Stigma of mental illness among Chinese people

I read with interest the paper by Chung & Wong ‘Experiences of stigma among Chinese mental health patients in Hong Kong’ (Psychiatric Bulletin, December 2004, 28, 451–454). They cited as one limitation of their study that their results might not extrapolate to the Chinese population in other countries. A preliminary assessment of the mental health needs of Chinese young people in Birmingham, UK (Chinese National Healthy Living Centre, 2005) revealed that stigma remains an important issue among Chinese in the UK. The assessment concluded that the majority of Chinese young people and their parents perceive mental illness as being ‘crazy’ and associated with violence. This finding agrees with the conclusion of Chung & Wong’s paper that many Chinese patients have experienced stigma and discrimination in Hong Kong.

Chung & Wong stated that the term ‘mental illness’ can be associated with stigma, yet they used the same term in their study questionnaire. In their clinical implications section, they have sensibly suggested that cranial CT scans might influence patient management. I conducted an audit review of 56 cranial CT scans in elderly people. In 51%, clinical management was not influenced by the CT scan. This group included those who were unwilling to receive treatment. Fielding stated that the prevalence of truly reversible causes of dementia identified by cranial CT is extremely low. In support of this, in my audit review none of the scan results showed evidence of potentially reversible causes of dementia.


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Do we really need a duty consultant?

Do consultant psychiatrists really need to provide a conventional out of hours service? How often does a clinical insight, resulting from a face-to-face, out-of-hours interview with the duty consultant psychiatrist, genuinely contribute to the management of a situation, in a way that could not have waited until the following day? Between 17.00 h and 09.00 h, could it not be replaced by telephone advice? A single consultant (working a reasonable shift of say 8 h) could provide advice to junior doctors, and others, for a large catchment of several million people, with a local consultant still available to review patients between 09.00 h and 17.00 h on weekends and public holidays.

There are two strong arguments for making such a change. First, the effort and expenditure invested by the National Health Service in ensuring the physical presence of a consultant psychiatrist at all times could be better spent on other service developments. Second, recruitment and retention are major challenges for the psychiatric profession (Storer, 2002) and we compete with other specialties for 'malignant alienation'.

Malignant alienation

I read with interest the letter by Darryl Watts ‘Malignant alienation – a concept that has not yet arrived’ (Psychiatric Bulletin, December 2004, 28, 459). I also read the earlier editorial on malignant alienation by Watts & Morgan (1994). It would appear to me that the term ‘malignant alienation’ does describe a group of patients who according to Watts and Morgan are ‘hard to like’. I believe that quite a number of these patients overlap with persons who would now be diagnosed with Asperger syndrome. The major problems in relationships with others, and the loss of sympathy from staff who perceive their behaviour as being unreasonable, would fit with Asperger syndrome. It is hardly surprising if this continues that there could be a suicidal outcome. I would suggest that patients with this description ‘malignant alienation’ be assessed for Asperger syndrome.


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