

**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.

**R. Haghighat** Adult Department, Tavistock Clinic, 120 Belsize Lane, London NW3 5BA

**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.

**A. H. Crisp** Psychiatric Research Unit, Atkinson Morley's Hospital, 31 Copse Hill, Wimbledon, London SW20 0NE

### 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.

**E. Corker** Address supplied. Correspondence c/o *The British Journal of Psychiatry*, 17 Belgrave Square, London SW1X 8PG

### 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).

Rather than being ready for an assessment of its effectiveness and cost-effectiveness in non-experimental settings, as Thornicroft & Susser argue, cognitive therapy may be in the process of meeting the fate of an earlier treatment for schizophrenia where advocacy preceded rigorous evaluation – insulin coma.

**Curtis, D. (1999)** Intensive cognitive behaviour therapy for chronic schizophrenia. Specific effect of cognitive behaviour therapy for schizophrenia is not proved (letter). *British Medical Journal*, **318**, 331.

**Drury, V., Birchwood, M., Cochrane, R., et al (1996)** Cognitive therapy and recovery from acute psychosis: a controlled trial. I. Impact on psychotic symptoms. *British Journal of Psychiatry*, **169**, 593–601.

**Kuipers, E., Garety, P., Fowler, D., et al (1997)** London–East Anglia randomised controlled trial of cognitive–behavioural therapy for psychosis. I. Effects of the treatment phase. *British Journal of Psychiatry*, **171**, 319–327.

**Sensky, T., Turkington, D., Kingdon, D., et al (2000)** A randomised controlled trial of cognitive–behavioural therapy for persistent symptoms in schizophrenia resistant to medication. *Archives of General Psychiatry*, **57**, 165–172.

**Tarrier, N., Yusupoff, L., Kinney, C., et al (1998)** Randomised controlled trial of intensive cognitive behaviour therapy for patients with some schizophrenia. *British Medical Journal*, **317**, 303–307.

**Thornicroft, G. & Susser, E. (2001)** Evidence-based psychotherapeutic interventions in the community care of schizophrenia. *British Journal of Psychiatry*, **178**, 2–4.

**P. J. McKenna** Fulbourn Hospital, Cambridge  
CBI 5EF

### No long-term benefit for cognitive therapy in acute psychosis: a type II error

Drury *et al* (2000) reported no significant difference in relapse rates, positive symptoms or insight between a cognitive therapy group and a recreational activities and support group of patients who had an acute episode of a non-affective psychosis. This 5-year outcome study assessed 34 out of an original cohort of 40 patients.

Working on the basis of small trials having a large type II error, the group size for each group can be estimated. If the anticipated mean response in one group is  $\mu_1$  and the standard deviation is  $\sigma$ , to show a significant result the mean relapse of one group can be estimated at  $2(\mu_1)$  and the standard deviation can be estimated at  $1.5(\sigma)$ . The estimated difference between the groups ( $\delta$ ) can be set at  $0.5(\mu_2 - \mu_1)$ . A formula to calculate the number ( $n$ ) in each

group (Pocock, 1983: 127–128) can be used as follows:

$$n = \frac{2\sigma^2}{(\mu_1 - \mu_2)^2} \times f(\alpha, \beta)$$

The  $\alpha$  (type I error) is by convention set at 0.05, and the  $\beta$  (type II error) can be set at 0.2. The power of finding a true result ( $1 - \beta$ ) will therefore be 0.8 or 80% and, by using a statistical table,  $f(\alpha, \beta)$  is 7.9. Therefore,  $n$  can be calculated as

$$\frac{2 \times 1.5^2}{0.5^2} \times 7.9 = 142$$

patients in each group.

It would therefore take a very large sample to prove the null hypothesis in the above hypothetical estimate. In the study by Drury *et al* (2000), it would be misleading to extrapolate that there was no long-term benefit of using cognitive therapy in schizophrenia in terms of relapse. Larger studies are needed in this rapidly evolving area.

**Drury, V., Birchwood, M. & Cochrane, R. (2000)** Cognitive therapy and recovery from acute psychosis: a controlled trial. 3. Five-year follow-up. *British Journal of Psychiatry*, **177**, 8–14.

**Pocock, S. (1983)** *Clinical Trials: A Practical Approach*. Chichester: John Wiley & Sons.

**K. Marlowe** Lambeth Mental Health Services, South London and Maudsley NHS Trust, 108 Landor Road, London SW9 9NT

### Seasonal variation in suicides: hidden not vanished

Yip *et al* (2000) demonstrated that, in England, the seasonal variation in suicide rates in the 1980s and 1990s decreased considerably when compared with that in the 1960s and 1970s. From monthly suicide frequencies, they concluded that current data hardly show any seasonal effects on suicide rates, and they predicted that seasonal variation in suicide rates would disappear completely in the years to come.

Although we fully agree with Yip *et al* (and several other authors) that there is a global decline in the amplitude of seasonal variation in suicide rate, we do not agree with the conclusion that seasonal influences are beginning to fade away. We came to this conclusion by a recent study of train

suicides (i.e. suicide by jumping before a moving train) in The Netherlands (van Houwelingen & Beersma, 2001). In this study ( $n=30$ ) we confirmed the absence of a seasonal pattern in suicide rates as observed in 28-day intervals. We did, however, observe a strong seasonal influence on 24-hour patterns. Whereas the winter season showed two daily peaks in suicide rates, at around 9–11 am and 7–10 pm, the summer season revealed one major peak around 12–4 pm and a smaller peak shortly before midnight. The timing of the major summer peak is in the trough between the two winter peaks.

This more subtle influence of time of year on suicide rates adds a different dimension to what has been considered seasonality in suicidal behaviour and may generate new ideas concerning relevant factors involved. In train suicide data, seasonal influences are clearly present. This may also be true of other methods of suicide. In order to see this, time of day and time of year have to be taken into account simultaneously.

**van Houwelingen, C. A. J. & Beersma, D. G. M. (2001)** Seasonal changes in 24-h patterns of suicide rates: a study on train suicides in The Netherlands. *Journal of Affective Disorders*, in press.

**Yip, P. S. F., Chao, A. & Chiu, C. W. F. (2000)** Seasonal variation in suicides: diminished or vanished. Experience from England and Wales, 1982–1996. *British Journal of Psychiatry*, **177**, 366–369.

**C. A. J. van Houwelingen** GGZ Eindhoven, PO Box 909, 5600 AX Eindhoven, The Netherlands

**D. G. M. Beersma** Department of Psychiatry and Zoological Laboratory, University of Groningen, PO Box 14, 9700 AA Haren, The Netherlands

### Soviet-style psychiatry is alive and well in the People's Republic

The involuntary committal to psychiatric institutions of political dissenters has long been associated with the abuses of psychiatric practice perpetrated in the former Soviet Union. The detention of dissenters may be based upon psychiatric judgement but political factors are relevant when such abuse becomes widespread. International concern has been growing following the decision of the Chinese Government to outlaw the practice of *Falun Gong* and forcibly to assign psychiatric treatment to practitioners of this meditative discipline. *Falun Gong*, also known as *Falun Dafa*,