



the columns

correspondence

Conspiracy of silence?

Sir: The finding of Clafferty *et al* (*Psychiatric Bulletin*, September 2001, **25**, 336–339) that only 59% of consultant psychiatrists told people their diagnosis of schizophrenia at the time of the first “established episode” raises a number of interesting issues that deserve further discussion and debate. The conclusion that failure to disclose such a diagnosis constitutes a “conspiracy of silence”, contributing to the stigma of mental illness, is highly questionable. Even with operationalised diagnostic criteria, the diagnosis of schizophrenia is often highly unreliable and premature diagnosis may lead to considerable negative effects for the individual concerned and his/her family (McGory, 1995).

The finding that large numbers of consultant psychiatrists use the term psychosis may reflect an increasing trend away from the use of a diagnosis of schizophrenia that has low reliability and questionable validity. There is a growing voice of opinion in favour of the use of the term psychosis, which seems to be meaningful and acceptable to patients (Spencer *et al*, 2001).

Perhaps there is a need for greater consensus between psychiatrists about how best to give helpful and honest diagnostic information to patients and their families.

McGORY, P. D. (1995) Psychoeducation in first episode psychosis: a therapeutic process. *Psychiatry*, **58**, 313–328.

SPENCER, E., BIRCHWOOD, M., McGOVERN, D. (2001) Management of first-episode psychosis. *Advances in Psychiatric Treatment*, **7**, 133–142.

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Sir: Clafferty *et al* (*Psychiatric Bulletin*, September 2001, **25**, 336–339) report some very interesting findings. Some of their conclusions urging increased disclosure of the diagnosis of schizophrenia are, however, problematic.

In the course of studying the social correlates of insight in 150 people with schizophrenia (White *et al*, 2000), we found that individuals with poor insight reported, strikingly, that they were

rarely able to trust or confide in health professionals.

There is no evidence that telling this surprisingly large group of patients their diagnosis will impact on their poor insight. It is more likely that it will antagonise them, and further damage an already fragile therapeutic relationship.

It would seem much more important in this instance to recommend that doctor and patient develop an understanding of the patient’s experiences that is shared by them both, and that can subsequently form the basis of mutually acceptable therapeutic interventions. This principle, which is collaborative rather than didactic, egalitarian rather than authoritarian, underpins much cognitive–behavioural therapy for psychosis and requires the clinician to work more with the patient’s existing beliefs. Seen in this light, blanket recommendations regarding the disclosure of diagnosis for the sake of reducing the stigma of schizophrenia lack subtlety, and indeed seem misplaced.

WHITE, R., BEBBINGTON, P., PEARSON, J., *et al* (2000) The social context of insight in schizophrenia. *Social Psychiatry and Psychiatric Epidemiology*, **35**, 500–507.

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Women patients in medium secure psychiatric units

Sir: The development of separate secure services for women (Hassell & Bartlett, *Psychiatric Bulletin*, September 2001, **25**, 340–342) is essential. However, in my experience the campaign to develop such services is brushing aside the limitations of both our phenomenological understanding of a particular group of patients, and the evidence base for interventions for this group. These patients, who I anticipate will be instantly recognisable to clinicians, present with many features of borderline personality disorder and some “are subject to episodic descent into psychosis”. I do not want to revisit the failings of the personality disorder/mental illness dichotomy. However, even when our current pharmacopoeia is exhausted,

many of these patients continue to manifest evidence of severe psychological vulnerabilities, which have been present from an early age, and for which long-term psychological interventions are recommended. Forensic psychiatrists have become increasingly cautious about admitting male patients who present with problems primarily attributable to their personality. Disproportionately more women than men with a primary diagnosis of personality disorder are admitted to secure services (Coid *et al*, 2000). Does this gender bias reflect a particular therapeutic optimism or medical paternalism?

COID, J., KAHTAN, N., GAULT, S., *et al* (2000) Women admitted to secure forensic services: I: Comparison of women and men. *The Journal of Forensic Psychiatry*, **11**, 275–295.

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Sir: Hassell and Bartlett (*Psychiatric Bulletin*, September 2001, **25**, 340–342) provide a welcome snapshot of women in medium security. They report large increases in numbers of women in such conditions, of whom almost all those detained in NHS facilities are in mixed gender units. They find that women are more often in private sector units than men, and comment that some units no longer accept women because the environment is considered unsuitable.

Service planners have woken up to the fact that mixed gender wards do not work. This is not a surprise, given the historical lessons that prison development has taught us. In the early 19th century women comprised around 20% of the prison population. High profile campaigning led to formal recognition of the problems they faced when regularly outnumbered by men in gaols. The Gaol Act, passed in 1823, led to gradual separation of penal facilities and presently there are 10 establishments in England (none in Wales) that care for women only (Home Office, 1997).

The National Service Framework (Department of Health, 1999) gives a clear commitment to ending mixed gender hospital accommodation, and makes it clear that “as part of the strategy to provide safe services NHS trusts need to . . . recognise that the needs of male