

Schizophrenia sans frontieres: concepts of schizophrenia among French and British psychiatrists

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Abstract

Objective—To compare the first admission rates for schizophrenia in England and France, and to compare the concept of schizophrenia held by practising British and French psychiatrists.

Design—Comparative study of incidence rates in England and France; and postal questionnaire survey of a sample of about 1 in 30 psychiatrists in the United Kingdom and in l'Aquitaine, France.

Subjects—All first admissions for schizophrenia to psychiatric hospitals in England and France 1973-82; 92 psychiatrists in the United Kingdom and 69 in France.

Main outcome measures—Age adjusted first admission rates for schizophrenia between 1973-82; and opinions on the aetiology, diagnosis, and management of schizophrenia.

Results—First admission rates were much higher in France than in England before the age of 45, but lower after that age. Rates were falling in England over the 10 year period, while they were rising in France. In the questionnaire study English and French psychiatrists showed prominent differences of opinion for 31 out of 38 statements. The French sample did not diagnose schizophrenia after the age of 45 and endorsed psychoanalytical concepts.

Conclusions—British and French psychiatrists use different diagnostic criteria and contrasting methods of treatment for schizophrenia. Differences in diagnostic criteria probably contribute towards the disparity in administrative incidence rates and time trends for schizophrenia in the two countries. Doctors in the European Community can now work in any country. Further work is needed to ensure psychiatrists are talking a common language.

Introduction

Economic and political union are high on the agenda in the European Community, and medical doctors can work in any member state. Nevertheless, widespread differences in medical practice exist in Europe, ranging from the diagnosis and treatment of low blood pressure¹ to the treatment of testicular cancer.² Psychiatric practice seems to have been particularly affected by the traditional divide between Anglo Saxon empiricism and continental rationalism—between trying to reach the truth through experiment and trying to reach it through ideas. This is perhaps most apparent in the psychiatric traditions of the United Kingdom and France.

Psychoanalysis, focusing on “unconscious” conflicts, has been much more influential in France,³ whereas in the United Kingdom psychiatry has enjoyed a close relation with physical medicine. In the United Kingdom the old diagnostic dichotomy between affective and schizophrenic psychoses has survived, with the category of “other psychoses” accommodating those psychotic disorders not con-

sidered to belong to either category. The *International Classification of Diseases* category “paranoid states” (ICD 297) is traditionally considered to be part of the schizophrenic spectrum in the United Kingdom,⁴ and is combined with schizophrenic disorders in national mental health statistics. In France diagnostic practice appears more refined, not unlike DSM III-R, the *Diagnostic and Statistical Manual of Mental Disorders III, revised* of the American Psychiatric Association.⁵⁻⁸ Apart from schizophrenia and manic-depressive psychoses, separate categories exist to accommodate acute, good outcome, non-affective psychotic states (*psychoses délirantes aiguës*), and the delusional disorders (*délires chroniques*). The “heboïdophrenic” (pseudo-psychopathic) schizophrenia subtype is encountered in psychiatric textbooks in France,⁹ but is not recognised in the United Kingdom. Deniker’s classification of antipsychotic agents into “incisive,” “alerting,” and “sedating” subtypes¹⁰ does not appear to be recognised in the United Kingdom, which presumably indicates that there are differences in the clinical use of these compounds in the two countries.

Given the prospect of European union, it is opportune to define more precisely the psychiatric concepts of schizophrenia as currently held in France and the United Kingdom. The aims of this study were to compare, firstly, the incidence of schizophrenia in France and the United Kingdom as recorded by national statistics on hospital admissions and, secondly, the concept (aetiology, diagnosis, and management) of schizophrenia as assessed by a postal survey of a random sample of practising French and British psychiatrists.

Methods

EPIDEMIOLOGICAL STUDY

Data collection—In the United Kingdom, figures were obtained from the statistical division of the Department of Health and refer to first admissions for schizophrenia (ICD codes 295 and 297) to psychiatric hospitals and units in England in 1973-82 (data for both countries were unavailable after 1982). In France figures on first admissions for schizophrénies chroniques (INSERM code 02¹¹) were provided by the Institut National de la Santé et de la Recherche Médicale (INSERM) for the same period. Figures for the categories psychoses maniaques et dépressives (INSERM code 01), délires chroniques (INSERM code 03), and psychoses délirantes aiguës (INSERM code 04) were also obtained. General population data for the years under study were obtained from the Department of Health in the United Kingdom and the Observatoire Economique de Paris in France.

Analyses—We adjusted the rates for age when appropriate, using a method of indirect standardisation with the United Kingdom rates as the standard. The United Kingdom rates were applied to the French population to calculate the expected number of schizophrenics.

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The ratio of observed to expected events in France was then used to multiply the English rates.

QUESTIONNAIRE SURVEY

Subjects—A sample of practising consultant psychiatrists with addresses in the United Kingdom (n=130, child psychiatrists excluded) was randomly selected from the 1985 membership list of the Royal College of Psychiatrists. In France a regional sample (n=100, child psychiatrists excluded) was randomly selected from the 1990 list of registered psychiatrists of the Département Régional des Affaires Sanitaires et Sociales de l'Aquitaine (south west France). The sample was restricted to a single département, as we hoped that local collaboration would increase the response rate, and we are not aware of important regional differences in psychiatry in France. About half of all psychiatrists in France practise solely in the private sector, where less psychotic patients are treated than in the public sector. French psychiatrists were therefore asked to indicate whether their practice was exclusively private or not. The purpose of the study was explained to each subject, who was asked to provide details on age, sex, experience in psychiatry, and whether they had seen a schizophrenic patient in the past six months. Psychiatrists were also asked if they found the following classification manuals useful in clinical practice: ICD-9, DSM-III, INSERM. Subjects could denote preference for more than one manual and could also indicate that the classification was not useful.

Questionnaire—The questionnaire consisted of 38 statements with a seven point Likert scale (midpoint 4 indicating neither agreement nor disagreement) anchored at both ends between agreement and disagreement (higher values indicating greater agreement). The questionnaire was translated from English to French by two authors fluent in both languages, differences were negotiated, and the result corrected by a professional translator.

Analysis—Data were analysed using the SPSS/PC + program.¹² Mean scores and 95% confidence intervals of the differences were calculated, and *t* tests were used to test for significance. Differences between the means were adjusted for using multiple regression. Proportions were compared using the χ^2 test with continuity correction.

Results

EPIDEMIOLOGICAL STUDY

Sharp differences existed in first admission rates for both sexes (fig 1). Before the age of 45 rates were much higher in France, but much lower after that age,

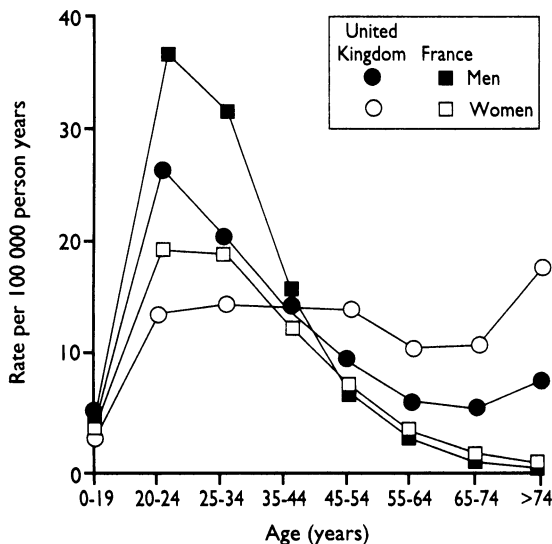


FIG 1—First admission rates for schizophrenia by sex and age group United Kingdom and France 1973-82

especially in women. In England there was a sharp increase after the age of 65 years, whereas in France rates continued to fall. Examination of longitudinal trends in age adjusted rates in both sexes showed that in France, especially in men, rates were increasing over the second half of the period, whereas in England rates were falling throughout the period (fig 2). In France first admission rates of psychoses délirantes aiguës and délires chroniques remained stable, and rates of psychoses maniaques et dépressives decreased over the first half of the 10 year period, especially in women.

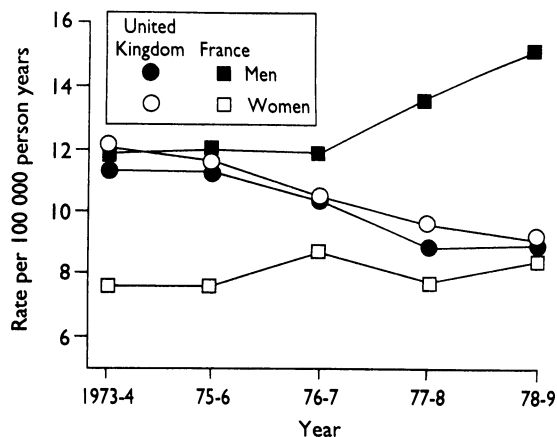


FIG 2—Age adjusted first admission rates for schizophrenia for men and women England and France 1973-82

QUESTIONNAIRE SURVEY

Sample characteristics

Of the British sample 12 (9%) had moved, retired, or died. Of the remainder, 92 (78%) returned completed questionnaires and five (4%) refused to participate. Of the French sample one had moved, 69 (70%) participated, and two refused. The French sample had fewer years of experience in psychiatry (United Kingdom 21.1, France 15.6; 95% confidence interval of difference 2.9 to 7.9) and were more likely to have last seen a schizophrenic patient more than six months ago (United Kingdom seven (8%), France 15 (22%); 95% confidence interval of difference 3 to 26). Among the French psychiatrists 34 (49%) worked exclusively in private practice. Of these, 22 had had contact with a schizophrenic patient in the past six months, compared with 32 of the 35 working in the public sector.

Diagnostic manuals

Table I lists preferences for diagnostic manuals among British and French psychiatrists. Among the French psychiatrists 43% indicated that they did not find classification useful. Among both British and French psychiatrists who did use a classification, DSM-III was the most popular. Only 11% of the French sample found ICD-9 useful.

Questionnaire responses

Over the whole range of statements about the causation, diagnosis, and management of schizophrenia French and British psychiatrists showed marked differences, reaching conventional significance.

TABLE I—Preferred diagnostic manual of United Kingdom and French psychiatrists. Results are numbers (and percentages)

	UK	France	95% Confidence interval of differences
Classification not useful	10/87 (12)	27/63 (43)	17-45
DSM III	66/84 (79)	24/54 (44)	18-50
ICD-9	61/85 (72)	5/46 (11)	48-74
INSERM	1/56 (2)	19/54 (35)	20-46
Other	5/92 (5)	7/69 (10)	-3-13

TABLE II—Mean scores for United Kingdom and French psychiatrists on questionnaire items. Higher values indicate greater agreement with statement

Statements about schizophrenia	United Kingdom (n=92)	French (n=69)	95% Confidence interval of difference	p Value
<i>Causation</i>				
Biological predisposition	5.74	3.76	1.51-2.45	0.000
Neurodevelopmental	5.05	3.14	1.36-2.45	0.000
Family dynamics	2.70	3.45	0.17-1.33	0.013
Hostile relationships/contradictory messages in family	4.02	5.36	0.81-1.86	0.000
Maternal ambivalence	3.18	5.25	1.50-2.65	0.000
Absence of paternal image	2.81	5.20	1.85-2.91	0.000
Origins in infancy, apparent during psychotherapy	2.18	5.09	2.39-3.43	0.000
Familial clustering is environmental, not genetic effect	2.19	4.72	2.08-2.98	0.000
Premorbid personality contributes significantly	4.24	5.69	0.94-1.95	0.000
Premorbid personality abnormalities part of illness itself	4.54	4.63	-0.50-0.68	0.764
Cognitive deficits frequently antedate illness	3.30	5.05	1.22-2.27	0.000
Psychological mechanism is dissociation of psychological experience	5.03	5.80	0.23-1.31	0.005
Aetiological heterogeneity exists in schizophrenia	5.90	5.11	0.23-1.35	0.007
<i>Diagnosis</i>				
Key symptoms discordance and dissociation	3.69	6.21	2.07-2.97	0.000
Key symptoms Schneider's "first rank" symptoms	5.53	4.23	0.79-1.81	0.000
Diagnosis needs to take into account course of illness	5.55	6.64	0.62-1.56	0.000
Diagnosis can be made on florid symptoms alone	4.00	2.75	0.62-1.88	0.000
Chronic delusional states included	4.68	3.02	1.06-2.26	0.000
Mixed affective and schizophrenic states included	3.91	4.85	0.37-1.51	0.002
Onset after age 50 included	5.10	2.00	2.66-3.52	0.000
Rorschach's projection test useful in making diagnosis	2.00	4.72	2.19-3.22	0.000
Subtype characterised by psychopathic traits in young individuals	2.92	5.58	2.13-3.19	0.000
<i>Management</i>				
Involuntary admission warranted in:				
Delusions and hallucinations in previously healthy person	3.03	3.74	0.08-1.35	0.028
Delusions and hallucinations with acute onset and psychotic excitement	4.87	5.06	-0.41-0.78	0.535
Intense psychological suffering in itself	3.52	5.02	0.81-2.19	0.000
Psychoanalytical psychotherapy useful	1.80	4.32	2.03-3.02	0.000
Behavioral psychotherapy in general not indicated	3.76	4.98	0.65-1.79	0.000
Recognition of unconscious processes constitutes therapeutic aid	3.27	5.87	2.06-3.15	0.000
Combination therapy with two neuroleptics often best	2.72	4.21	0.92-2.04	0.000
Certain "alerting" neuroleptics indicated for negative symptoms	4.80	5.67	0.40-1.34	0.000
Certain neuroleptics more effective for aggressive patients	5.18	6.09	0.47-1.34	0.000
<i>Hospital treatment</i>				
Institutional therapy gives best results in long term management	2.61	4.09	0.98-1.98	0.000
Community services not adequate after deinstitutionalisation	6.65	5.37	0.86-1.70	0.000
Hospital remains cornerstone in management	4.45	5.28	0.23-1.43	0.008
Hospital should shelter homeless patients	5.07	4.66	-0.16-1.17	0.137
<i>Outcome</i>				
Schizophrenia results in residual handicap	5.41	5.76	-0.08-0.78	0.117
Schizophrenia can be brief without further consequences	4.54	2.83	1.02-2.40	0.000
Defect state more often result of psychosocial adversity	2.75	3.22	-0.10-1.04	0.110

ance levels in all but five of the 38 statements (table II). Not infrequently the mean scores indicated that psychiatrists in the two countries—on average—actually disagreed with each other.

French psychiatrists reserved the label schizophrenia for disorders with an onset before the age of 45, a chronic course, and poor outcome, with dissociation and discordance as the key symptoms. In the United Kingdom, good outcome and late onset cases tended to be included as well as the delusional disorders. Schneider's first rank symptoms were considered core features. French psychiatrists favoured psychoanalytically orientated aetiological statements, such as absence of the paternal image and maternal ambivalence, while the British scored high on items postulating neurodevelopmental and genetic causation. There were striking differences over the role of family dynamics and parental factors in the causation of schizophrenia; French psychiatrists gave these much more importance than their British colleagues.

Different attitudes to management were also observed. The British sample disagreed with psychoanalytical statements in favour of biological and behavioural theory. In France psychiatrists saw a more important role for the hospital than in Britain, but the latter were more frustrated with the perceived inadequacy of community services. French psychiatrists had more distinctive indications for different antipsychotic agents, and probably as a consequence showed a preference for treating patients with two antipsychotic agents—which was disapproved of by the British.

Adjustment for sex of psychiatrist, psychiatric experience, and recent contact with a schizophrenic patient did not affect the Anglo-French differences. Comparison of French private and public psychiatrists showed significant differences in only three of the 38 statements, but these differences remained small in comparison with those between the French and British samples.

Discussion

The epidemiological study illustrated a disparity between incidence rates in England and France. French rates were much higher, especially before the age of 45, and longitudinal trends in the two countries were in opposite directions over the period under investigation. The questionnaire study showed differences between British and French psychiatrists about the aetiology, diagnosis, and management of schizophrenia.

Data on first admissions and their longitudinal trends do not necessarily reflect real changes in the incidence of a disorder such as schizophrenia.^{13,14} Though the observed differences might reflect differences in real incidence,¹⁵ they might also reflect differences in factors such as arrangements for community care and diagnostic bias.

Like most west European countries, both the United Kingdom and France have pursued the policy of community care over the past 25 years. Between 1972 and 1982 the number of psychiatric beds per 100 000 population decreased from 250 to 227 (a possible underestimate) in France, and from 280 to 217 in the United Kingdom.¹⁶ Though these figures suggest that the bed numbers may have decreased more rapidly in the United Kingdom, this difference is not large and can explain neither the divergence in male and female trends in France nor the fact that rates in France were rising while they were falling in England.

Diagnostic divergence, on the other hand, probably does contribute to the contrasting incidence rates in the two countries. According to our survey, French psychiatrists are reluctant to diagnose schizophrenia after the age of 45. This is corroborated by the epidemiological findings, which showed a sharp decline in rates of first admission after that age in France. Before the age of 45 first admission rates were much higher in France. Evidence from the survey suggests, on the one hand, that French diagnostic criteria are narrower, as schizophrenia is viewed as a chronic syndrome resulting in deterioration, with exclusion of cases of acute onset or good outcome. On the other hand, however, the French regard the less clearly defined Bleulerian signs,^{17,18} such as "dissociation," as the key symptoms of the disorder, reminiscent of the situation in the United States before the advent of standardised criteria.¹⁹ Also, the French have a "pseudopsychopathic" subtype of schizophrenia, not recognised by the British. The French concept of schizophrenia therefore seems to encompass a variety of chronic states that would be excluded in the United Kingdom for lack of specific symptoms.

Some diagnostic drift may have occurred in both countries, but in opposite directions, and this might explain the differences in longitudinal trends observed in both countries. In England there was a proportional increase in the category "other psychoses" over the period under investigation,¹⁵ which may reflect the use of standardised and restrictive criteria for schizophrenia.²⁰ In France, a broadening of the concept of schizophrenia might have occurred because of the influence of Jacques Lacan (and other psychoanalysts). Lacan has been considered the mainspring of the "invasion of French intellectual life by psychoanalysis"²¹ and had a profound influence on the con-

ceptualisation and psychoanalytic treatment of psychosis in French psychiatry throughout the 1960s and 1970s.

The questionnaire survey showed that British and French psychiatrists also differed over the management of schizophrenia. Although opinion should be distinguished from behaviour, the difference in views probably affects clinical practice. Thus the same patient might be treated very differently in the two countries, even if they happened to have received the same diagnostic label.

Conclusion—In psychiatry there is a need for further collaborative projects within the European Community to promote mutual understanding, facilitate communication, and arrive at a consensus for the diagnosis and management of schizophrenia and other psychiatric disorders. In a dialectical Europe different psychiatric traditions should be able to learn from each other but talk in a common language.

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Epilepsy and pregnancy

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The prevalence of recurrent epilepsy is about 0.5-1.0%, and slightly less than half of those affected are women. The possibility of pregnancy should be considered in any woman of childbearing age with epilepsy because treatment is likely to be necessary for a minimum of two years and maybe indefinitely. This certainly applies to any girl over the age of 15. Withdrawal of antiepileptic drugs well before a planned pregnancy should be considered because neural tube defects occur before 28 days, but if a patient requires antiepileptic drugs treatment should be continued throughout pregnancy.

In this article we answer the questions commonly asked by epileptic patients regarding contraception and pregnancy. Patients may ask only a few of the questions at one time, but most will appreciate a discussion of other potential problems.

Contraception

COMBINED CONTRACEPTIVE PILL

There is no reason why women with epilepsy taking antiepileptic drugs should not take combined oral contraceptives, which act by giving a sufficient dose of oestrogen to inhibit ovulation. In most women this requires an oral dose of oestrogen above 20 µg and the most widely prescribed drugs contain 30 µg of oestrogen (Microgynon 30, Eugynon 30, Ovran 30, Ovranette, and Marvelon), giving some measure of safety. The induction of microsomal liver enzyme activity by some antiepileptic drugs (phenytoin, carbamazepine, phenobarbitone, and primidone) increases the rate of metabolism of both oestrogen and progesterone, thereby lowering the blood concentrations of these drugs, often by 50% or more. It is therefore usual to recommend a combined oral contraceptive preparation containing at least 50 µg of

Summary of main points

- Women taking enzyme inducing antiepileptic drugs should take higher doses of oral contraceptives
- Progesterone concentrations should be measured on day 21 of the first or second cycle to ensure that ovulation is being suppressed
- Risk of fetal abnormalities, especially cleft lip and palate and congenital heart abnormalities, is raised in women taking antiepileptic drugs
- Women taking antiepileptic drugs should all have α fetoprotein concentrations measured at 18 weeks and high resolution ultrasonography
- Impaired absorption of antiepileptic drugs during pregnancy and increased blood volume may make it necessary to adjust the dose, particularly in women with poorly controlled epilepsy
- Vitamin K₁ supplements in the last week before delivery help raise fetal plasma concentrations. Infants should also be given vitamin K₁ at birth
- Breast feeding is relatively contraindicated only in women taking phenobarbitone or primidone

oestrogen (Ovran) for women taking enzyme inducing antiepileptic drugs. Sodium valproate, the benzodiazepines (clobazam, clonazepam), vigabatrin, and lamotrigine do not have this effect.

If breakthrough bleeding occurs contraception cannot be assured and the dose of oestrogen should be

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