

Correspondence

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Towards a unitary theory of stigmatisation

I thank Crisp (2001) for his editorial on my paper and am pleased that he agrees with a range of propositions in the unitary theory of stigmatisation (Haghighat, 2001). Yet, his overemphasis on evolution as the foundation of stigmatisation raises a pivotal question. If stigmatisation is so biologically determined, what is the point of anti-stigmatising campaigns which essentially imply belief in the determining roles of cultural, political and socio-economic factors? Would this overemphasis not somehow respond to our despair in tackling stigmatisation, in that it allows its attribution primarily to something deeply ingrained?

Historically, the intensity of stigmatisation has varied in response to socio-economic and political contingencies – the genetic evolutionary machinery being inhibited or stimulated by these environmental factors. By analogy, milk is necessary for inducing the production of lactase but for this the genetic evolutionary machinery giving rise to lactase is not necessarily any more fundamental than the presence of milk in the environment.

As the title of my paper implies, one of its targets is to define routes to destigmatisation. Crisp questions why I distinguish constitutional from evolutionary factors. I do so to work towards this target. Constitutional factors involve rather 'primitive', 'vegetative' and 'spontaneous' responses less, or perhaps differently, amenable to anti-stigmatising interventions (if at all) while evolutionary factors involved in, for example, whether to let your sister marry someone with mental illness, are more amenable to conscious reflection and decision-making and are therefore subject to different types of anti-stigmatising interventions.

In finding the aetiology of stigmatisation one should not be misled by the form of a discourse but explore its *raison d'être* and motivating factors. Crisp seems to miss the fact that the same discourse can serve very different purposes for different social

groups. The discourse of free will and self-infliction in addictions, when deployed by a conscientious doctor, social worker or family member, is likely to serve to induce feelings of responsibility in the patient. The same discourse used by the public is likely to have been primarily devised to allay their guilt faced with suggestions that they are stigmatisers. Patients with addiction, despite their indisputable relative responsibility in causing their condition, are attributed a wider range of imperfections than they deserve and are thus stigmatised. The discourse of self-infliction is an example of the 'Just World hypothesis' already discussed in my paper.

Crisp refers to Hughes' (2000) consensual psychoanalytic proposition: people use projection as a defence against dysphoric mood. Yet, in order to remain evidence-based and not to rebuff those not dynamically oriented, my theory had to rely, as much as possible, on experimental facts of social psychology (e.g. Gibbons & Gerard, 1989). I agree with Crisp that the tendency to stigmatise depends on robustness of the stigmatiser's personality – those with high self-esteem are less likely to derogate others (Nunnally, 1961) and so gain psychologically – but it is, at the same time, likely to depend on the importance and self-interest value of what is at stake.

Crisp suggests that I have not considered links between psychological and socio-political factors seriously. Yet, in my paper I alert the reader that not all core issues related to stigmatisation could be discussed because of space limitations. Factors involved in stigmatisation are of course all interconnected. In a decision to reject a partner whose control of resources is poor, the mind may be weighting negative attributions more than positive ones – the allocation of 'badness' to another can yield psychological gain, the decision can prevent loss in socio-economic competition and finally the evolutionary need to distance poor reproductive bets can be satisfied. As another example, the choice of a certain political ideology favouring strict division

between social groups, classes and persons is likely to respond to a psychological need to distance, dominate or control as opposed to a wish to share and to promote compassion, equality and interdependence. At the same time, this is likely to involve mind categorising and labelling and to profit the protagonists through a differential system of social privileges as well as responding to a primitive evolutionary urge.

Finally, Crisp observes that while I have taken a categorical approach I have ended up extolling a monistic philosophy. You can use different fields of enquiry to delve into the same phenomenon and endeavour to sum up the partial visions provided into the synthesis of a picture as the best possible approximation of reality. What I call constitutional or economic or other 'origins' are routes of enquiry into domains in which stigmatisation shows its face. If you asked what was the origin of the production of energy in the body, dietetics would refer mainly to food and calories, cellular biology primarily to mitochondria, biochemistry to the Krebs cycle or oxidative phosphorylation, physics to thermodynamics, etc., while these are all aspects of a single, ultimate mechanism. By the same token, all versions of the origin of stigmatisation, although divided and labelled by our brain as related to a distinct branch of knowledge, refer to a unitary, ultimate source: the pursuit of self-interest. When trying to understand stigmatisation we must not fall into the same trap that makes us stigmatise. The paradigms of physics, chemistry, sociology, politics, etc., all have human dimensions, such as our tendency to divide, partition and parcel out – they are labels we have found to name the branches of what used to be called philosophy before we decided to carve it up into pieces. We did so because of our brains' lack of capacity to cope with the extent and volume of the accumulated knowledge and now none of these branches can give us a global picture of reality. But we have the capacity to free ourselves from the same reductionism by recognising the limitations of our categorisations and by looking at the shared core of different versions of reality that these branches of knowledge present – where these versions overlap is likely to be the nearest to where we can reach in grasping the essence of reality.

Crisp, A. (2001) The tendency to stigmatise. *British Journal of Psychiatry*, 178, 197–199.

Gibbons, F. X. & Gerard, M. (1989) Effects of upward and downward social comparison on mood states. *Journal of Social and Clinical Psychology*, **1**, 14–31.

Haghighat, R. (2001) A unitary theory of stigmatisation. Pursuit of self-interest and routes to destigmatisation. *British Journal of Psychiatry*, **178**, 207–215.

Hughes, P. (2000) Stigmatisation as a survival strategy: intrapsychic mechanisms. In *Every Family in the Land* (ed. A. H. Crisp). www.stigma.org.

Nunnally, J. (1961) *Popular Conceptions of Mental Health: Their Development and Change*. New York: Holt, Rinehart & Winston.

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Author's reply: Dr Haghighat's response to my invited editorial comments (Crisp, 2001) upon his paper (Haghighat, 2001) adds to his overall discourse and may illuminate this matter for readers of these articles. I respect his proposition that self-interest is a basis of the stigmatisation process and all that flows from it. It advances thinking on the matter. Self-interest could be proposed as an explanatory hypothesis for much of human nature. Within the arena of stigmatisation of people with mental illness probably it can range across human experiential and ingrained biological needs, from its protective value for preservation of self-esteem through to selective mating subserving evolutionary purposes. He has emphasised cultural, political and socio-economic factors. I have suggested that greater emphasis is needed on our existential concerns and fears and the biological substrates to our personal survival strategies in the face of such perceived threats. All require our attention if we are to maximise our capacity to change.

He appears to despair of us changing our biologically driven nature and behaviours which, in this context, translate into crude defensive categorisations and labelling of those with mental illness, often leading to distancing rather than exploitation. I believe that the best chance of achieving such change is first to acknowledge the power of human biology. In civilised society we have usually striven then to shape and curb it by influencing attitudes and behaviour via moral, educative and legislative channels. We have sometimes succeeded. Importantly, we also need to address individual vulnerabilities and related triggers to such innate mechanisms. I reiterate that they probably importantly include the degrees of

personal psychological fragility and related defensiveness, along with their social extensions and projections such as Haghighat emphasises. It may also benefit from clarification of the social handicaps and sometimes the advantages that can accompany some mental illness diatheses.

The College's anti-stigma campaign is about to go public after 3 years of development and planning. Thoughtful input within contributions such as Haghighat's paper, along with this welcome support from the *Journal*, are at its heart.

Crisp, A. (2001) The tendency to stigmatise. *British Journal of Psychiatry*, **178**, 197–199.

Haghighat, R. (2001) A unitary theory of stigmatisation. Pursuit of self-interest and routes to destigmatisation. *British Journal of Psychiatry*, **178**, 207–215.

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Stigma caused by psychiatrists

Chaplin (2000) could have made an interesting read but unfortunately seemed to miss making any particular point. The effects of medication and Mental Health Act assessments can and do have powerful effects on both the ill person and his or her family. Alas, Chaplin failed to expand on a major issue – the attitudes some psychiatrists hold have far more devastating effects on their patients than either medication or the Mental Health Act.

I have written elsewhere (Corker, 2001) about the deeply harming effects that stigmatisation and discrimination by psychiatrists can have on people who may have suffered mental illness and may or may not have been their patients. While many articles have been written about the stigma of mental illness, too little has been said about the effect that the attitude of mental health professionals may have on patients.

For the patient the mental health professional must maintain a position of trust and also remember that they provide the building blocks for modelling at a point of extreme vulnerability in the life of the patient. As a mental health professional for 20 years, both in the National Health Service and private practice, I have also experienced the discrimination and stigma of being a patient during and following two

major depressive illnesses. The experience of being ill has certainly changed my life and resulted in major losses; worse is the way in which the illnesses have been used by fellow professionals, both medical and non-medical, to stigmatise and discriminate. I do admit to making mistakes as a result of illness but would have expected that this would be seen as the result of illness, where poor decision-making is acknowledged as one of the key signs.

I agree with Chaplin that psychiatrists “must be prepared to identify and challenge our own prejudices and attempt to modify our clinical practice”. First and foremost, this requires a sense of humility to examine a personal approach. Second, attitudes and practices that need to be changed must be identified. Third, the responsibility needed to make the change must be accepted.

Chaplin, R. (2000) Psychiatrists can cause stigma too (letter). *British Journal of Psychiatry*, **177**, 467.

Corker, E. (2001) Stigma and discrimination – the silent disease. *International Journal of Clinical Practice*, **55**, in press.

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Cognitive therapy in schizophrenia

In the course of a favourable review of cognitive therapy in schizophrenia, Thornicroft & Susser (2001) cite the recent trial by Sensky *et al* (2000), but fail to mention that it had negative results. This 90-patient, 9-month randomised controlled trial, carried out under blind conditions, compared this form of treatment with a control intervention (befriending) and found no significant difference between the two. It is true that differences emerged 9 months after completion of treatment, but this latter part of the study was uncontrolled.

Of the other trials of cognitive therapy cited in their article, that of Drury *et al* (1996) did not use blind evaluations, and that of Kuipers *et al* (1997) employed neither blind evaluations nor a condition to control for the non-specific effects of intervention (the Hawthorne effect). Only one other published study (TARRIER *et al*, 1998) incorporated both these design features; this found a non-significant advantage of cognitive therapy over supportive counselling (Curtis, 1999).