trial, it is impossible to decide whether any public health benefit has resulted from introducing psychiatric screening. Given the weakness of the individual predictor variables, the timing of screening (at the end of adolescence) and the fact that to date no programme of psychiatric screening for events that have yet to happen (i.e. future breakdown) has been shown to be effective in a randomised controlled trial, I think that I am entitled to stay with my conclusions that psychiatric screening to detect vulnerability to future breakdown remains unproven and continues to have the potential to do more harm than good. Until such evidence is forthcoming, it may be more useful to devote resources to increasing resilience through support and training, and providing better and more acceptable services to help those who do succumb to the rigours of military life.

Declaration of interest

S.W. is Honorary Civilian Advisor in Psychiatry (unpaid) to the British Army Medical Services.

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Is gestational week at birth a predictor of schizophrenia?

We read with great interest the article by Isohanni *et al* (2005), which investigated subtle motor, emotional, cognitive and behavioural abnormalities as predictors of schizophrenia. The authors concluded that these are not useful predictors of illness. However, Isohanni *et al* did not investigate gestational age as a predictor of psychological abnormalities in later life. This has recently been used as a predictor in some cohort studies (Thompson *et al*, 2001; Gale & Martyn, 2004; Wiles *et al*, 2005), and is obstetrically one of the most important predictors of childhood outcomes that are also related to psychological abnormalities in later life (Thompson, 2001; Gale & Martyn, 2004; Cunningham *et al*, 2005). We feel strongly that birth cohort studies of psychological abnormalities in later life should include gestational week at birth. The study of Isohanni *et al* would have benefited from inclusion of this variable.

Cunningham, E. G., Leveno, K. J., Bloom, S. L., *et al* (2005) *Williams Obstetrics* (22nd edn). New York: McGraw-Hill.

Gale, C. R. & Martyn C. N. (2004) Birth weight and later risk of depression in a national birth cohort. *British Journal of Psychiatry*, **184**, 28–33.

Isohanni, M., Lauronen, E., Moilanen, K., *et al* (2005) Predictors of schizophrenia. Evidence from the Northern Finland 1966 Birth Cohort and other sources. *British Journal of Psychiatry*, **187** (suppl. 48), s4–s7.

Thompson, C., Syddall, H., Rodin, I., *et al* (2001) Birth weight and the risk of depressive disorder in late life. *British Journal of Psychiatry*, **179**, 450–455.

Wiles, N. J., Peters, T. J., Leon, D. A., *et al* (2005) Birth weight and psychological distress at age 45–51 years. Results from the Aberdeen Children of the 1950s cohort study. *British Journal of Psychiatry*, **187**, 21–28.

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Authors' reply: We welcome the comments of Shukinami *et al* but it is important to realise the basic theoretical and practical difference between a risk factor and prediction of illness in the premorbid phase. When exposures are common (as are many obstetric complications) but incidence ratios of the illness are not high and outcomes fairly rare (as is schizophrenia), prediction of future disease is difficult.

Abnormal gestational age may or may not be a subtle risk factor for schizophrenia. This has been analysed in a recent meta-analysis (Cannon *et al*, 2002) of eight prospective population-based studies of the association between obstetric complications and schizophrenia. Gestational age under 37 weeks was weakly associated with schizophrenia (odds ratio=1.22, 95% CI 0.90–11.65). The results within the Northern Finland 1966 Birth Cohort were similar (Jones *et al*, 1998).

Our review mentioned abnormal foetal growth and development as a potential risk factor for schizophrenia, as did Cannon *et al*, but the predictive power of abnormal foetal growth is weak as it is a rather common phenomenon. Prediction in this situation is not easy at the population level. Our aim was to describe the best known risk factors for schizophrenia, which is why we did not conduct a detailed analysis of gestational age.

The references included in the letter of Shukinami *et al* suggest that the association of gestational age with other mental disorders may be stronger than for schizophrenia.

Cannon, M., Jones, P. B. & Murray, R. M. (2002) Obstetric complications and schizophrenia: historical and meta-analytic review. *American Journal of Psychiatry*, **159**, 1080–1092.

Jones, P. B., Rantakallio, P., Hartikainen, A.-L., *et al* (1998) Schizophrenia as long-term outcome of pregnancy, delivery, and perinatal complications: a 28-year follow-up of the 1966 North Finland general population birth cohort. *American Journal of Psychiatry*, **155**, 355–364.

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Stigmatisation of people with schizophrenia in Japan

Lee *et al* (2005) reported that in Hong Kong individuals with schizophrenia experience stigma even from family members. This stigma as well as public attitudes towards mental illnesses are serious issues. Mental health professionals are expected to take a supportive stance against such stigmatisation. However, is this always the case?

Practising clinicians may have unconsciously been partly responsible for assigning prejudice to the condition. The terminology routinely used in Japanese clinical practice to describe the characteristics of schizophrenia is somewhat derogatory, e.g. the term *jinkaku suijun no teika* (a decline in the level of personality) is often used to describe a feature ascribed to the larger domain of negative symptoms. The symptoms checklist used in the official mandatory evaluation of long-term inpatients includes one item regarding 'the morbid state of personality'; apathy and abulia are assigned the label of 'residual personality changes', and no other items are assigned to the category of negative symptoms. These descriptions imply that the affected person's personality has decayed and, consequently, that the process is irreversible.

There are other expressions often used in Japanese clinical practice that may encourage prejudice: these include *jigiteki sokai kan* (silly or childish cheerfulness). *kekkan jotai* (a defective state), *hinekure* (perverseness) and *omoi agari* (conceited). The latter two terms were introduced in

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Japan in 1956 from the original descriptions (*Vershrobenheit* and *Verstiegenheit*, respectively) of L. Binswanger (1881–1966) and are still in use.

Demands to eradicate the stigmatisation of people with mental illnesses have never been higher in modern psychiatry (Porter, 1998; Crisp *et al*, 2000; Corrigan *et al*, 2001). Caregivers need to be alert to the intrinsic problems that may exist in daily practice. The disclosure of medical records is still uncommon in Japan (Takei, 2001) and standardised diagnostic systems such as the ICD–10 (World Health Organization, 1992) have not been widely used. These practices have fostered reliance on subjective judgement and the use of rather undesirable terminology in clinical practice. Mental health professionals may themselves stigmatise people with schizophrenia and such an unbecoming attitude may not be limited to a particular country.

Corrigan, P. W., Edwards, A. B., Green, A., *et al* (2001) Prejudice, social distance, and familiarity with mental illness. *Schizophrenia Bulletin*, **27**, 219–225.

Crisp, A. H., Gelder, M. G., Rix, S., *et al* (2000) Stigmatisation of people with mental illnesses. *British Journal of Psychiatry*, **177**, 4–7.

Lee, S., Lee, M. T. Y., Chiu, M. Y. L., *et al* (2005) Experience of social stigma by people with schizophrenia in Hong Kong. *British Journal of Psychiatry*, **186**, 153–157.

Porter, R. (1998) Can the stigma of mental illness be changed? *Lancet*, **352**, 1049–1050.

Takei, N. (2001) Present status of access to medical records in England – special reference to psychiatry. *Seishin Shinkeigaku Zasshi*, **103**, 15–20.

World Health Organization (1992) *The ICD–10 Classification of Mental and Behavioural Disorders: Diagnostic Criteria for Research*. Geneva: WHO.

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Authors' reply: Takei *et al* give salient examples of how psychiatrists and psychiatric treatment contribute to the stigmatisation of individuals with schizophrenia in Japan. We discuss similar and other related instances of such treatment-related stigma in a separate paper (Lee *et al*, in press).

Compared with stigma in most social situations, treatment-related stigmatisation exhibits two features that render its impact on patients particularly poignant. First, whereas patients can conceal their illness from friends, colleagues or even family members, total secrecy within the psychiatric treatment system is nearly impossible. Nor can they distance themselves from psychiatric treatment without running the risks of being labelled as 'non-compliant' or 'lacking insight', and having a relapse of illness. Second, patients often experience unconscious stigmatisation by mental health staff. Instances such as those described by Takei *et al* frequently occur in the course of routine clinical management by psychiatrists and nurses.

However, even when there is no conscious intent to stigmatise, certain institutional practices in psychiatry that cause stigma are examples of structural discrimination (Pincus, 1996). This arises less from personal prejudice than a combination of causes such as poor quality of health services, inadequate budget allocation and neglected rights of patients.

Psychiatrists have routinely blamed negative social attitudes for the stigmatisation of people with schizophrenia. Public health campaigns have sought to reduce the stigma associated with mental illness by increasing public knowledge. Without doubting the benefit of attitudinal shifts among the general population, we believe that programmes aimed at reducing stigma must be informed as well as evaluated by patients' lived experience of psychiatric treatment. Tackling structural discrimination and the resulting power difference is at the root of such a change.

Lee, S., Chiu, M. Y. L., Tsang, A., *et al* (in press) Stigmatizing experience and structural discrimination associated with the treatment of schizophrenia in Hong Kong. *Social Science and Medicine*, in press.

Pincus, F. L. (1996) Discrimination comes in many forms – individual, institutional, and structural. *American Behavioral Scientist*, **40**, 186–194.

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One hundred years ago

Criminality in the feeble minded

The weak-minded criminals of the type which we have indicated are, Dr. SMALLEY tells us, for the most part recidivists. Beginning their penal career at a relatively early age, generally about the period of adolescence, when they are forced to enter on the struggle for existence for which they are so heavily handicapped by their defective organisation, they continue through the rest of their lives to oscillate between the prison, the asylum, and the workhouse, with brief intervals of freedom, during which they can be more actively noxious. Ordinarily the offences which they commit are of a relatively trivial character, being indeed, very often rather sins of social omission than acts really meriting the name of crime. This general rule, however, is subject to many and grave exceptions. The feebleness of mind which renders these defectives incapable of sustained effort and of due adaptation to environment drives them to parasitic ways of life, while it involves a lack of self-control which leaves their conduct at the mercy of every casual impulse of unusual intensity. An outburst of lust will provoke them to rape or bestiality, or an exaggerated sense of injury aroused by some trivial incident will impel them to wreak their vengeance in murder or arson.

The number of the criminal defectives of this lowest class is not, it would appear from the available records, very large. The official figures for the last three years put

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