freedom of the child and his family. It emphasises and labels the separateness of children with special needs permanently and it reduces flexibility of provision. It takes up much valuable professional time and is therefore costly.

Warnock[4] considered that the acknowledged disadvantages of recording were outweighed by the following advantages: (i) unless needs are recorded there will be defaults in provision; (ii) it ensures continuing specialised help if children move from one school or LEA to another; and (iii) it gives the right to parents to demand that the child's needs are met and to appeal if they are not. We recommend that consideration be given to a less cumbersome and more informal method of recording for all cases where there is agreement between parents, professionals and LEA about the child's needs.

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Whatever Happened to Stigma?

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Even before Erving Goffman's *Stigma: Notes on the Management of Spoiled Identity* was published in 1963, it had been a commonplace notion that there was a *stigma* attached to psychiatric illness. King Lear's cry 'Let me not be mad, not mad, sweet heaven' echoes down the ages. But in the years since Goffman's book there has been a concerted attempt by psychiatrists, by patients' groups, by the media, to 'destigmatise' and 'demythologise' psychiatry. This has taken many subtle forms, but several major themes were apparent.

One school felt that the labelling of an individual, as a schizophrenic for example, tended to promote a persistent handicap and should therefore be avoided, particularly in young people. But the substitution of terms such as 'situational crisis in a vulnerable individual' or 'schizoid personality' or 'adjustment reaction' did not actually make nuclear symptoms go away. Such euphemisms may even have led to inadequate treatment and a reinforcement of the belief that psychiatric illness was untreatable. Nor is it entirely clear why the term 'schizophrenia' should have had a more noxious, stigmatising effect than the terms 'multiple sclerosis' or 'diabetes mellitus'. It seems to have been a conceit of psychiatrists that the general public, many of whom are ignorant of where their liver is, should somehow know all about the severe effects of a true schizophrenic illness. Nevertheless, at least the real issue behind this concern, misdiagnosis, has been systematically tackled. Improved training, operational criteria for diagnosis, and the WHO studies have all helped, while it is probably true that the vagueness and variability of psychiatrists in describing psychopathology is in thankful decline.

Other attempts to destigmatise have involved the transfer of psychiatric facilities to general hospital premises. Thus out-patient and in-patient care can now be equated with *medical* treatment and plans to phase out the large asylums continue apace. It is difficult to gauge how successful this has been.

Some psychiatrists clearly welcome no longer being isolated from their professional colleagues. Whether these same professional colleagues welcome psychiatrists and their patients wandering around the general hospitals is less clear. 'Liaison psychiatry' has an enthusiastic priesthood, but seems to be viewed by some physicians primarily as a means of disposing of their difficult or uncooperative patients. Perhaps it is fortunate that the modern fashion of medicalising one's distress by taking an overdose has made psychiatric involvement something of a necessity on the acute medical wards. But this very fashion of overdosing, of seeking white-coated hospital care, may well derive in part from the public's anxiety about direct psychiatric referral. It is *because* of the persistence of stigma that we, the psychiatrists, have had to follow our patients into the general hospitals? Are we merely reinforcing the stigma by camouflaging ourselves as humdrum hospital doctors?

Alongside this professional sidestep has been the growth of care in the community, a contentious issue often seen in black or white terms. While deinstitutionalisation was the main thrust behind this policy, there was also a belief that the stigma of mental illness would be reduced by the presence of psychiatrically handicapped individuals living normally and safely in the house next door. Provided these clients/patients—should we name them according to medical or social terminology?—are well behaved, such community care may be successfully destigmatising. But the increase in vagrancy, the much-publicised pressures on the prison system, the occasional episode of psychotic violence (e.g. the ex-Broadmoor patient who stabbed someone at random so as to return to an institution) may well be reinforcing the old, primal prejudices. Psychiatrists trying to establish medium secure units have also met powerful local resistance of the NIMBY (Not In My Back Yard) variety.

Nevertheless, outside the profession as well there have been important initiatives. The work of MIND in establishing patients' rights, the changes in the 1983

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Mental Health Act, the regular discussion of psychiatric problems in the media (e.g. the TV series 'Maybury' with its gentle, semi-didactic tone), the much-publicised efforts of Betty Ford and Rosalynn Carter in the USA, all have aimed in part at changing public attitudes towards mental illness. Even the common journalistic mistake, the use of the word schizophrenic to mean 'in two minds', may be seen as an unconscious attempt to assimilate and demythologise psychiatric terminology and illness. How successful has all this been? It is hard to judge, but there are some extremely worrying trends.

For example, Tyrer,[1] in his survey of community care, reported that 37 per cent of patients preferred attending a GP psychiatric clinic as there was less stigma attached. This reflected Shepherd's 1966 study,[2] wherein the stigma of psychiatric illness was 'the most frequently cited reason for not referring appropriate cases to a psychiatrist'. More informally, in the City and Hackney District non-attendance rates of newly referred out-patients are much higher at the Psychiatric Unit based below the acute wards, than in the out-patient only department of the general, teaching hospital. Furthermore, going back to our old friends, the serious media, they no longer seem to be as complimentary as they were. 'GPs, physicians and *even psychiatrists* are called Doctor' writes Katharine Whitehorn in an article quaintly entitled 'Who's hysterical now?' (*Observer*, 2 June 1985, p. 41). More alarming still, the old bogey of 'violence means madness' seems to be raising its ugly head. In *Killing for Company*[3] Brian Masters is somewhat dismissive of the psychiatric contribution to the Denis Nilsen trial, but the whole tone of the book suggests that a psychiatric disease, of some sort, *must* be forthcoming when a mass murderer is being assessed.

Likewise, a more direct example comes from a trial report in the *Hackney Gazette* of 5 March 1985: 'S-, convicted of double murder, wounding and affray was described as a "lunatic" by Judge Mason who added, "What you did was wicked beyond belief".' The judge is also reported as saying, 'You behaved, as I think you know now, like a lunatic and caused misery and distress to many.' Here the equation of lunacy with wickedness is quite overt, a cruel insult to the great majority of psychiatric patients. Moving beyond the area of the law and journalism, it should also be noted how stigma pervades the world of commerce. Mental illness is often excluded from health insurance plans; it is not a justifiable excuse for cancellation of a holiday and compensation thereby; it excludes the sufferer from a range of harmlessly routine jobs. Ex-patients are thus put in the unpleasant and unfair dilemma of having to lie or miss out on these standard benefits of 'normal' society.

But how can all this be altered given the deep roots of our fear of insanity? There are no obvious answers. Perhaps, as a start, the attitudes of doctors—who are still said to be respected members of society—can be changed. For the stimulus to this brief review arose from a routine survey made of students' attitudes to psychiatry, using a 21-point questionnaire. Three questions were relevant. To the question 'Has psychiatry a high status amongst medical disciplines here?' : 9 per cent answered positively, 59 per cent negatively and 32 per cent 'don't know'. To the question 'Psychiatry is a respected subject among the general populace?': 25 per cent answered positively, 59 per cent negatively and 16 per cent 'don't know'. Finally, to the question 'Are most non-psychiatric doctors dismissive of psychiatry?": 64 per cent replied positively, 22 per cent negatively and 14 per cent 'don't know'. Which may all be dismissed as only relevant to a particular medical school and a poorly designed questionnaire. But its truth can be tested and action taken. I have little doubt that it is doctors' attitudes, especially those promulgated in some teaching hospitals, that need to be tackled. We must eliminate psycho-jargon such as 'hysterical' or 'psychotic' from our terms of disapproval. We must *not* be reasonable when snide remarks about psychiatry are made by other specialists. Nothing will happen to stigma unless active steps are taken, ideally at the very roots, at the first interview for medical school training.

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Twins with Anorexia Nervosa

A further study of twins with anorexia nervosa has been planned following an initial study reported by Holland *et al* (*British Journal of Psychiatry*, October 1984, **145**, 414–419). We would be grateful if anyone who knows of identical or non-identical twins in which one or both have suffered from anorexia nervosa, could contact us, so that we may discuss the possibility of including them in this study. All information would be held in complete confidence and any expenses incurred by the twins fully reimbursed. If you know of any suitable twins could you write to or telephone Dr Tony Holland or Nancy Sicotte at the Genetics Section, Institute of Psychiatry, De Crespigny Park, London SE5 8AF (telephone 01-703 5411 ext. 66).

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