is not without problems, not least the theological imperatives implied in the word (Atkinson, 1993), and that it seems to suggest the person's whole life is one of suffering.

Current labels/descriptions used by 'patients' focus on behaviour/experience, such as 'voice hearer' favoured by those in the Hearing Voices Network, or 'status', such as 'survivors' (of the system or of the illness) as in the group Survivors Speak Out. 'User' is common and often used as the best of a bad lot. In her last editorial (1995) in *Openmind*, Helen Imam confesses "that I never did like the term 'user' (nor 'carer' come to think of it!)" and the incoming editor offers a prize for "the best argued case for a better word than 'user'" (Daley, 1995). 'User' can be seen to imply choice, which many 'users' would deny they had.

Different situations call for different degrees of precision. 'People with mental health problems' fits some situations, but some argue that it diminishes the seriousness of their problem. The problems and stigma surrounding descriptive/diagnostic terms are not special to psychiatry. The disability rights movement eschews medical labels, seeing these as a major hindrance to overcoming barriers to their integration into society.

We might all agree that 'schizophrenic' is no longer acceptable, but there is probably no (lasting) stigma free description (witness the use of 'care-in-the-community-patient' as a term of derision in the media). Much of the stigma surrounding schizophrenia comes from misconceptions about the condition and a (careless? malevolent?) misuse of the word by the media. No matter how idealistic, our best hope of reducing the stigma attached to 'schizophrenia' probably has more to do with education and changing attitudes than with just changing labels. It is reassuring that groups as diverse as the Royal College of Psychiatrists and the user-based Schizophrenia Media Agency are working to change press reporting of mental illness.

ATKINSON, J. M. (1993) The patient as sufferer. *British Journal of Medical Psychology*, **66**, 113–120.
DALEY, P. (1995) Comment. *Openmind*, **75**, 3.
IMAM, H. (1995) Comment. *Openmind*, **75**, 3.

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Offensive or stigmatising labelling: an open letter to Sue Stephens

Sir: The letter from Sue Stephens (*Psychiatric Bulletin*, July 1995, **19**, 453) requires comment.

Over the centuries, technical term after technical term relating to neuropsychiatric disorders has been abandoned as stigmatising. This is because they eventually come into common parlance and generally in a pejorative way.

Examples of this abound: cretin, idiot, imbecile are long gone, psychopath and psychotic seem destined to go this way and now the term schizophrenia is raised as a further potential casualty.

There will, of course, come a time when we run out of replacement terms and perhaps we should anticipate this now and go back to archaic usage. The varying terms for mental handicap (sorry, learning difficulties!) are too embedded in the English language to resurrect. With regard to schizophrenia, however, perhaps we might return to Kraepelin's term, and, wishing to avoid obfuscation through the use of Latin, start calling our schizophrenic patients 'precocious dements?'

It is a sad reality of life that psychiatrists treat patients who are very frequently viewed by society as worthy of stigmatisation and until society changes its view of mental disorder, the trend towards repeated campaigns for heuristic relabelling will do nothing but to add to the growing vocabulary of terms of abuse.

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Is this racism?

Sir: I was astonished to read Birgit Berg's letter (*Psychiatric Bulletin*, July 1995, 449–450). While there can be no doubt that racism occurs, I do not understand Dr Berg's need to confront her patients regarding their behaviour during a manic episode.

We detain manic patients because of just this inappropriate, disinhibited behaviour as it may lead to the patient being at risk from others' possibly aggressive reaction to this behaviour. How therefore can we, on the one hand say this behaviour is secondary to mental illness, and on the other chastise patients for behaving in an offensive way to ourselves.

I doubt whether there is anyone working in psychiatry who has not been insulted by a manic patient over some personal issue, be it appearance, weight, clothes or competence. But surely the way to respond is to recognise these actions as the result of illness. The real cause for concern is the racism encountered from non-disinhibited patients, their relatives and worse other professionals, and it is they who need to be 'engaged in discussion' regarding their behaviour. Not the recovered patient who is often horrified by his/her behaviour when ill.

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Sir: In response to Dr Mulligan's letter, racism is defined as "discrimination against a person on the grounds of the person's race/nationality". Even though a patient's symptoms like elation, disinhibition or the occurrence of delusions are explained by their mental illness, the content of those symptoms are not. This forms part of an individual's cognitions influenced by belief systems of the particular time and society. These cognitions are displayed in a kind of 'raw form', are 'exaggerations' of the person's normal perception when for example in a manic phase. But they are also to a certain extent under a patient's control – a fact one uses in cognitive-behavioural therapy.

The patients in question were clearly in remission and their behaviour concerned was provocative and a means of getting attention. By setting boundaries in showing which behaviour is unacceptable they learned how to change. This made a difference to the general atmosphere and set also an example. After all mental health workers are not 'dustbins' but human beings.

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