

Correspondence

EDITED BY KHALIDA ISMAIL

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Utilisation of psychotropic medications

The timely article by Verdoux & Bégaud hopefully begins to redress the imbalance between randomised controlled trials and other ways of evaluating drug treatments. I would like to present further evidence for the ‘gap between guidelines and utilisation ... for psychotropic medications’ (Verdoux & Bégaud, 2004).

Using the Drug Report of the German Public Health Insurance (Schwabe & Pfaffrath, 1996), which is a database of all prescriptions reimbursed by the general health insurance system (which accounts for more than 80% of all prescriptions), and a database from the Institute for Medical Statistics, Frankfurt/Main, which refers to a representative sample of 2806 physicians in private practice who report four times a year all prescriptions during 1 week, we found that only 14% of prescriptions for neuroleptic drugs were for schizophrenic psychoses, 18% for other paranoid psychoses and 5% for affective disorders (Linden & Thiels, 2001). Almost half of the neuroleptic prescriptions were written for patients aged 65 years or older. Over the period 1986 to 1995 the prescribing of neuroleptics increased steadily in parallel with a decrease in prescriptions for benzodiazepines.

Also I would like to contradict the assumption that antipsychotics are ‘mainly prescribed by specialists’ (Verdoux & Bégaud, 2004). Using the pharmaco-epidemiological data described above, we found that only 40% of neuroleptic drugs were prescribed by psychiatrists/neurologists (i.e. by *Nervenärzten* who trained in both specialties, as most German psychiatrists and neurologists do).

Data from a 6-month prospective drug utilisation observation study on 3858 women and 1594 men prescribed the selective serotonin reuptake inhibitor sertraline shows that it is not only the type of

psychotropic drug that determines whether it is ‘commonly prescribed by primary care practitioners’ (Verdoux & Bégaud, 2004) but also the gender of the patient. A higher percentage of women with depression were treated by general practitioners, compared with men with depression who were more likely to be seen by psychiatrists, although women were more likely to present with recurrent rather than first-episode depression and to have been previously treated for depression.

Declaration of interest

C.T. has twice been paid for writing publications for drug companies, most recently for Boehringer Ingelheim Pharma KG, Germany.

Linden, M. & Thiels, C. (2001) Epidemiology of prescriptions for neuroleptic drugs: tranquilizers rather than antipsychotics. *Pharmacopsychiatry*, **34**, 150–154.

Schwabe, U. & Pfaffrath, D. (eds) (1996) *Arzneiverordnungsreport*, 96. Jena: Gustav Fischer.

Thiels, C., Linden, M., Grieger, F., et al (2005) Gender differences in prescribing and treatment outcome of the SSRI sertraline in depressed outpatients. *International Clinical Psychopharmacology*, in press.

Verdoux, H. & Bégaud, B. (2004) Pharmaco-epidemiology: what do (and don't) we know about utilisation and impact of psychotropic medications in real-life conditions? *British Journal of Psychiatry*, **185**, 93–94.

C. Thiels Department of Social Sciences, University of Applied Sciences, Kurt-Schumacher-Strasse 6, 33615 Bielefeld, Germany. E-mail: cornelia.thiels@fh-bielefeld.de

Authors' reply: The German findings on antipsychotic prescription in naturalistic conditions provide a good illustration of the question raised in our editorial regarding the risk of widespread use of antipsychotics in primary care (Verdoux & Bégaud, 2004). Contrary to the statement of the author, there is no contradiction between her point of view and ours regarding the fact that antipsychotics are widely prescribed in primary care. The exact quotation of our text is ‘drugs assumed to

be mainly prescribed by specialists, such as antipsychotics’, suggesting that there may be differences between assumptions and facts. The German findings are strikingly similar to those obtained using the social security insurance database in Aquitaine (south-west France), showing that general practitioners (GPs) were the most numerous prescribers (64%) of risperidone, followed by psychiatrists (34%) (Martin *et al*, 2004). More recently, we have carried out a survey questionnaire mailed to all GPs ($n=3829$) practising in Aquitaine to explore management of early psychosis in primary care, with a response rate of 23% (further details available from the authors on request). As part of this survey, we collected data on prescription behaviour. We found that over the preceding month, one out of three GPs (34%) initiated at least one new treatment with one of the antipsychotic drugs marketed in France at this time (amisulpride, olanzapine, risperidone). Over the same 1-month period, nearly half of GPs (42%) reported a visit from at least one pharmaceutical company representative promoting these antipsychotic drugs. Hence, we have further reason to feel concerned by the widespread use of these drugs in primary care, probably, at least in part, as a result of drug promotion. As proposed by Thiels, it is thus of great interest to explore which specific subgroups are at greater risk of being exposed to increased use of antipsychotics. With respect to the hypothesis that there may be a trend favouring antipsychotic instead of benzodiazepine prescription in elderly patients, it is however difficult to conclude that such a strategy is more risky than beneficial for this population, considering the risks potentially associated with benzodiazepine prescription in the elderly (Verdoux *et al*, 2004).

Declaration of interest

H. V. has acted as a consultant to the pharmaceutical companies Bristol-Myers-Squibb, Eli Lilly, Janssen-Cilag, Lundbeck and Sanofi-Synthelabo.

Martin, K., Bégaud, B., Verdoux, H., et al (2004) Patterns of risperidone prescription: a utilization study in south-west France. *Acta Psychiatrica Scandinavica*, **109**, 202–206.

Verdoux, H. & Bégaud, B. (2004) Pharmaco-epidemiology: what do (and don't) we know about utilisation and impact of psychotropic medications in real-life conditions? *British Journal of Psychiatry*, **185**, 93–94.

Verdoux, H., Lagnaoul, R. & Bégaud, B. (2004) Is benzodiazepine use a risk factor for cognitive decline and dementia? A literature review of epidemiological studies. *Psychological Medicine*, **35**, 1–9.

H. Verdoux, B. Bégaud Université Victor Segalen Bordeaux 2, Hôpital Charles Perrens, 121 rue de la Béchade, 33076 Bordeaux Cedex, France. E-mail: helene.verdoux@ipso.u-bordeaux2.fr

Urbanisation and psychosis

A recent study of urbanisation and incidence of psychosis was based on data from the excellent Swedish population registers (Sundquist *et al*, 2004). Unfortunately, there are methodological problems with the study.

Sundquist *et al* argue that the prospective nature of their data allowed them to calculate incidence rates of psychoses rather than prevalence rates. However, their study confuses readmission and incidence rates. In incidence studies, the event of interest is new occurrence of a specified disease (see e.g. Clayton & Hills, 1993). Sundquist *et al*'s cohort consists of people aged 25–64 years in 1996 (i.e. born 1932–1971). They analyse the data as incident data although they do not have this information. For persons who enter the study in old age, they claim that when admitted during the study period 1997–1999 this is the first admission ever of these people. They do, however, exclude people admitted 1992–1996, but this only partly solves this problem (e.g. for people born in 1932 in their study, the earliest possible age at onset of psychosis is 60 years). Let us say the earliest age at onset of psychosis is 25 years, the authors lack information on first admission for psychosis among people born 1966 or earlier. Roughly, they do not have information on first admission for psychosis among people born 1932–1966, about 85% of the study population. If the earliest age of first admission for psychosis is 15 years (Pedersen & Mortensen, 2001), the authors lack information on first admission for all people. This severely violates the assumptions of an incidence study (Breslow & Day, 1987), and the results may be extremely biased.

Sundquist *et al* measure urbanisation as the place where cohort members lived around 1996. Using this measure of urbanisation – in combination with the problems mentioned above – implies problems with causality; is the disease a result of the urbanisation or is the urbanisation a result of the disease?

Based on these methodological errors, it is difficult to interpret their findings. However, some possible biases include selective migration of people with psychosis after disease onset, and urban–rural differences in the readmission rates for people with psychosis.

Breslow, N. E. & Day, N. E. (1987) *Statistical Methods in Cancer Research. Vol. II: The Design and Analysis of Cohort Studies*. IARC Scientific Publications No. 82. Lyon: International Agency for Research on Cancer.

Clayton, D. & Hills, M. (1993) *Statistical Models in Epidemiology*. Oxford: Oxford University Press.

Pedersen, C. B. & Mortensen, P. B. (2001) Family history, place and season of birth as risk factors for schizophrenia in Denmark: a replication and reanalysis. *British Journal of Psychiatry*, **179**, 46–52.

Sundquist, K., Frank, G. & Sundquist, J. (2004) Urbanisation and incidence of psychosis and depression: follow-up study of 4.4 million women and men in Sweden. *British Journal of Psychiatry*, **184**, 293–298.

C. B. Pedersen, E. Agerbo National Centre for Register-Based Research, University of Aarhus, Taasingegade 1, 8000 Aarhus C, Denmark. E-mail: cbp@ncrr.dk

Authors' reply: We agree that in strict terms the definition of incidence rates is in accordance with the definition described by for example Clayton & Hills (1993) and Last (1998).

However, we disagree when Pedersen & Agerbo state that we claim 'this is the first admission ever of these people'. Nowhere in the article have we used the phrase 'first admission ever'. In the Method we clearly described that the 4.4 million women and men were followed from 1 January 1997 until 31 December 1999 for first admission to hospital for treatment of psychosis or depression (i.e. during the study period). Individuals with previous hospital admissions for treatment of psychosis or depression from 1992 to 1996 were excluded (i.e. the 'wash-out' period was 5 years). We calculated the urbanisation measure for the year 1996 (i.e. the year when we defined our study population).

Pedersen & Agerbo also say that our article implies problems with causality. However, we did not claim that we have solved the causality problem. In addition, we discussed that we were unable to adjust our results for selective migration (i.e. migration from urban to rural areas). However, we did adjust our model for migration between neighbourhoods and the results remained almost unaltered.

We agree that urban–rural differences in admission rates could exist if, for example, the distribution of psychiatric beds differed between urban and rural areas. We checked this possible bias and found that the number of psychiatric beds per 1000 inhabitants differed very little across Sweden.

To sum up, our large-scale study sheds new light on the inconsistencies in previous research since we used the comprehensive Swedish registers and adjusted our results for several possible confounders. In addition, the urbanisation measure was calculated as actual numbers of inhabitants per area unit, which should reflect the level of urbanisation in the most appropriate way.

Clayton, D. & Hills, M. (1993) *Statistical Models in Epidemiology*. Oxford: Oxford University Press.

Last, J. M. (1998) *A Dictionary of Epidemiology* (2nd edn). Oxford: Oxford University Press.

K. Sundquist, G. Frank, J. Sundquist Family Medicine Stockholm, Karolinska Institutet, Alfred Noblesallé 12, SE-141 83 Huddinge, Sweden. E-mail: Kristina.Sundquist@kllihvet.ki.se

Anthropology and psychiatry

From the perspective of anthropological psychiatry, Harland *et al* (2004) suggest that the social change experienced by migrants may predispose to schizophrenia. The same may apply to other forms of social change, such as those changes which lead to revitalisation phenomena and new religious movements. Psychiatric anthropologists who have studied new religious movements have pointed out that new forms of belief system may originate in the hallucinatory or delusional experience of a single individual (Littlewood, 1984). Wallace (1956) applied the term 'mazeway resynthesis' to the change in belief system which occurs in prophets, the mazeway being to the individual what culture is to society, so that the prophet awakes to a new reality which he or she then tries to impart to followers; if successful, the prophet becomes the leader of a new religious movement; otherwise, he or she is alienated from the parent group and is likely to be labelled as mentally ill. Foulks (1977) compared the prophet to the patient with schizophrenia, and noted that they shared not only the capacity to undergo a radical change in belief system but also various 'premorbid' features.