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## Artículo de revisión

# El complejo estigma-discriminación asociado a trastorno mental como factor de riesgo de suicidio

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## R E S U M E N

**Introducción:** Se propone el concepto “complejo estigma-discriminación asociado a trastorno mental” (CEDATM) para englobar los términos usados en la teoría de la atribución: estigma, estereotipo, prejuicio y discriminación. El CEDATM (el internalizado y el percibido) es un fenómeno frecuente que puede explicar un porcentaje de los casos de suicidio.

**Objetivo:** Revisar los factores que pueden explicar la asociación existente entre CEDATM y suicidio y postular posibles mecanismos implicados subyacentes.

**Resultados:** Se identificaron artículos en MEDLINE con los descriptores en inglés para “estigma”, “trastornos mentales” y “suicidio” o “tasa de suicidio”. Se incluyeron artículos publicados entre enero de 2000 y junio de 2014. No se consideraron revisiones del tema y estudios de casos. Los dos estudios incluidos mostraron que el estigma incrementa el riesgo de comportamientos suicidas. Se evidenció que las personas con estigma internalizado realizaron más intentos de suicidio y que la tasa de suicidio en población general es más alta en los países con mayor estigma percibido. Se consideró que la relación entre CEDATM y suicidio se establece por mecanismos interrelacionados: un mecanismo “directo” que incluye el CEDATM percibido y se configura como barreras de acceso a servicios y acciones en salud mental, y un mecanismo “indirecto” que involucra el CEDATM internalizado y que incrementa la vulnerabilidad a episodios depresivos y comportamientos autolesivos repetidos que pueden terminar en suicidio.

**Conclusiones:** El CEDATM impacta negativamente en la calidad de vida de las personas que reúnen criterios de trastornos mentales y da cuenta de un número importante de suicidios. Una primera vía se relaciona con el estigma percibido, que se configura como barrera de acceso a servicios y acciones en salud mental, y una segunda ruta que incluye comportamientos autolesivos repetidos que reducen la autoestima e incrementan el estrés percibido. Se necesitan investigaciones que profundicen en el conocimiento de esta asociación.

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## The Stigma-discrimination Complex Associated With Mental Disorder as a Risk Factor for Suicide

### A B S T R A C T

#### Keywords:

Social stigma  
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Review

**Background:** The concept stigma-discrimination complex associated with mental disorder (SDCAMD) is proposed to encompass the terms used in the attribution theory: stigma, stereotype, prejudice and discrimination. SDCAMD is one of the most frequent disorders worldwide. Internalized and perceived SDCAMD may explain a number of suicide cases.

**Objective:** To update the factors that may explain the association between SDCAMD and suicide, and postulate possible underlying mechanisms.

**Results:** Articles were identified in MEDLINE using the descriptors for “stigma”, “mental disorders” and “suicide” or “suicide rate”. Articles published between January 2000 and June 2014 were included. Reviews and case studies were not considered. The two included studies showed that stigma increased the risk of suicidal behaviors. It was evident that people who meet criteria for mental disorder and reported high self-stigma made a greater number of suicide attempts, and countries with high stigma in the general population have a higher suicide rate. It was considered that the relationship between SDCAMD and suicide is established by a set of interrelated mechanisms. A “direct” mechanism involving perceived stigma and is configured as a barrier to access mental health services, and an “indirect” mechanism involving the self-stigma, which increases the vulnerability to depressive episodes and repeated self-injurious behaviors that ultimately end in suicide.

**Conclusions:** The SDCAMD impacts negatively on the quality of life of people who meet criteria for mental disorders, and accounts for a significant number of suicides. One way is related to the perceived stigma that is configured as a barrier to access mental health services and, the second one includes repeated self-injurious behaviors that reduce self-esteem and increases perceived stress. Further research is required to increase the knowledge of this association.

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## Introducción

Estigma, estereotipo, prejuicio y discriminación son conceptos altamente imbricados, producto de una compleja dinámica sociocultural<sup>1-4</sup>. El estigma se configura en el momento que un estereotipo o una idea preconcebida frente a un atributo o rasgo<sup>1</sup> toma una connotación negativa (prejuicio)<sup>2,5</sup> y que valida la cultura hegemónica en las situaciones en que niegan algún derecho (discriminación) a los miembros del grupo con la característica estigmatizada<sup>6</sup>.

Tradicionalmente, desde la teoría de la atribución, el estigma, el estereotipo, el prejuicio y la discriminación se conciben como una secuencia lineal de estigma-estereotipo/prejuicio-discriminación<sup>7-10</sup>. Aunque este modelo de entender el estigma es congruente y convincente, en la vida real son conceptos cuya separación no es posible y, por el contrario, puede resultar funcional para el diseño de acciones y políticas públicas que, con el objetivo de reducir o eliminar el estigma, terminan por reforzarlo a través de la invisibilización de los asuntos fundamentales, con la consecuente perpetuación del estigma<sup>11</sup>. Para mayor claridad puede tomarse como ejemplo el estigma hacia las personas con trastornos mentales. Se han expedido normas y políticas públicas para la reducción o eliminación del estigma hacia estas personas mediante planes, programas, estrategias y actividades que buscaron informar

sobre los trastornos mentales, acercar y promover la asistencia a los servicios en salud mental y colocar el tema en la agenda pública, acciones todas muy positivas y convenientes<sup>9,12</sup>. Sin embargo, esta manera tradicional de abordar el estigma hacia las personas con trastornos mentales deja de lado los contextos particulares y la mirada holística que una situación tan compleja requiere, con el riesgo de acentuar la patologización y medicalización de la salud mental, al alejarla del bienestar social, de modelos de calidad de vida que no estén regidos primordialmente por el consumismo y la acumulación de capital y de la necesidad que deberían tener las sociedades de eliminar las inequidades<sup>13</sup>.

Por lo insuficiente que resulta la explicación lineal estigma-estereotipo/prejuicio-discriminación, los autores del presente artículo proponen el uso del constructo complejo estigma-discriminación (CED) para agrupar estos conceptos asociados e inseparables. La presente revisión se ocupa del CED hacia las personas con trastornos mentales, por lo que se utiliza la denominación complejo estigma-discriminación asociado a trastorno mental (CEDATM) entendido como una secuencia compleja, indivisible y en espiral de los cuatro términos, como otros autores han propuesto recientemente sin dar una denominación particular<sup>14-16</sup>. No obstante, se puede ampliar a otros rasgos frecuentemente estigmatizados tan evidentes o manifiestos como étnico-raciales, sexuales, por discapacidad física y sensorial u otras condiciones que pueden disimularse

u ocultarse, como la orientación sexual o la infección por el VIH<sup>17-19</sup>.

También es importante diferenciar dos formas del CEDATM. La primera es la modalidad percibida, que implica el ejercicio de etiquetamiento y exclusión que perpetran otras personas y la sociedad a las personas que reúnen criterios de trastorno mental<sup>2,20-22</sup>. La segunda, la internalizada o el autoestigma-discriminación, que alude a que las personas que reúnen criterios de trastorno mental asimilan o aceptan como ciertas las opiniones negativas acerca de estas condiciones humanas<sup>2,23</sup>.

Lo que se propone como CEDATM es frecuente en el mundo y supera en prevalencia a los relacionados con la orientación sexual y la infección por el VIH<sup>24,25</sup>. No obstante, tanto el CEDATM como los complejos asociados a otras características varían de acuerdo con el momento histórico y las diferencias culturales, económicas y sociales de las sociedades. Igualmente, la frecuencia de CEDATM guarda asociación con el trastorno clínico específico implicado; por ejemplo, según la forma de medición, hasta el 72% de las personas que reúnen criterios de trastornos depresivos y algo más del 85% de las personas con trastornos del espectro de la esquizofrenia son víctimas de alguna forma de estigmatización-discriminación<sup>26,27</sup>.

El suicidio es un fenómeno clínico complejo relacionado con un conjunto diverso de factores de riesgo individuales, familiares, culturales, históricos, políticos y por la determinación social<sup>28,29</sup>. El suicidio es un desenlace fatal que se asocia en aproximadamente el 90% de los casos a la presencia de un trastorno mental<sup>30</sup>.

En general, se observa que los trastornos mentales incrementan de manera estadísticamente significativa la posibilidad de un episodio autolesivo. El riesgo de suicidio en presencia de trastorno mental puede multiplicar de 4 a 25 veces el que se observa en la población sin trastorno mental, con excepción del trastorno del desarrollo de la capacidad intelectual y el deterioro cognitivo mayor<sup>31</sup>. Los trastornos depresivos, del espectro de la esquizofrenia, bipolares, de ansiedad y de personalidad explican un número importante de los diagnósticos formales que reúnen este grupo de personas, en particular, los casos en que hay comorbilidad<sup>28,30-32</sup>.

A la fecha, algunos investigadores han observado que las personas que reúnen criterios de trastornos mentales presentan más riesgo de mortalidad temprana no solo debido a comportamientos suicidas, sino también relacionadas con enfermedades respiratorias, cardiovasculares, neoplásicas y por condiciones que afectan a la realización del proyecto de vida de las personas o su papel en la familia, en los grupos sociales a los que pertenece, en la comunidad en general o en el ámbito educativo y laboral<sup>33-44</sup>.

No obstante, las variables que explican la mayor mortalidad por suicidio entre las personas con trastorno mental se conocen parcialmente en número, extensión y profundidad<sup>27,30</sup>. En los años recientes se ha prestado mayor atención al estigma asociado a trastornos mentales y su impacto en la calidad de vida<sup>45-48</sup>. Se plantea que las actitudes y acciones relacionadas con el CEDATM, como en otros complejos de estigma-discriminación, las víctimas las perciben como amenazantes, como otro estresor, y se traduce en una respuesta fisiológica, psicológica y comportamental<sup>49-54</sup>. De tal suerte

que el CEDATM se configura por sí mismo en un factor que considerar en personas con comportamiento suicida<sup>55</sup>. Sin embargo, el rol directo o indirecto del CEDATM en estas personas no se ha estudiado ampliamente.

El objetivo de este trabajo es proponer los conceptos de CED y CEDATM, revisar los factores que pueden explicar la asociación existente entre el CEDATM y el suicidio y postular los posibles mecanismos implicados subyacentes.

### Desarrollo del tema

Algunas investigaciones exploran la asociación particular entre estigma y discriminación relacionada con trastorno mental y suicidio. Para conocer el estado del conocimiento específico, se buscaron los artículos disponibles en MEDLINE a través de PubMed. Se usaron los descriptores en inglés para "estigma" (*stigma*), "trastornos mentales" (*mental disorders*) y "suicidio" o "tasa de suicidio" ("*suicide*" or "*suicide rate*"). Se incluyeron artículos originales publicados desde el 1 de enero de 2000 hasta el 30 de junio de 2014. No se consideraron para este análisis las revisiones del tema y los estudios de casos. Es importante anotar que se usaron especificadores del tipo de diseño de los estudios (observacional, ecológico o transversal) para limitar aún más.

En la búsqueda inicial se identificaron 49 artículos; sin embargo, la inclusión de cada uno de los tipos de estudios redujo entre 0 y 5 el número de títulos posibles, por lo que se desestimó el uso de estos especificadores. De los 49 títulos, se seleccionaron seis resúmenes sugestivos de las investigaciones formales. No obstante, fue necesario descartar cuatro de ellos después de la lectura, dado que dos no exploraron la asociación de interés<sup>56,57</sup>, uno era un estudio relacionado con estigma distinto de trastorno mental<sup>58</sup> y otro era una revisión narrativa<sup>59</sup>.

En la revisión se identificaron dos investigaciones que exploraron la asociación entre estigma, discriminación y comportamientos suicidas. En la primera, Assefa et al<sup>60</sup>, en un grupo de 212 personas que reunían criterios de esquizofrenia (el 65% varones; el 72% sin pareja estable; el 71% desempleados) cuantificaron estigma internalizado con la Escala para Estigma Internalizado (alfa de Cronbach = 0,92) y la historia de intento de suicidio con una pregunta (¿Alguna vez se ha sentido tan desesperado/a que incluso ha intentado hacerse daño o quitarse la vida?) e informaron que el 71% de los pacientes tenían alto autoestigma y el 45% informó al menos un intento suicida alguna vez en la vida; quienes presentaron alto autoestigma mostraron el doble de riesgo de intento suicida (*odds ratio* [OR] = 2,3; intervalo de confianza del 95% [IC95%], 1,3-4,1).

En la segunda investigación, Schomerus et al<sup>61</sup> llevaron a cabo un estudio ecológico con información del año 2010 de 24 países de la Unión Europea, y cuantificaron "aceptación o rechazo social" como medida de estigma percibido, con la respuesta a una de dos preguntas (¿Podría resultar difícil hablar con alguien con un problema de salud mental? y ¿No tendrías ningún problema en hablar con alguien con un problema de salud mental?), y la tasa de suicidio (lesiones autoinfligidas y suicidios, según los registros de la décima versión de la Clasificación Internacional de Enfermedades). Los autores omitieron la información sobre la frecuencia de estigma y las tasas de suicidio; no obstante, mostraron que el estigma se relacionaba

directamente con la tasa de suicidio (coeficiente beta estandarizado,  $\beta = 0,46$ ). El beta estandarizado indica que, por cada unidad que se incrementa el estigma, la tasa de suicidio en la población aumenta en 0,46.

En resumen, estas investigaciones mostraron que el estigma, tanto el internalizado como el percibido, puede ser una variable intermedia o mediadora en la asociación observada entre trastorno mental y los comportamientos suicidas y el suicidio consumado.

## Discusión

Según el resultado de los estudios analizados y al retomar la propuesta de los autores de que el estigma visto en forma aislada no dice mucho sobre la realidad que viven las personas que sufren discriminación, como consecuencia del estigma y el estereotipo/prejuicio, sino que son un complejo (CEDATM), en el que sus componentes son inseparables física, emocional e históricamente, puede afirmarse que el CEDATM está asociado a la presentación de comportamientos suicidas y es un factor de riesgo de suicidio.

Las observaciones anteriores permiten postular un par de posibles mecanismos involucrados en la relación entre el CEDATM y el suicidio. Sin duda, estos mecanismos están ampliamente interrelacionados, con estadios comunes o compartidos.

Primero se propone una vía expedita o mecanismo "directo", que implica que el CEDATM percibido conlleva una pérdida de estatus y suele afrontarse con aislamiento social, deterioro en las redes de apoyo y reducción de oportunidades laborales, sociales, etc. Se configuran así barreras de acceso a servicios en salud mental<sup>62,63</sup>. Las personas sintomáticas o sus familiares con frecuencia ocultan el sufrimiento ocasionado por los trastornos mentales y, con ello, se retrasa la consulta a profesionales de la salud mental<sup>64</sup>. Estas demoras incrementan de manera importante la gravedad del episodio y, en consecuencia, se acrecienta el riesgo de suicidio<sup>28,30-32</sup>. Asimismo, una vez las personas asisten a valoración médica es habitual el rechazo del diagnóstico formal y los posibles factores etiológicos que llevan al incumplimiento del plan terapéutico, ya sea psicoterapia o farmacoterapia<sup>62-64</sup>. El incumplimiento terapéutico es la principal causa de recaídas, recurrencias y rehospitalizaciones de personas que reúnen criterios de trastorno mental<sup>65-67</sup>. La falta de adhesión a las recomendaciones profesionales reagudiza los síntomas y, con ello, se eleva el riesgo de suicidio. El suicidio es la peor consecuencia del incumplimiento terapéutico<sup>58,68</sup> y también del CEDATM<sup>69</sup>.

Segundo, se plantea una ruta más intrincada, un mecanismo "indirecto" que involucra el CEDATM internalizado que incrementa la predisposición de los pacientes a reunir criterios de un episodio depresivo mayor<sup>70,71</sup>. Los pacientes con alto CEDATM internalizado expresan con mayor frecuencia ideas de minusvalía, baja autoeficacia, desesperanza, deterioro social, desempleo y dificultades para iniciar o mantener una relación de pareja si así lo desearan, es decir, un deterioro general de la calidad de vida<sup>72-78,46,79,80</sup>. A mayor número de episodios depresivos, se eleva el nivel de CEDATM

internalizado, y con ello la posibilidad de intentos de suicidio y suicidio consumado<sup>69,72</sup>.

Adicionalmente, los pacientes con historia de intentos de suicidio suman un nuevo complejo estigma-discriminación, ahora relacionado con el intento o los intentos de suicidio repetidos<sup>81-83</sup>. Este complejo estigma-discriminación se configura como barrera de acceso a servicios de salud mental e incumplimiento del plan terapéutico<sup>63,64</sup>. Los obstáculos incrementan, sin duda, el riesgo de suicidio en este grupo de personas<sup>16,24,71</sup>. El modelo para estos mecanismos se muestra en la figura 1.

Es preferible considerar el conjunto estigma-estereotipo/prejuicio-discriminación como un "complejo", más que conceptos interrelacionados. Por una parte, existen diferentes aproximaciones, no mutuamente excluyentes, para precisar el origen del complejo: constitucional, económico, psicológico, institucional o evolutivo<sup>84</sup>, y por otra, el complejo incluye varios componentes: cognitivo, afectivo y conductual, con una base biológica que los explica, dentro de un contexto social y cultural particular<sup>49-53,84,85</sup>.

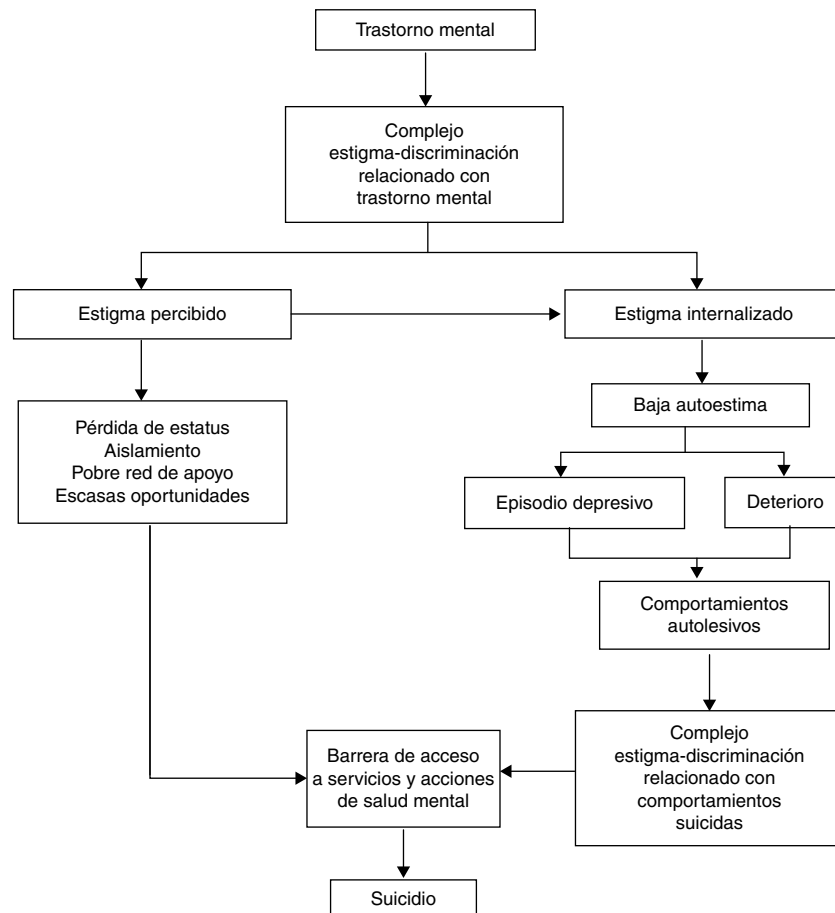
Aunque se acepta que los CED asociados a diferentes características socialmente degradadas comparten algunos puntos de convergencia o similitudes<sup>20,22,23</sup>, es necesario tener presente que el CEDATM muestra algunos matices distintivos, particulares y relevantes<sup>4</sup>. El CED es mayor si el rasgo, la situación o la condición señaladas como indeseables son muy evidentes o visibles, se piensa estar bajo el control voluntario del señalado o si se percibe como peligroso<sup>4,22,23</sup>.

En un número importante de personas que reúnen criterios de trastorno mental, en especial los llamados trastornos mayores, la visibilidad de la condición es alta, por los síntomas en sí mismos o los efectos secundarios de la medicación utilizada para controlarlos<sup>4,25</sup>.

De la misma forma, el conjunto de imaginarios y representaciones sociales de los trastornos mentales da cuenta de que las personas no pueden controlar los síntomas y, en consecuencia, se califican como perezosas, manipuladoras o afectadas de una deficiencia en la personalidad<sup>26,27</sup>. Es frecuente que las personas legas e incluso los profesionales de la salud con poca experiencia en salud mental no consideren que los "trastornos" mentales sean condiciones objeto de atención para el sistema de salud, a diferencia de las "verdaderas enfermedades" (físicas), por lo que persisten las explicaciones mágicas o pintorescas y la fragmentación del concepto de salud<sup>4,11,22</sup>.

Finalmente, el CEDATM guarda relación con la alta peligrosidad que se endilga a las personas que reúnen criterios de trastorno mental. Por lo general, se relacionan erróneamente los trastornos mentales con mayor frecuencia de comportamientos violentos, hacia otras personas y contra sí mismos, que cuando no hay diagnóstico formal de trastorno mental, lo que posiblemente se relacione con el origen histórico de la psiquiatría, vinculada al sistema judicial como un componente de las evaluaciones forenses para determinar la responsabilidad criminal o legal<sup>21,26,86-88</sup>.

Estas peculiaridades de los trastornos mentales se articulan para negar la solidaridad a las personas que reúnen criterios y la poca respuesta de las instituciones o de la sociedad en general (capital social)<sup>89,90</sup> para mostrar benevolencia y



**Figura 1 – Modelo de la asociación entre el complejo estigma-discriminación relacionado con trastorno mental y suicidio.**

atender las necesidades de estos colectivos, con la persistencia del CEDATM<sup>91</sup>.

Actualmente, la prevención del suicidio es un proceso complejo y desalentador<sup>92-94</sup>. La estimación y la cuantificación del riesgo son inexactas e imprecisas<sup>95,96</sup>, dado que pocas acciones en salud pública han mostrado efectos positivos en la prevención del suicidio, la educación del personal sanitario, especialmente médico, en el diagnóstico y el tratamiento adecuado de los episodios depresivos, el control del acceso a métodos suicidas, el seguimiento adecuado de personas con intento suicida reciente y la regulación de los medios de comunicación en el manejo informativo de los eventos suicidas en la comunidad son fundamentales<sup>97-100</sup>.

Por su lado, la respuesta institucional orientada a reducir el CEDATM se ha centrado en dos puntos fundamentales: el continuo proceso de cambios en la nominación, el uso lingüístico del concepto de trastorno mental, para minimizar el estigma (por ejemplo, el cambio entre el DSM-IV-TR y el DSM-5 de retraso mental por trastorno del desarrollo de la capacidad intelectual y demencia por deterioro cognitivo mayor<sup>31,85</sup>), y la insistencia en llamar a estos sufrimientos humanos “trastorno” y no “enfermedades”, dados la poca claridad y el escaso conocimiento de las verdaderas naturaleza y causas de estos padecimientos<sup>101,102</sup>. La segunda se ha centrado en el manejo de la información sobre los trastornos mentales, en poner al alcance de los colectivos y comunidades las perspectivas y los hallazgos en neurociencia, en un proceso de

consolidación de la medicalización de la vida cotidiana y de la salud mental<sup>101-103</sup>. La medicalización ha tenido un efecto contraproducente, pues se ha convertido en otra fuente de CEDATM. El mero conocimiento de la implicación de factores biológicos en la presentación de estos padecimientos no modifica sustancialmente los mitos y otros imaginarios o representaciones sociales negativas<sup>101,102</sup>.

Es indiscutible la necesidad de conocer la frecuencia y las variables asociadas al CEDATM, internalizado y percibido, ya que la presencia de un estigma potencia otros estigmas<sup>104</sup>. En países en vía de desarrollo, como Colombia, se debe conocer el desempeño de los instrumentos disponibles para la cuantificación de este fenómeno en personas que reúnen criterios de trastornos mentales y en la población general como una forma eficaz de detectar la situación problemática<sup>105</sup>. Se esperaría observar una alta prevalencia de este fenómeno en América Latina<sup>106,107</sup>.

Asimismo, una de las principales medidas en la prevención del suicidio debe ser la comprensión y la reducción del CEDATM internalizado, dado que supone un estresor para las personas que reúnen criterios de trastorno mental<sup>9,12,13,108,109</sup>.

## Conclusiones

El estigma, el estereotipo, el prejuicio y la discriminación relacionados con los trastornos mentales deben

considerarse como un “complejo”. La visibilidad de los síntomas, el supuesto control que se puede tener de los síntomas y la percepción de peligrosidad son características distintivas del CEDATM.

El CEDATM tiene un impacto negativo en la calidad de vida de las personas que reúnen los criterios de estos trastornos y puede explicar un número importante de suicidios. Una primera vía se relaciona con el CEDATM percibido, que se transforma en una barrera de acceso a servicios y acciones en salud mental, y la segunda ruta incluye comportamientos autolesivos repetidos que incrementan el CEDATM y el estrés percibido.

Se necesitan investigaciones que profundicen la asociación entre CEDATM y suicidio y los mecanismos implicados en la asociación. También es preciso diseñar, implementar y evaluar el impacto de nuevas acciones preventivas orientadas a la reducción del CEDATM en el contexto nacional e internacional.

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### Conflicto de intereses

Los autores declaran no tener ningún conflicto de intereses.

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## Correspondence

EDITED BY STANLEY ZAMMIT

**Contents** ■ Explanatory models in psychiatry ■ Ethnic differences in prisoners: describing trauma and stress ■ Specialist care for prisoners? ■ Consent and treatment in prisons ■ Amisulpride-induced mania in a patient with schizophrenia ■ Changing use of ECT ■ Inappropriate use of psychostimulants ■ Stigma as a cause of suicide ■ Social capital and mental health v. objective measures of health in The Netherlands

### Explanatory models in psychiatry

Dein (2002) comments on our editorial on explanatory models (Bhui & Bhugra, 2002), but fails to apprehend the conceptual flaws in his assertions, promotes a complacent attitude to the challenges of cultural psychiatry, and is threatened by a patient's explanatory model that differs from his own. Dein agrees with us that explanatory models are not stable, and are dynamic, complex, shifting entities, making more research necessary for any consistent theory about their role in routine clinical practice. None the less, their role in improving understanding of patients' cultural world views has not previously been in dispute (American Psychiatric Association, 2002). Although Dein gives greater weight to behavioural expressions of explanatory models, he does not question whether explanatory models can or should be considered as a psychological construct of the individual, or as a group or social-behavioural phenomenon, or both. Each of these conceptualisations is certainly distorted by theorising more concrete, but more easily understood, expressions of explanatory models. Contrary to the historical anthropological paradigm, it is not useful to psychiatric practice if valuable anthropological critiques simply ignore psychological and non-behavioural data. More worryingly, Dein assigns a patriarchal role to the psychiatrist, a role that cannot lead to a collaborative therapeutic relationship. It seems Dr Dein is not prepared to accept that a patient may pursue his or her own explanatory model and associated interventions, alongside those recommended by the psychiatrist. A fuller discussion of these alongside the psychiatrist's own models allows for a shared vision of treatment and recovery.

Why is an exorcism problematic for the psychiatrist? It is not in the realms of psychiatric knowledge or skills, and if helpful for recovery from illness, rather than

disease, it should not be hindered. Dein appears to show contempt for a territory in which psychiatrists are not expert (possession and exorcisms: see Pereira *et al*, 1995), and certainly does not show the respect for cultural beliefs that is part and parcel of a scientific or anthropological study of healing, let alone clinical practice. His approach smacks of a patriarchal conviction that the diagnosis is more than a theory, and that psychiatric interventions are not to be questioned. To diagnose is to classify and to predict a course and treatment based on the vagaries of statistics and experience: it is to take what can be a serious risk (Romanucci-Ross *et al*, 1991).

Although he cites a single example, it is not the case that the evidence base of traditional healing approaches are researched to the levels of esoteric knowledge found in biomedicine, except for, perhaps, acupuncture and Ayurveda where there is a growing literature. People will always be keen to try anything that helps them, biomedicine or culturally sanctioned traditional therapies. Surely he does not mean that we as psychiatrists have nothing to learn about treating illness from the traditional and complementary sector. Our view is we have plenty to learn and research. Eliciting explanatory models is a beginning of the process in consultations and offers an easily understandable method of learning about a patient's culture. However, Dein's view appears to be that we know enough, and need not discover more. We are surprised at this view and cannot agree.

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### Ethnic differences in prisoners: describing trauma and stress

I read with interest the two articles by Coid *et al* (2002a,b) but was puzzled by the use of the term 'post-traumatic stress' to describe the psychiatric response of prisoners who had experienced adverse or negative life events. The authors use the term post-traumatic stress without specifying whether they are referring to the specific diagnosis of post-traumatic stress disorder (PTSD), a recognised psychiatric condition in the DMS-IV (American Psychiatric Association, 1994) or simply a vague amalgam of neurotic symptoms which the authors infer are a consequence of the various stresses the prisoners experienced in their lifetimes. The confused terminology in this respect, which is present in both papers, is unhelpful in assessing what precisely is psychiatrically wrong with these prisoners. A Criterion A trauma, that is a trauma that may precipitate PTSD in some individuals, is specifically defined and described in the DSM-IV as an event in which the person experiences, witnesses or is confronted with an event or events that involves actual or threatened death or serious injury to the self or to others, and to which the individual responds with intense fear, helplessness or horror. The experiences that were screened for in the original study by Singleton *et al* (1998) would not normally be considered to represent a Criterion A event, but merely negative or adverse life events which have no specific aetiological links with any distinct clinical diagnosis. The experiences included by the authors in their screening include bullying and marital separation, which do not constitute Criterion A events for the purpose of making a PTSD diagnosis. Similarly, many other traumatic experiences were not apparently screened for by the authors, such as rape or adult sexual assault, combat, being assaulted in the street (although violence in the home or at work are included). Thus, the selection, definition and description of these events as traumatic is misleading, while the inclusion of negative life events that are clearly more traumatic

makes the interpretation of any resulting phenomenology extremely difficult.

It is also clear from the original publication by Singleton *et al* that no specific assessment for PTSD was carried out, although validated and reliable instruments for this exist (e.g. the Clinical Assessment for PTSD, Blake *et al* (1995) or the Posttraumatic Stress Symptoms Interview (PSSI) or Posttraumatic Stress Symptoms Self-Report (PSS-SR), Foa *et al* (1993)). The authors did a partial screen for a few recognised PTSD symptoms, such as re-experiencing and avoidance, but there was no systematic assessment of the condition that would have allowed them to diagnose the full disorder. It should be recognised that PTSD is a major psychiatric disorder that constitutes a serious burden for the individual and for society (Kessler, 2000). A diagnosis of PTSD has implications in terms of assessing the individual's risk and in terms of treatment recommendations. It is important that the term post-traumatic stress should not be confused or conflated with the term 'post-traumatic stress disorder'. The description of post-traumatic stress made by Coid *et al* cannot be evaluated without deconstructing more precisely what this means. As there are now well-recognised instruments to assess PTSD and lifetime experience of traumatic events in a range of settings, without these being used then terms such as post-traumatic stress should be avoided.

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### Specialist care for prisoners?

In his recent editorial on mental health in prisons Dr Reed (2003) urges, understandably and in most cases correctly, that the quicker that patients with psychosis are transferred to specialist psychiatric care, the better.

However, there are prisoners with schizophrenia, willing to take medication, who survive reasonably comfortably in the prison milieu. Their great fear is that they will be transferred to a special psychiatric hospital; 'nutted off' in prisonspeak. They have reason to fear a transfer, for it effectively exchanges a finite sentence for an indefinite one. In the case of those serving a life sentence, it means their fate is in the hands of a mental health review tribunal rather than the Parole Board, the latter, they believe, being less cautious in recommending discharge. As an ex-member of both organisations, I would agree with them.

So, while prison is obviously bad for people with mental illness, hospital is sometimes worse.

**Reed, J. (2003)** Mental health care in prisons. *British Journal of Psychiatry*, **182**, 287–288.

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### Consent and treatment in prisons

I read the article by Earthrowl *et al* (2003) with interest. The issue of providing treatment to prisoners, who are frequently incapable of consenting, will not be unfamiliar to psychiatrists providing mental health care in these establishments. Although the authors correctly state that there is no legislative framework for providing treatment for mental disorders in prisons, this may be slightly disingenuous. The current legislative framework that provides for the treatment of mental disorders, namely the Mental Health Act 1983, is clear that prison health-care wings are not hospitals. It follows that any treatment that is administered forcibly must be consistent with common law. Separate legislation is therefore unnecessary.

They also appear to have overlooked recent guidance on this matter. The Department of Health (2002) in collaboration

with the Prison Service has set out, in detail, good practice guidelines for providing care to both competent and incapacitated adult prisoners. These outline circumstances in which prisoners who lack capacity can receive treatment. We have found this very helpful in developing protocols for treatment in the prisons we visit.

The development of policies and protocols will assist in establishing who, when and in which circumstances incapacitated prisoners may be treated and allow us to be more confident when making these difficult decisions.

**Department of Health (2002)** *Seeking Consent: Working with People in Prison*. London: Department of Health.

**Earthrowl, M., O'Grady, J. & Birmingham, L. (2003)** Providing treatment to prisoners with mental disorders: development of a policy. Selective literature review and expert consultation exercise. *British Journal of Psychiatry*, **182**, 299–302.

**I. Qurashi** Gulid Lodge, Whittingham Lane, Preston PR3 2AZ, UK

**Authors' reply:** We fail to understand Dr Qurashi's comment that 'separate legislation is therefore unnecessary'. Our paper sets out a *policy* for providing treatment to people with mental disorder based on common law (Earthrowl *et al*, 2003). We are not proposing separate legislation.

Dr Qurashi also mentions that we appear to have overlooked recent guidance from the Department of Health (2002). The Department of Health guidelines were produced in July 2002, after our paper was accepted for publication.

These guidelines provide guidance on establishing capacity but, in our opinion, they do not tackle the practical issues relating to the management of prisoners with mental disorder in any great detail, they do not deal with the ethical issues surrounding the provision of an equivalent service in prisons adequately and detailed guidance on making a concerted effort to obtain treatment under the Mental Health Act in hospital before proceeding with treatment under common law is lacking. In our view, these are serious omissions.

### Declaration of interest

J.O. is a member of the Department of Health Prison Expert Group.

**Department of Health (2002)** *Seeking Consent: Working with People in Prison*. London: Department of Health.

**Earthrowl, M., O'Grady, J. & Birmingham, L. (2003)** Providing treatment to prisoners with mental disorders: development of a policy. Selective literature review and expert consultation exercise. *British Journal of Psychiatry*, **182**, 299–302.

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### Amisulpride-induced mania in a patient with schizophrenia

Numerous case reports of atypical antipsychotics inducing hypomanic/manic symptoms have been published; most concern the use of risperidone and olanzapine (Aubry *et al*, 2000), but quetiapine (Benazzi, 2001) and ziprasidone (Lu *et al*, 2002) have also been implicated. A literature search using Medline and PubMed revealed no such reports associated with amisulpride. Although the manufacturer has accumulated a small number of reports of manic symptoms developing during amisulpride treatment, a recent internal review concluded that no causality could be established (Sanofi-Synthelabo, personal communication, 2002). I report a case of amisulpride-induced mania.

A 17-year-old female with a 4-year history of schizophrenia was commenced on amisulpride for persistent negative symptoms. It was cross-titrated with olanzapine, over a 4-week period, to 400 mg. She continued taking citalopram 20 mg, which had been started 6 months previously on the basis that her negative symptoms could be secondary to a masked depression. On commencement of amisulpride her negative symptoms, as rated on the Scale for the Assessment of Negative Symptoms (SANS; Andreasen, 1982), rapidly and linearly improved. Her mood, however, continued to rise and by 3 months she had developed a manic episode without psychotic features. She exhibited insomnia, hyperactivity, distractibility, disinhibition and an abnormally and persistently elevated mood that continued despite the immediate cessation of citalopram. There was no evidence of substance misuse or akathisia. These features improved after halving the amisulpride to 200 mg and re-introducing olanzapine 15 mg. They fully remitted within days of stopping the amisulpride.

No other concomitant medication was used. The delay in development of overt manic symptoms may reflect having to overcome a baseline SANS score of 68.

The mechanism of action of mood changes induced by atypical antipsychotics is unknown, with speculation centring exclusively on a 5-HT<sub>2a</sub>:D<sub>2</sub> economy. Lane *et al* (1998) argue that a higher ratio will increase frontal dopamine release, whereas others point to the combined blockade enhancing the ability of 5-HT<sub>1a</sub> to release frontal dopamine (Ichikawa *et al*, 2001). These theories do not explain the manicogenic effects of amisulpride, which has no serotonin affinity. I propose that the ability of low doses of amisulpride to differentially block presynaptic D<sub>2</sub> and D<sub>3</sub> autoreceptors enhances dopamine transmission in the frontal cortex and can lead to the development of manic symptoms in susceptible subjects. Presumably this mechanism contributes to its antidepressant efficacy, for which it is used in many countries. The theory implies induction of manic features at low doses only.

#### Declaration of interest

B.P.M. works for ORYGEN, which has received an unrestricted educational grant from Sanofi-Synthelabo.

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**Benazzi, F. (2001)** Quetiapine-associated hypomania in a woman with schizoaffective disorder. *Canadian Journal of Psychiatry*, **46**, 182–183.

**Ichikawa, J., Ishii, H., Bonaccorso, S., et al (2001)** 5-HT<sub>2a</sub> and D<sub>2</sub> receptor blockade increases cortical DA release via 5-HT<sub>1a</sub> receptor activation: a possible mechanism of action of atypical antipsychotic-induced cortical dopamine release. *Journal of Neurochemistry*, **76**, 1521–1531.

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**Lu, B. Y., Lundgren, R., Escalona, P. R., et al (2002)** A case of ziprasidone-induced mania and the role of 5-HT<sub>2a</sub> in mood changes induced by atypical antipsychotics. *Journal of Clinical Psychiatry*, **63**, 1185–1186.

**B. P. Murphy** Early Psychosis Prevention and Intervention Centre, ORYGEN Youth Health, Locked Bay 10 (35 Poplar Road), Parkville, Victoria, Australia 3052

#### Changing use of ECT

I would like to point out a couple of facts about the decline in electroconvulsive

therapy (ECT) use not mentioned by Eranti & McLoughlin (2003) in their recent editorial.

The use of ECT without consent has not declined at all since 1985. There were 3362 people given ECT without their consent under section 58 of the Mental Health Act 1983 in England and Wales in the 2-year period 1985–87, 4454 in 1987–89 and 4463 in 1999–2001, with little change in the years between (Mental Health Act Commission, 1988–2002).

It was the 1970s that saw the greatest decline in ECT use, from an estimated 60 000 courses in Great Britain in 1972 to 30 000 in 1979 (Pippard & Ellam, 1981).

The decline in ECT use over the past 20 years or so has been marked by regional variations. While in England ECT use fell fairly steadily during the 1980s, in Scotland it remained fairly constant during the 1980s and early 1990s and then fell by about a half in the mid-1990s (Freeman *et al*, 2000). In the East Anglian region ECT use actually increased during the 1980s (Pippard, 1992).

I think it is hard to reconcile these facts with the authors' suggestion that new drugs, improvements in patient care and better appreciation of the indications for ECT are responsible for the decline in ECT; although this would be the most respectable explanation for the decline in use of a treatment which is still described as safe, effective and life-saving – especially since the textbook indications for its use have changed little over the past two or three decades. Is it really the case that fewer people need ECT nowadays – or was it given needlessly to large numbers of people in the recent past? Since no research into the reasons for the decline in the use of ECT has been done, it remains impossible to answer this question with any certainty.

**Eranti, S. V. & McLoughlin, D. M. (2003)** Electroconvulsive therapy – state of the art. *British Journal of Psychiatry*, **182**, 8–9.

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**Mental Health Act Commission (1988–2002)** *Biennial Reports (2nd to 9th)*. London: Stationery Office.

**Pippard, J. (1992)** Audit of electroconvulsive treatment in two National Health Service regions. *British Journal of Psychiatry*, **160**, 621–637.

— & **Ellam, L. (1981)** *Electroconvulsive Treatment in Great Britain 1980*. London: Gaskell.

**S. Kemsley** Address supplied; correspondence c/o the *British Journal of Psychiatry*, 17 Belgrave Square, London SW1X 8PG, UK

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**Authors' reply:** Sue Kemsley has raised some important issues regarding ECT. The use of ECT without consent has not declined in absolute numbers since 1985 but, as discussed in our editorial (Eranti & McLoughlin, 2003), the total number of patients receiving ECT has substantially fallen during this period. Little research has been directed at understanding this change in the pattern of ECT use. One possibility is that there exists a core group of patients with severe depressive illness and possible psychosis that requires treatment with ECT, while the decline in use predominantly occurs in people with less severe illness. So why has the use of ECT declined in this latter group?

As we have already suggested, we believe that this is due to historical changes in general psychiatry, especially psychopharmacology. One has to bear in mind that, following its introduction in 1938, ECT was one of the first truly effective treatments for severe debilitating psychiatric disorders and thus its use rapidly became widespread (Fink, 2001). We are currently investigating trends in ECT practice over the past 50 years in the Maudsley and Bethlem Royal Hospitals in south London. Its use peaked in 1956 when 34% of admissions were treated with ECT. This rate fell steadily thereafter to 30% in 1959, 21% in 1968 and 5% in 1987. It is interesting to note here that imipramine was introduced in 1958, coinciding with the beginning of this decline in use of ECT. Similarly, ECT use further declined after the introduction of fluoxetine, the first of the selective serotonin reuptake inhibitors, in 1988, such that by 1991 2% of admissions received ECT. Currently, less than 1% of admissions are treated with ECT and nearly 90% of these have a diagnosis of major depressive disorder, which is well-established as being the main indication for contemporary ECT (Carney *et al*, 2003).

**Carney, S., Cowen, P., Geddes, J., et al (2003)** Efficacy and safety of electroconvulsive therapy in depressive disorders: a systematic review and meta-analysis. *Lancet*, **361**, 799–808.

**Eranti, S. V. & McLoughlin, D. M. (2003)** Electroconvulsive therapy – state of the art. *British Journal of Psychiatry*, **182**, 8–9.

**Fink, M. (2001)** Convulsive therapy: a review of the first 55 years. *Journal of Affective Disorders*, **63**, 1–15.

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### Inappropriate use of psychostimulants

Rey & Sawyer (2003) ask 'Are psychostimulant drugs being used appropriately to treat child and adolescent disorders?' – the answer is no. Like most articles on psychostimulants, they avoid discussion of the fundamental question that needs tackling for their conclusions to have any meaning – is attention-deficit hyperactivity disorder (ADHD) a valid medical disorder? The answer is no (see Timimi, 2002). This disorder is best understood as a cultural creation. Rey & Sawyer illustrate how deeply practice in this area is influenced by cultural dynamics. They show how there are large variations in the way diagnostic criteria are used both between countries (not surprisingly, they only mention Western ones) and within them. They show that there are also large variations in the way psychostimulants are used.

Children are already the losers here. There are reports of some primary schools where nearly 40% of the students were taking psychostimulants (Runnheim, 1996). Rates of diagnosis of ADHD and subsequent medication use continue to rise alarmingly in most Western countries. This is a massive, dangerous and scandalous experiment in which millions of children are being exposed to highly toxic, addictive and brain-disabling drugs whose medium- and long-term efficacy and safety have not been established (Breggin, 2002). The only winner is the profit margin of the pharmaceutical industry.

I realise this is emotive language, but then the business of what values we hold when it comes to children is too important to allow us to hide behind dry, detached, academic pretence. We live in a culture that has a deep intolerance for children. This is at the heart of why we are labelling physically healthy children with fictional medical disorders. Doctors become a symptom of this intolerance, not part of the solution.

This is all so unnecessary. For years I have been working with these children and their families using diverse perspectives based on a more humanitarian value system (Timimi, 2002). Not only are my clients grateful for this, they often recommend others to come and see me.

**Breggin, P. (2002)** *The Ritalin Fact Book*. Cambridge, MA: Perseus.

**Rey, J. M. & Sawyer, M. G. (2003)** Are psychostimulant drugs being used appropriately to treat child and

adolescent disorders? *British Journal of Psychiatry*, **182**, 284–286.

**Runnheim, V. A. (1996)** Medicating students with emotional and behavioural disorders and ADHD: a state survey. *Behavioural Disorders*, **21**, 306–314.

**Timimi, S. (2002)** *Pathological Child Psychiatry and the Medicalization of Childhood*. Hove: Brunner-Routledge.

**S. Timimi** Child and Adolescent Mental Health Services, Ash Villa, Willoughby Road, Sleaford, Lincolnshire NG34 8QA, UK

### Stigma as a cause of suicide

We read with great interest the article by Eagles *et al* (2003) in which, among the various interventions discussed to prevent suicide, it was suggested that according to patients' opinions there should be a decrease in the stigma attached to psychiatric illness. We share that opinion and suggest that another goal of suicide prevention is the reduction of the stigma attached to suicide.

The term stigma refers to a mark that denotes a shameful quality in the individual so marked. Mental illness is widely considered to be such a quality, an assumption supported by a number of beliefs such as the association between mental illness and irrational and unpredictable violence as portrayed by the media and the notion that mental illness is not a 'true' illness like organic disease. And yet, people do fear mental illness and do not know how to avoid it by following the types of precautions and guidelines available for so many organic disorders.

Not only does the stigmatisation of mental illness prevent people from seeking treatment, which in turn exposes them to a greater risk of suicide, but also suicide can appear to be the best solution for a stigmatised individual. A number of environments can be traced where this process takes place. In the family, the family members' relationship to the patient may affect the extent to which the patient's stigma is transferred to the family members, as in the case of schizophrenia (Phelan *et al*, 1998). In such extreme cases, difficulties in dealing with a chronic disease, which often results in relapses, hospitalisations and social impairment, leads family members to stigmatise the patients. They behave in a way that may lead the patient to assume that suicide might be a solution for their situation. Family members may also unconsciously believe that suicide might be a solution. In the hospital, staff's

attitudes towards patients who are at risk of suicide deserve consideration. Acceptance of a patient's suicide as a solution to problems, wishes that a patient would commit suicide as a solution to his or her problem, fear of the patient and difficulties in dealing with suicidal individuals are some of the most important sources of stigma in mental health environments. Also, following an attempt many individuals feel isolated or ignored by health professionals (McGaughey *et al*, 1995). In the military environment, stigma towards mental illness is very strong and military personnel tend to deny any form of mental disorder unless they are hoping to get another job. This exposes such a population to the risk of suicide.

Yet suicide is, itself, a source of stigma as anyone with suicidal ideation is considered weak, shameful, sinful and selfish, which prevents these individuals from seeking treatment early in the suicidal process. These judgements are often shared by active churchgoers (Sawyer & Sobal, 1987), teachers and parents. Also, parents and widows of victims of suicide are stigmatised, which makes recovery from this type of loss particularly difficult (Smith *et al*, 1995). Destigmatisation should be addressed to mental illness as well as suicide. Increasing the stigma associated with having suicidal feelings will increase the suicide rate. Interventions among families, mental health professionals, military personnel and church activists aimed at decreasing the stigma associated with mental illness and suicide may contribute to the reduction of deaths by suicide.

**Eagles, J. M., Carson, D. P., Begg, A., et al (2003)** Suicide prevention: a study of patients' views. *British Journal of Psychiatry*, **182**, 261–265.

**McGaughey, J., Long, A. & Harrison, S. (1995)** Suicide and parasuicide: a selected review of the literature. *Journal of Psychiatric and Mental Health Nursing*, **2**, 199–206.

**Phelan, J. C., Bromet, E. J. & Link, B. G. (1998)** Psychiatric illness and family stigma. *Schizophrenia Bulletin*, **24**, 115–126.

**Sawyer, D. & Sobal, J. (1987)** Public attitudes toward suicide: demographic and ideological correlates. *Public Opinion Quarterly*, **51**, 92–101.

**Smith, B. I., Mitchell, A. M., Bruno, A. A. et al (1995)** Exploring widows' experience after suicide of their spouse. *Journal of Psychosocial Nursing and Mental Health Services*, **33**, 10–15.

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### Social capital and mental health v. objective measures of health in The Netherlands

McKenzie *et al* (2002) reported that social capital in the neighbourhood may be beneficial for health and mental health in adults. We have reported associations between neighbourhood social capital and mental health service use in children (Van der Linden *et al*, 2003). We wished to investigate whether such effects on mental health were accompanied by similar effects on physical development, and investigated sensitive, cumulative objective measures of child health, height and weight at different ages, in relation to the neighbourhood environment.

We recorded all height and weight data registered regularly in the Municipal Youth Health Care Centre from birth up to the baseline measurement of our cohort study of 1009 children aged approximately 11 years living in the 36 neighbourhoods of a Dutch city (response rate of both child and one parent of 54%) (Drukker *et al*, 2003). This study on the effects of neighbourhood variables also included family-level and child-level measures, such as family socioeconomic status. In addition, social capital dimensions of (a) informal social control and (b) social cohesion and trust were measured in a community survey and aggregated to neighbourhood level.

Data were part of a three-level structure with height and weight measurements at different ages nested within children, and children nested within neighbourhoods. Growth curves were estimated using a multi-level random-effects regression model (including age and age<sup>2</sup>). The outcome measures were height, weight, and body mass index (weight/height<sup>2</sup>), and all variables except for age were considered fixed factors. When neighbourhood variables and individual level confounders were added to the models, results showed that none of the social capital measures was associated with any of the outcomes.

Therefore, we conclude that neighbourhood measures play a role in mental health, but that effects are more readily expressed in the psychological rather than the physical domain, in children living in The Netherlands.

**Drukker, M., Kaplan, C. D., Feron, F. J. M., et al (2003)** Children's health-related quality of life, neighbourhood socio-economic deprivation and social capital. A contextual analysis. *Social Science and Medicine*, **57**, 825–841.

**McKenzie, K., Whitley, R. & Weich, S. (2002)** Social capital and mental health. *British Journal of Psychiatry*, **181**, 280–283.

**Van der Linden, J., Drukker, M., Gunther, N., et al (2003)** Children's mental health service use neighbourhood socio-economic deprivation and social capital. *Social Psychiatry and Psychiatric Epidemiology*, in press.

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## One hundred years ago

### Epileptic colony, Ewell, Surrey

ON Wednesday, July 1st, the first rate-supported epileptic colony in this country, founded by the London County Council for the epileptic insane of the metropolis,

was opened by H.R.H. the Duchess of Fife and the Duke of Fife, K.T., Lord Lieutenant of the County of London.

Situated on the north-eastern corner of the Horton Estate (facing the Epsom Downs), purchased in 1896 for asylum

purposes, and on which the Manor Asylum (for 700 female lunatics) and the Horton Asylum (for 2,000 lunatics) have already been erected, it has a demesne of 112 acres, to be devoted to colony purposes, separated from the rest of the estate by a public road.

The buildings, consisting of an administrative block and eight villas have been erected upon the most elevated part of the ground, some 200 feet above the sea level. A corridor leads from the administrative centre – wherein are offices for the medical superintendent, assistant medical officer, matron, clerk, etc., apartments for some of these officers, and quarters for the resident subordinate staff – to a group of buildings consisting of stores, main kitchen, and a hall for recreation and dining purposes. The boiler house, workshops, and water tower are situated between the stores and the female admission ward, the latter being a portion of the central block. On the other side of the corridor, immediately opposite the boiler house, a laundry will shortly be erected. The dining and recreation hall has seating accommodation for 326 persons, the number of colonists to be received. Here it is intended that all whose condition permits their being present shall assemble for dinner, the other meals being taken in the several wards. It is so arranged as also to serve as the chapel. At one end of the hall a platform has been provided for entertainments. The hall will be well lighted, and its heating (which is by means of steam-heated radiators) and ventilation are very completely arranged for.

Within the 20 acres of land on the east side of the administrative block are dotted

the eight villas (named after trees – Holly, Lime, Pine, Elm, Chestnut, Hawthorn, Walnut, Beech) in which all the colonists, with the exception of the 32 females to be accommodated in the admission ward at the administrative centre, will be housed. . . Each villa is similarly arranged, and has a south-eastern aspect, and the roads giving access to them enclose a space to be laid out by the colonists, and used as a cricket and recreation ground. Each villa is arranged to accommodate 38 patients, and will be under the charge of a resident married couple. The interiors are designed to enable the individual patients to have the maximum amount of freedom under supervision. The verandahs and spreading porches to the villas are important features, enabling the colonists to be in the open in all weathers. The method of warming is by double fireplace stoves arranged in the centres of the rooms.

The ventilation is by means of fresh-air inlets at floor level and outlets through the ceilings into the roof space, the necessary upcast movement being obtained by the heat from the hot-water storage tank which is placed at the base of a shaft leading into the open air. Four of the villas are built in red brick with artificial stone dressings, as are also the administrative buildings. The stores and the remaining villas are faced with rough case. All the roofs are tiled.

The lighting is by electricity throughout. Telephones connect all the buildings, and an electrical fire alarm places the villas and the centre in communication.

The estimated cost of the buildings, including fixtures, fittings, and equipment, is £98,000, which with its provision for 326 patients (60 females and 266 males) gives a total cost per bed (exclusive of the cost of land) of £300. The plans of the buildings were designed by the Asylums Committee's Engineer, Mr. William Charles Clifford Smith, M.I.C.E.

Dr. Charles Hubert Bond (D.Sc., M.D., Ch.M.Edin.), Senior Assistant Medical Officer at the Heath Asylum, Bexley, formerly Assistant Medical Officer at Banstead Asylum, and Clinical Assistant at the National Hospital for Epilepsy, and at the Wakefield and Morningside Asylums, has been appointed Medical Superintendent. For this officer a detached residence has been appointed conveniently near the administrative buildings.

#### REFERENCE

*British Medical Journal*, 4 July 1903, 43.

Researched by Henry Rollin, Emeritus Consultant Psychiatrist, Horton Hospital, Epsom, Surrey

## Corrigendum

Early intervention service for non-abusing parents of victims of child sexual abuse. Pilot study. *BJP*, 183, 66–72. Table 1

(p. 69), published norms (col. 3) for the Child Behavior Checklist should read: total score: referred=52.1, non-referred=23.1;

internalising sub-scale: referred=14.6, non-referred=6.3; externalising sub-scale: referred=17.5, non-referred=8.2.