Correspondence

EDITED BY MATTHEW HOTOPF

Continuing stigmatisation by psychiatrists

In response to the Royal College of Psychiatrists' anti-stigma campaign, Chaplin (2000) emphasises the role psychiatrists can have in both creating and perpetuating stigma. Chaplin particularly focuses on people with alcohol problems and on those with learning disabilities. However, she omits a third and important group: those with personality disorders.

Lewis & Appleby (1988) showed that such patients are readily stigmatised by psychiatrists. They found that the introduction of the term personality disorder produced marked levels of negative attributions in psychiatrists when comparing otherwise similar clinical vignettes. The reasons for this are complex but there is little evidence that such attitudes have changed. Hinshelwood (1999) has discussed some of the problems this group of patients can present.

The Government's proposed reforms of the Mental Health Act (Department of Health, 2001) present major challenges to forensic psychiatry in relation to the proposals concerning those with 'dangerous severe personality disorder'. In the controversy surrounding these proposals it should not be forgotten that they redefine 'mental disorder' in its broadest sense, specifically including personality disorder within its scope. Any clinical separation that existed between personality disorder and mental illness may thus be consigned to history. In the light of psychiatry's stigmatisation of those with personality disorders, the proposals present a very clear challenge to present services.

The Government's proposed reforms are also contributing to further stigmatisation of those with personality disorders, via the routine newspaper equation of 'dangerous severe personality disorder' with personality disorder and the false generalisation of risks from one group to the other that this entails (Gillan & Campbell, 1998). This demonstrates again that stigmatisation is an active and continuing process. The profession of psychiatry itself needs to recognise when it contributes to this process, as well as addressing the contributions of others.

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

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Gillan, A. & Campbell, D. (1998) Personality disorder 'untreatable'. *The Guardian*, 24 October.

Hinshelwood, R. D. (1999) The difficult patient. The role of 'scientific psychiatry' in understanding patients with chronic schizophrenia or severe personality disorder. *British Journal of Psychiatry*, **174**, 187–190.

Lewis, G. & Appleby, L. (1988) Personality disorder: the patients psychiatrists dislike. *British Journal of Psychiatry*, **153**, 44–49.

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Common mental disorders in urban *v.* rural Pakistan

I read with interest Mumford *et al*'s (2000) paper on stress and psychiatric disorder in urban Rawalpindi. Their findings and explanations of a lower prevalence of common mental disorders in an urban area compared with a rural area of Pakistan (Mumford *et al*, 1997) need to be treated with caution.

Their study population is unrepresentative of the city as a whole. Although they studied an urban slum, strictly speaking, it is a relatively 'prosperous' urban slum. The assets and income of this population lie between the fourth and the richest quintile for the Pakistani population (Gwatkin *et al*, 2000). The use of only male interviewers for female subjects in an orthodox society is also a source of potential bias and cannot be ignored. This was not the case in the rural study. Thus, their findings are unlikely to be generalisable to the urban population of Rawalpindi or other cities of Pakistan. A more plausible explanation for their findings is that financial prosperity together with strong and varied social networks might be associated with a lower prevalence of common mental disorders. Their study attempts to address one aspect of urbanisation due to rural migration, rather than looking at stress and psychiatric disorder in urban Rawalpindi.

Gwatkin, D., Rustein, S., Johnson, S., *et al* (2000) *Socioeconomic Differences in Health, Nutrition and Population in Pakistan*. Washington, DC: HNP/Poverty Thematic Group, The World Bank.

Mumford, D. B., Saeed, K., Ahmad, I., *et al* (1997) Stress and psychiatric disorder in rural Punjab. A community survey. *British Journal of Psychiatry*, **170**, 473–478.

——, Minhas, F. A., Akhtar, I., *et al* (2000) Stress and psychiatric disorder in urban Rawalpindi. Community survey. *British Journal of Psychiatry*, **177**, 557–562.

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Author's reply: It is difficult to find a truly representative area of any city, since its districts vary greatly in socio-economic terms. Nevertheless, we made a careful selection in Rawalpindi of a recently established housing area, with poor public utilities, of middle to lower socio-economic status. As presented in our paper, the socio-economic findings confirmed our choice and revealed a wide social spectrum. For example, among men, 31% had had no formal education yet 38% had been educated to tertiary college level. Over half the households had an income of less than 5000 rupees (currently worth £55) per month.

As it happens, the socio-economic status of the nearby rural population in our Gujar Khan study (Mumford *et al*, 1997) was quite similar to that in Rawalpindi in terms of education and income, and in fact they reported greater ownership of most electrical appliances. So financial prosperity alone is not a plausible explanation for the very striking difference we found in psychiatric morbidity (i.e. less than half) in urban Rawalpindi compared with a rural village in the Punjab.

Whether urban populations in Pakistan indeed have more "strong and varied social networks" than rural populations, as Dr Mirza suggests, remains to be investigated, but this is doubtful. We are planning

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