return it offers a reflection on the whole of the subject's personality (life-situation, history etc., which are assembled from a multitude of actions, motives and reasons as they are observed by us). Here we have the hermeneutic circle which is not really circular, as Will[4] would have it, but leads by each revolution to a deeper, richer and more accurate, but of course never complete, understanding.

Thus, unlike Will, who rejects both a Popperian and an hermeneutic interpretation of psychoanalytic method, his philosophical mentor Bhaskar would accept the limitations of the human sciences in their dependence on understanding to define their generative mechanisms.

K. P. EBMEIER

University of Aberdeen
Department of Mental Health
Aberdeen

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DEAR SIRS

Whilst sharing Dr Mathers[1] concern at the uncritical use of some of Karl Popper's writings to justify a particular position with regard to psychoanalysis, I feel less hopeful that a descriptive model of science which includes psychoanalysis will provide psychiatry with sufficient justification for research into its practical applications. There is an absurdity in a description of science which leads to the conclusion that the activities of the nuclear physicist and the psychoanalyst are similar in a way which is more important than their differences and that the similarity means psychoanalysis is inescapably scientific, sensible and fit for research. The analogy, it seems, changes only the status of the analyst and not the physicist.

Indeed, it is not clear that definition is the most valuable contribution the philosophy of science makes to psychiatry or if such definition is at all possible. Some philosophers, like Laudan[2], feel that 'The quest for a specifically scientific form of knowledge, or for a demarcation criterion between science and nonscience has been an unqualified failure . . . it is time we abandoned that lingering scientistic prejudice which holds that the 'sciences' and sound knowledge are co-extensive: they are not'.

Surely more challenging, but ultimately more rewarding than description and definition, is to attempt to apply logic, epistemology and metaphysics to our intellectual enquiry irrespective of its scientific status in order to determine 'what principles are assumed in the use of time honoured methods of acquiring knowledge'.[3] If psychoanalysis provides logical reasoning, a clear conceptual framework, and a coherent theory of knowledge, why should the status of nonscience in itself lead us to regard it as nonsense?

RACHEL M. A. BROWN

The Maudsley Hospital
London SE5

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The Yorkshire Regional Psychiatric Association—an appeal for memories

DEAR SIRS

The Leeds Regional Psychiatric Association was founded on 24 January 1949. Open to psychiatrists, psychologists, social workers, chaplains, nurses and others working in the field of mental health, it claims the distinction of being the first inter-disciplinary society of professional workers in mental health to be established in the United Kingdom.

In May 1982, to maintain consistency with NHS administrative reorganisation, the Association changed its title to the Yorkshire Regional Psychiatric Association.

The 40th Anniversary of the Association will fall in 1989 and its Executive Committee has discussed marking this achievement with a publication. The Association is therefore seeking to complete its records as far as possible.

If any psychiatrists who have had past membership of the Association can supply information and memories from old programmes, diaries and recollections, their help will be gratefully appreciated by the Association.

D. A. SPENCER
Honorary Secretary
YRPA

Meanwood Park Hospital
Tongue Lane, Leeds

Is psychiatry stigmatising?

DEAR SIRS

Turner has recently reviewed some of the attempts to reduce the stigma attached to the receipt of psychiatric services, and concludes that in order to reduce stigma it is necessary to improve the status of psychiatry.[1] I can understand that this conclusion might appeal to psychiatrists, if only on the basis of self interest, but there are grounds for scepticism. There has been extensive research in the US into the grounds for the rejection of mentally ill people. It is never possible to generalise with confidence between different countries, but the evidence that there is suggests that the problem of stigma, and the rejection of people who are mentally ill, is more complex than Turner's analysis suggests.

Turner asks why mental illness should be rejected more than other complaints, like multiple sclerosis or diabetes. It

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is evidently true that mentally ill people are rejected more than many others. Tringo suggests, on the basis of survey research, that there is a 'hierarchy of preference' between different diseases and disorders ranging from arthritis, diabetes and asthma (at the lowest degree of rejection), through amputation, blindness and stroke, to cancer, old age and epilepsy, and at last to the strongest rejection of tuberculosis, mental handicap, alcoholism and mental illness.[2] Tuberculosis is infectious, and both alcoholism and mental illness carry moral stigmas, but it is difficult to see why mental handicap should be rejected to anything like the same extent. The hierarchy is difficult to explain in any rational terms, and it appears that in practice much is identifiably irrational—based in superstition, fear of contagion or prejudices which are scarcely founded in reality.

Despite the clear differences between these conditions—and major differences between different types and kinds of mental illness—there is a surprising amount in common between social reactions to them. People with multiple sclerosis, to take Turner's example, may not be stigmatised to the same degree as mentally ill people, but they are substantially rejected.[3] Like mental illness, the disease often creates a sense of anxiety, or of personal threat. There is a tendency to 'blame the victim' for the condition. And there are other factors shared by people who are chronically sick: in particular, they are liable to be poor, which limits their ability to live a normal life. They may feel a sense of rejection because of their inability to participate fully in society. They are likely to have a dependent and inferior social role. None of this has been relieved by the more precise definitions of multiple sclerosis as an illness, and the idea that exact diagnosis can help to reduce stigma may be illusory.

It does seem only common sense to say that if mentally ill people are rejected because of fear or uncertainty, the degree of rejection should be reduced by more confidence in the medical response to mental illness; but in practice, the opposite may be true. In a classic study, Cumming & Cumming found that members of the public were more negative in their attitudes to mental illness after a programme of community education than before it.[4] The members of the public had a higher initial tolerance of disturbed behaviour than the psychiatrists in the programme did. However, they also made a strong distinction between people who were *ill* and those who were not. The effect of learning about mental illness was to define the limits of acceptable behaviour more clearly and strictly, and so to increase the degree of rejection. There is a clear dilemma here in community education. If mental illness is described as a set of disorders of varying degrees of severity which can affect anyone, it increases the uncertainty and anxiety associated with the concept. On the other hand, if psychiatry is represented as a precise science, it may emphasise the dichotomy between mental illness and 'normal' behaviour. Among the Cummings' respondents, the confidence that mental illness could be treated 'scientifically' made the problem of rejection worse, because they expected patients to be isolated until they were 'cured'.

It is true that people are stigmatised as a direct consequence of seeking psychiatric help. Changes in the way that psychiatric services are given can make a significant difference to this. Phillips offered survey respondents short pen-portraits of people with various degrees of disturbed behaviour. He found that rejection of these people increased according to the source of help that was asked for; a person with mental difficulties who sought help from a friend was less rejected than someone who sought help from a general medical practitioner, a person who visited a psychiatrist was rejected more, and someone who had been treated in a mental institution was rejected most of all.[5] The type of help sought is one of the best indicators that a lay person has of the seriousness of the problem. Someone whose behaviour was normal would, perhaps unsurprisingly, be substantially rejected if he had been treated in a mental institution;[6] the person is 'labelled', and there may reasonably be some uncertainty as to how that person will behave in the future. The effect of seeking psychiatric treatment may, then, be to define the condition more specifically, and to give a focus for rejection. One of the main arguments for dealing with mental illness within the general health service is that it can help to conceal the problems of individuals from public view.

This does not mean that the label is all-important. Mentally ill people are visible as much through their behaviour as through the medical response to their condition, and Segal, reviewing the literature on attitudes towards mental illness, concludes that 'The behaviour itself, or the pattern of behaviour, is the major determinant of the positive or negative character of the public's attitudes towards mental illness.'[7] The negative attitudes attached to people who use psychiatric services mainly stem, not from the nature of the services, but from beliefs about the users themselves.

PAUL SPICKER

Trent Polytechnic
Nottingham

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