

comparison with a statistical model based on baseline variables. I would like to express three concerns about the technical details of this article.

First, the kappas they report are Cohen's kappas whereby the disagreement between "full recovery within 6 months" and "partial recovery" is penalised equally to disagreement between "full recovery within 6 months" and "no recovery". Clinically, however, the former is apparently less grave than the latter. More appropriate statistics would be weighted kappas, which are 0.31 (95% CI 0.15–0.46) for GP prognosis for depression, 0.35 (95% CI 0.16–0.54) for GP prognosis for anxiety, 0.56 (95% CI 0.43–0.70) for model prognosis for depression and 0.51 (95% CI 0.33–0.69) for model prognosis for anxiety. These figures are appreciably larger than those originally reported.

Moreover, regardless of whether we use Cohen's kappas or weighted kappas, the authors did not examine whether the GP prediction is indeed statistically significantly worse than the model's. The reported 95% confidence intervals overlap, and we do not know whether the clinicians are actually performing worse than the maximally attainable model.

Third, as the authors rightly note in the Discussion, their way of using the total sample to construct a predictive model may have 'overfitted' the model to the data and produced artificially inflated agreement. A more ideal way may have been the 'leaving-one-out method' (Lachenbruch, 1975), in which analysts would repeatedly build a model based on a sample minus one observation and examine whether each model could predict the one excluded observation.

In this connection it may be worthwhile to point out that the comparison between human performance and that of a statistical model is a theme repeatedly found in clinical psychology (Meehl, 1954; Goldberg, 1970). These studies conclude that, because of the inevitable random error in human judgement, the latter almost always outperforms the former. It will, therefore, be most interesting to see how, in the authors' next round of proposed investigation, clinicians can improve their performance if they are given feedback on prognostic factors.

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The stigma of suicide

The Royal College of Psychiatrists is leading a campaign to reduce the stigma attached to mental illness. Stigmatisation of suicide has very deep roots in our collective thinking and judgement. Suicide was tolerated by the Greeks and Romans (Alvarez, 1990), but Aristotle argued that suicide weakens the economy and upsets the gods, and in so-doing he initiated stigmatisation of the act. Hinduism and Buddhism, among other Eastern religions, have not had a traditionally negative view of suicide. In the Judaeo-Christian tradition, stigma against suicide is not evident until the fourth century; the Bible does not condemn suicide (Barraclough, 1992), but St Augustine considered suicide as unacceptable within Christian values (Pritchard, 1996). Gradually, the stigma against suicide intensified in Europe and became a great sin, shame and eventually a crime. A number of philosophers and writers including William Shakespeare sought to encourage a more understanding and compassionate view but this movement had little impact before Durkheim's studies made clear the social rather than moral origins of suicide (Retterstol, 1993). Although suicide and attempted suicide were decriminalised in 1961 (Levine & Pyke, 1999), we have practised since within a culture of ambivalence wherein stigma is neither high nor totally eliminated. Indeed, the multicultural/multifaith dimension within society and its thinking has complicated matters considerably.

The stigma surrounding suicide remains just high enough to discourage people – especially the elderly – from talking about their suicidal thoughts. Some people feel that they might be labelled as weak, lacking faith, coming from bad families or indeed 'mad' if they were to declare their suicidal thoughts. This does not help when we are trying to detect early signs of suicide or reaching out to help victims of despair.

Any approach to prevent suicide should include the removal of blame and stigmatisation of that individual and his or her family. One would hope that all teachers and professionals from the different faiths will take into account this insight into the condition. Scientific approaches and spiritual approaches can work together in order to eliminate this kind of stigma and to make people more comfortable in trying to seek help in their moments of despair.

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Who is politicising psychiatry in China?

Having researched on *qigong*-related mental health problems in China, I am upset to read the statement of Lyons (2001), based indirectly on estimates from Amnesty International and a letter to the *Lancet*, that "Soviet-style psychiatry is alive and well in the People's Republic".

In China, resurgence of interest in *qigong* ('exercise of vital energy') started as early as 1980, when Chinese people were recovering from the social chaos brought about by the Cultural Revolution (1966–1976). It is worth noting that *qigong*-induced mental disorder was reported by Chinese psychiatrists long before recent accusations that psychiatry in China is used to imprison people who practise a specific kind of *qigong* known as *falungong*. There have been a sizeable number of controlled phenomenological, treatment and outcome studies published in the past two decades that testify that *qigong*-related mental disorders do not fall into a specific disease category recognised in the modern classifications (see Lee, 1996, for a brief review). In my own field studies, I interviewed people who suffered from acute psychosis induced by the inappropriate practice of *qigong* in several regions of China as well as in Hong Kong. The condition is intriguing but real, and is deserving of