

lithium can enhance the effect of SSRIs this must also be clinically monitored when used in combination. With regards to our success rate, compared with the authors, this may reflect clinical heterogeneity of the depressed populations being treated (Leonard, 1992). It is still inexplicable why some patients respond to a combination of a broad spectrum tricyclic antidepressant and an SSRI, while others respond to receptor-specific antidepressants, such as nortriptyline and desipramine in combination with an SSRI.

The final point made by Drs Cowen and Power recommending that the combination treatment should be reserved for those who do not respond to lithium augmentation of first line antidepressant treatment, is a prudent approach based on our current knowledge.

COWEN, P. J. (1990) Antidepressants: current concepts of mode of action. *International Clinical Psychopharmacology*, **5**, (suppl. 3), 45–55.

MANDELLS, J. (1968) Comparative trial of nortriptyline and amitriptyline in 100 depressed out-patients. *American Journal of Psychiatry*, **124** (suppl), 59–62.

LEONARD, B. E. (1992) Pharmacological differences of serotonin reuptake inhibitors and possible clinical relevance. *Drugs*, **43** (suppl. 2), 3–10.

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Incidence and epidemiology of schizophrenia in Denmark

SIR: I write in response to the interesting paper by Munk-Jørgensen & Mortensen (*Journal*, October 1992, **161**, 489–495). The authors examine the age-standardised rates of patients admitted to Danish psychiatric hospitals for the first time from 1969 to 1988 and who were diagnosed schizophrenic at least once during this period. They found a reduction of 50% in first-admission schizophrenics. This change is all the more remarkable since day patients were included in the statistics from 1975 onwards.

As they rightly point out, the method utilised will reduce the likelihood that these changes are due to alterations of diagnostic practices, such as a possible growing reluctance to diagnose schizophrenia at the

time of first admission. They conclude, however, that the most likely explanation for the change relates to a reduction during the study period of 43% of Danish in-patient beds. There are decreasing first-ever admissions concomitantly in all other diagnostic groups except alcohol-related illnesses and unspecified psychotic states. The authors cite Cooper *et al* (1987), whose study found that 10% of Nottingham schizophrenics were never admitted to hospital over a two-year period, in support of their contention. Their own study, however, looks at a longer period, deals with either admission or day patient attendances, and seeks to explain a reduction of 50%.

As in previous studies, the authors seem reluctant to grasp the nettle and conclude that the incidence of schizophrenia is possibly declining (Eagles, 1987). The fact that the milder categories of illness are declining in frequency of first admissions may well relate to changes in admission policy, but also relate to the fact that psychotic illnesses as a whole are becoming milder (Eagles *et al*, 1988) given that one adopts a continuum model of psychosis, such as that espoused by Crow (1986).

It would be instructive to have information about the extent to which the Danish bed reduction comprises acute psychiatric beds. If the bed reduction mirrors that in the UK, then it has been largely of long-stay beds, that is, not the type of beds which would be occupied by first-admission schizophrenic patients. If the reduction in numbers of new schizophrenic patients was due to the 'squeeze' due to falling bed numbers, it is difficult to explain why the numbers of patients with alcohol-related illnesses (surely much more readily treated as out-patients than schizophrenics) have failed to show a concomitant fall.

Finally, the authors note that there are 5314 newly diagnosed male schizophrenic patients compared with only 3254 females. This is an interesting gender disparity in view of the possibility that narrowly defined schizophrenia may indeed be less common among females (Lewis, 1992); this, if confirmed, could constitute an important clue in the search for the causes of the disorder.

COOPER, J. E., GOODHEAD, D., CRAIG, T., *et al* (1987) The incidence of schizophrenia in Nottingham. *British Journal of Psychiatry*, **151**, 619–629.

CROW, T. J. (1986) The continuum of psychosis and its implications for the structure of the gene. *British Journal of Psychiatry*, **149**, 419–429.

EAGLES, J. M. (1987) Decreasing rates of diagnoses of schizophrenia in Denmark. *Acta Psychiatrica Scandinavica*, **76**, 333–334.

—, HUNTER, D. & McCANCE, C. (1988) Decline in the diagnosis of schizophrenia among first contacts with psychiatric services in the North East of Scotland, 1969–1984. *British Journal of Psychiatry*, **152**, 793–798.

LEWIS, S. (1992) Sex and schizophrenia: vive la différence. *British Journal of Psychiatry*, 161, 445–450.

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AUTHORS' REPLY: Dr Eagles raises two very interesting questions. In our paper we hypothesise that the decreasing first admission rates of schizophrenia in Denmark could be explained partly by a parallel decrease in available psychiatric beds. The reduction in capacity was about 50% during the study period. Dr Eagles suggests that the bed reduction "has been largely of long-stay beds, that is, not the type of beds which would be occupied by first admission schizophrenic patients", and therefore could not be responsible for the decrease in schizophrenia first admission rates.

Unfortunately, the Danish registration system does not distinguish between beds for acute admissions and beds for long-stay treatment. But the fact that we, in the period 1980–1989, found a reduction in long-stay patients admitted for more than five years from 1820 to 320, a decrease of 1500 patients (census figures), might illustrate the situation. In the same period bed numbers were reduced by 2630.

Of course, we should not reject the possibility of a genuine decrease in schizophrenia rates in the population. However, as we discuss in our paper, there are still some possible nosocomial explanations to be tested.

Dr Eagles also points to the gender disparity in our material: 5314 newly diagnosed male schizophrenics compared with only 3254 females. He underlines the hypothesis that narrowly defined schizophrenia may be less common among females than among males which "could constitute an important clue in the search for the causes of the disorder". We fully agree with that. The Institute of Psychiatric Demography, Aarhus, Denmark is a World Health Organisation (WHO) Collaborating Centre and over the past few years has been investigating this in conjunction with the WHO Collaborating Centre, Mannheim, Germany.

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Origins of Delusions

SIR: I read with interest Dr Roberts' review article on the origins of delusions (*Journal*, September 1992,

161, 298–308). However, in an otherwise comprehensive review, in the section on psychodynamics, there is an omission of more recent psychoanalytic views on delusions. There is no mention of the concept of pathological projective identification, as formulated by Bion.

Based on detailed analytic work with schizophrenics, Bion described the genesis of hallucinations and their link with the formation of delusions. He differentiated the abnormal thinking process in the so-called psychotic part of the personality from the working of the non-psychotic personality. His views are not just of theoretical interest, but are, as I have attempted to illustrate elsewhere with clinical examples, of central importance in understanding psychotic patients' communications in general psychiatric practice (Lucas, 1991).

Dr Roberts comments that psychodynamic formulations on delusions are now giving way to cognitive psychology models. I believe the situation should not be regarded as a competitive one, but that each approach needs to be fully explored and appreciated in its own right. Bion has left us a rich legacy to explore further within general psychiatric practice.

BION, W. R. (1967) *Second Thoughts*. New York: Jason Aronson.
LUCAS, R. (1991) The psychotic personality. A psychoanalytic theory and its application in clinical practice. *Psychoanalytic Psychotherapy*, 6, 73–79.

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AUTHOR'S REPLY: I am grateful to Dr Lucas for drawing attention to the contribution of Bion. Since submitting the paper I have also been reminded of Jung's many ideas about the psychogenesis of delusions and the meaning of symptoms. My concern in constructing the review was to bring order into chaos and establish some means of navigating through a vast polyglot literature. In doing so I encountered what Roy Porter has called the "delicious danger of not knowing when to stop", and would welcome further correspondence with those able to point to any other significant omissions.

Dr Lucas also helpfully underlines the need for clinical work to be informed by wisdom wherever it may be found and the continuing value of psychodynamic insights to the daily practice of general psychiatry.

Holloway (1988) has emphasised that the care and treatment of patients suffering from long-term mental illness is ideally based on an "individualised