

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

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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 Shukunami *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 Shukunami *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