# Prevalence of schizophrenia: recent developments

The long held view that schizophrenia affects about 1% of the population has been shown to be an overestimate and in fact derived from incorrect data.[1] Also, for many years, it was believed that the prevalence of schizophrenia varied little between sites.[2,3] It is in fact the case that the estimates of the prevalence of schizophrenia are characterized by a multiplicity of variations.[1,4-6] The evidence for variations in incidence and prevalence of up to nine times in different populations as presented in recent systematic reviews has challenged such previously held views.[1,5] Some of these variations are due to differences in the measures of disease frequency, while others are due to the time of the study. For example, the quality of research in the field of psychiatry has improved due to access to larger and better characterized subjects over the past three decades.[2] Additionally, the populations that are reported in the studies may differ not only in age and sex structure, but also in migrant status, ethnic status, inpatient or outpatient status, to mention a few.[1,7]

While many of these variations may be due to methodological flaws, there are some that call for attention since they impact directly on clinical practice and on the estimated burden of the disorder, with consequence on the evaluation of control measures and planning for services. To a large extent such variations also make comparisons between different studies much more difficult to interpret. Issues relating to case definition, case ascertainment and diagnostic procedures come to the forefront in this regard. When standardized instruments such as CIDI (fully structured) and SCID (semi structured) were introduced to the psychiatry community, it was thought that they would deal with the problems of reliability associated with case identication, and consequently variation in epidemiological estimates. The current situation however is that these instruments have not adequately addressed these problems. There are significant differences between estimates generated by lay survey interviews and semi structured clinician assessments in terms of identifying which individuals are cases and therefore those likely to be in need of psychiatric interventions.[8] Similarly there is substantial discordance between what the two major classificatory systems identify as a case. Andrews et al showed that the concordance between DSM IV and ICD 10 for any mental disorder is 68% and that the concordance could be as low as 33% for harmful substance use or abuse and as high as 87% in the case of dysthymia.[9] This raises questions about the sensitivity, specificity and predictive values of both systems of diagnosis and further impairs accurate determination of risk factors and consequently the development of preventive and therapeutic interventions.

It is clear that our knowledge of the epidemiology of the disorder has improved substantially in the past few decades with evidence suggesting that some previously held views about its prevalence were not exactly accurate. Still, there remain important gaps in the literature that can only be filled with more population-based studies using widely accepted and validated ascertainment tools. Knowledge of the epidemiology of the disorder, especially when derived from diverse groups, with differences in exposure to putative risk factors may help shed light on the etiology of the disorder and provide insight to possible preventive measures.

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