Context: Recent general population surveys of psychotic disorders have found low lifetime prevalences. However, this may be owing to methodological problems. Few studies have reported the prevalences of all specific psychotic disorders.

Objective: To provide reliable estimates of the lifetime prevalences of specific psychotic disorders.

Design: General population survey.

Setting and Participants: A nationally representative sample of 8028 persons 30 years or older was screened for psychotic and bipolar I disorders using the Composite International Diagnostic Interview, self-reported diagnoses, medical examination, and national registers. Those selected by the screens were then reinterviewed with the Structured Clinical Interview for DSM-IV. Best-estimate DSM-IV diagnoses were formed by combining the interview and case note data. Register diagnoses were used to estimate the effect of the nonresponders.

Main Outcome Measures: Diagnosis of any psychotic or bipolar I disorder according to the DSM-IV criteria.

Results: The lifetime prevalence of all psychotic disorders was 3.06% and rose to 3.48% when register diagnoses of the nonresponder group were included. Lifetime prevalences were as follows: 0.87% for schizophrenia, 0.32% for schizoaffective disorder, 0.07% for schizophreniform disorder, 0.18% for delusional disorder, 0.24% for bipolar I disorder, 0.35% for major depressive disorder with psychotic features, 0.42% for substance-induced psychotic disorders, and 0.21% for psychotic disorders due to a general medical condition. The National Hospital Discharge Register was the most reliable of the screens (κ = 0.80). Case notes supplementing the interviews were essential for specific diagnoses of psychotic disorders.

Conclusions: Multiple sources of information are essential for accurate estimation of lifetime prevalences of psychotic disorders. The use of comprehensive methods reveals that their lifetime prevalence exceeds 3%.

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Diagnoses of psychotic and bipolar disorders from structured interviews conducted by lay interviewers have not been congruent with classification by psychiatrists. To provide more reliable and valid estimates of psychotic disorder rates, 2-stage procedures for case identification...
have been used. The problem with the 2-stage procedure is that no established method is available for screening individuals with psychotic disorders in the general population. Those methods that have been developed are usually sensitive and specific, but their positive predictive value is poor because of the low prevalence of psychosis in the general population.28

The Psychoses in Finland (PIF) Study is based on the Health 2000 Study, a Finnish general population survey.20 The aims of the PIF Study were to obtain the most accurate possible estimates of LTP of all psychotic and BPD disorders in the general population by gathering extensive information from semistructured interviews, registers, and case notes and to compare different screening methods for detecting psychotic disorders in the general population.

## METHODS

### STUDY DESIGN

The Health 2000 Study is based on a nationally representative sample of 8028 persons 30 years and older (http://www.ktl.fi/terveys2000/index.uk.html). A 2-stage stratified cluster sampling procedure was used to select 80 areas (including 160 municipalities) from Finland. All 15 of the biggest towns were included, and the remaining 65 health care districts were sampled as clusters by using the probability proportional to population size sampling. From these areas, a random sample of 8028 individuals 30 years and older was finally drawn from the National Population Register. Those 80 years or older were oversampled (2:1). Institutionalized and homeless persons were also included. The field work took place from 2000 through 2001 and consisted of a home interview and health examination at home or in an institution; n=211), and disability pension because of any psychotic disorder (National Hospital Discharge Register; n=238), free medication for severe psychotic and other severe mental disorders (Medication Reimbursement Register of the Finnish Social Insurance Institution; n=211), and disability pension because of any psychotic disorder, bipolar disorder, or major depressive disorder (MDD) (Pension Register of the Finnish Centre for Pensions; n=180).

For screening BPI disorder, we also used the Finnish National Prescriptions Register of the National Insurance Institution. All subjects not selected by any other screen who had used lithium or mood-stabilizing anticonvulsants from 1996 through 2002, but without a diagnosis of epilepsy or other somatic disorder to account for the medication, were also selected for reinterview (n=36).

Information on psychotic disorders was obtained from the registers from 1969 through 2002. In Finland, psychiatric diagnoses were coded according to the International Classification of Diseases, Eighth Revision before 1987; according to the Finnish version of the International Classification of Diseases, Ninth Revision, from 1987 until 1995, using the criteria of the DSM-III-R;35 and according to the International Statistical Classification of Diseases, 10th Revision (ICD-10), since 1996. The National Hospital Discharge Register covers all hospitals in Finland. It lists dates and diagnoses for each inpatient and day-patient stay. The Pension Register includes the start date and primary diagnoses for all disability pensions. The Medication Reimbursement Register lists persons receiving free outpatient medication. The Prescription Register records all reimbursed purchases of drugs in Finland.

### MENTAL HEALTH ASSESSMENT

The PIF participants were reinterviewed from 2002 through 2004. Subjects selected only via the National Hospital Discharge Register were contacted through the person responsible for the treatment, usually their general practitioner or the psychiatrist from the local mental health care unit. Those selected only by other registers were contacted through the institutions in question.

The study protocol began with a neuropsychological assessment, followed by the SCID-I.32 The Global Assessment of Functioning and the Social and Occupational Functioning Assessment Scale were completed using structured questions. Experienced research nurses or psychologists conducted the protocol. They attended a 1-month training session, with regular follow-up training and reliability sessions. All SCID-I findings were reviewed by a clinical supervisor (J.S., T.P., J.H., or T.K.), and final ratings and diagnoses were based on consensus between the interviewer and clinical supervisor.
**CASE NOTES**

For the final diagnostic assessment, all case notes from the hospital and outpatient treatments were collected with the approval of the Finnish Ministry of Social Affairs and Health, excluding the subjects who had refused participation in the Health 2000 Study. Case notes were compiled first using information from the National Hospital Discharge Register and self-reported mental health care contacts, and then from public general medical centers. The aim was to obtain information on all lifetime treatments for all mental health problems.

**BEST-ESTIMATE DIAGNOSES**

The final best-estimate diagnoses were made by 3 experienced clinicians (J.P., J.S., and S.I.S.) using DSM-IV-TR criteria. Diagnostically evaluated was based on all available, systematically evaluated information from the interview and/or the case records. The first 20 cases were assessed together to ensure consistency between the rating clinicians. Thereafter, the reliability of diagnoses was tested on 136 cases, selected by weighting toward those with a diagnosis of any psychotic disorder or of bipolar disorder in the registers or in the SCID-I, which were rated by all 3 clinicians. The \( \kappa \) values for the 3 rates were 0.89 to 0.92 for schizophrenia, 0.91 to 0.96 for schizophrenia spectrum disorders, 0.74 to 0.91 for all nonaffective psychotic disorders, 0.76 to 0.97 for affective psychotic disorders, and 0.85 to 0.93 for psychotic disorders induced by substances or a general medical condition (GMC). All substance-induced psychotic disorders were reviewed by a senior psychiatrist (K.K.), an expert in this area.

Only definite psychotic disorders were diagnosed. We estimated the LTP of psychotic disorders at the time of the baseline survey. Therefore, subjects with onset of psychotic symptoms after 2001 were considered unaffected.

**POPULATION WITH SCREEN-POSITIVE FINDINGS**

The PIF screen selected 9.29% of the Health 2000 Study population (Figure). Thirty-two subjects in the screened population had refused to participate in the Health 2000 Study at baseline, and only register information was available for them. Forty-six had died before our contact, but we obtained case notes for them. Of the remaining population, 66.3% were successfully reinterviewed. The final diagnostic assessment involved 692 subjects (92.8%) of the screened population.

**CONTROL SUBJECTS**

To obtain population reference data for the methods used in the assessment and to validate the PIF screen, 174 controls were randomly selected for reinterview from all those who had attended any phase of the baseline study. Some of the controls \((n=24)\) were later selected also by the PIF screen and were included only in the screened population in the analysis. Of the remaining 150 controls with screen-negative findings, 66.0% were reinterviewed, and the final diagnostic assessment involved 140 (93.3%) of the controls.

**STATISTICAL ANALYSIS**

The data were weighted to adjust for differential probabilities of selection in the sampling design and for correlation within clusters and to correct for the oversampling in the group 80 years or older. We used SAS version 8.02 and SUDAAN version 9.0.0 statistical software for the analyses. Prevalences were estimated by calculating proportions for dichotomous variables, and asymmetric 95% confidence intervals (CIs) for percentages were calculated using the logit transformation. Prevalences in different age groups and between sexes were compared using the \( \chi^2 \) statistic for survey design. To estimate the effect of nonresponse, we calculated the prevalences again using register diagnoses for those nonrespondents who had a register diagnosis of psychotic disorders, but only if the exact diagnostic code was available (77.1% of nonrespondents with register diagnosis). Concordances between the screen findings and the DSM-IV final diagnoses were evaluated by calculating the \( \kappa \), sensitivity, specificity, and positive and negative predictive values. The total number of subjects involved in the analyses was 174.
for each screen included all participants in that particular phase of the baseline study. Subjects in the nonresponse group were excluded.

RESULTS

SCREEN-POSITIVE FINDINGS AND DSM-IV DIAGNOSES

Table 1 presents the number and the overlap of subjects selected by different screens, and Table 2 presents the DSM-IV axis I diagnoses of the screen-positive subjects. Overall, 35.8% had any psychotic disorder. Diagnosis was deferred for 18 subjects, 8 of whom had had psychotic symptoms. Of the 248 subjects with a final diagnosis of any psychotic disorder, 127 (51.2%) tended the SCID-I. A diagnosis could be made in 59.7% of these on the basis of the SCID-I alone, but the remaining 40.3% did not report or remember some important details of their illness. For them, case notes were essential for accurate diagnosis.

LTP OF PSYCHOTIC AND BPI DISORDERS

Lifetime prevalence estimates of psychotic and BPI disorders and their 95% CIs are presented in Table 3. Table 4 presents the LTP estimates for both sexes in different age groups. The LTP was 3.06% for any psychotic disorder, 1.94% for nonaffective psychotic disorders, and 0.59% for affective psychotic disorders. When we used register diagnoses for subjects in the nonresponse group, the prevalences rose to 3.48%, 2.29%, and 0.62%, respectively. If BPI disorder without psychotic features is excluded, the estimates are 2.99% (95% CI, 2.59%-3.43%) for any psychotic disorder and 0.47% (95% CI, 0.34%-0.64%) for affective psychotic disorders, and 3.40% (95% CI, 2.98%-3.89%) and 0.51% (95% CI, 0.37%-0.68%), respectively, when the nonresponse group is included.

COMPARISON OF DIFFERENT SCREENING METHODS

Table 5 presents the numbers of subjects selected by specific screens as having a lifetime diagnosis of psychotic disorder and their percentages of the total group with the same diagnosis in the study. Of the subjects with nonaffective or affective psychotic disorder, 75.5% to 81.0% were captured by the National Hospital Discharge Register, compared with only 59.4% and 47.8% of the those with psychoses induced by substance use or a GMC, respectively. Only one third of the subjects with nonaffective psychotic disorders or substance-induced psychotic disorder (and an even smaller proportion of these with other psychoses) would have been found by the CIDI psychotic symptoms screen. Section F of the CIDI was able to detect only 25.0% of the subjects with BPI disorder.

Table 1. Overlap of Different Screens in the PIF Study*

<table>
<thead>
<tr>
<th>Screen</th>
<th>National Registers</th>
<th>Baseline Study</th>
<th>CIDI Section</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Hospital Discharge</td>
<td>Self-reported</td>
<td>Physician-Assessed</td>
</tr>
<tr>
<td>National Hospital Discharge Register</td>
<td>238</td>
<td>148</td>
<td>41</td>
</tr>
<tr>
<td>Other national registers†</td>
<td>148</td>
<td>293</td>
<td>55</td>
</tr>
<tr>
<td>Self-reported psychosis</td>
<td>55</td>
<td>50</td>
<td>23</td>
</tr>
<tr>
<td>GP-assessed psychoses</td>
<td>37</td>
<td>36</td>
<td>45</td>
</tr>
<tr>
<td>CIDI section G</td>
<td>41</td>
<td>49</td>
<td>28</td>
</tr>
<tr>
<td>CIDI section F</td>
<td>13</td>
<td>18</td>
<td>8</td>
</tr>
<tr>
<td>CIDI section P</td>
<td>24</td>
<td>33</td>
<td>9</td>
</tr>
<tr>
<td>Selected only by the respective screen</td>
<td>68</td>
<td>111</td>
<td>11</td>
</tr>
</tbody>
</table>

Abbreviations: CIDI, Composite International Diagnostic Interview; GP, general practitioner; PIF, Psychoses in Finland.
*The values in the main diagonal represent the total number of subjects selected by the respective screen. Other values represent the number of subjects selected by both screens in the respective row and column.
†Includes the Medication Reimbursement Register of the Finnish Social Insurance Institution and the Pension Register of the Finnish Centre for Pensions.

Table 2. The Best-Estimate DSM-IV Diagnoses of the Population With Screen-Positive Findings

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>No. (%) of Subjects</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any psychotic disorder*</td>
<td>248 (35.8)</td>
</tr>
<tr>
<td>Nonpsychotic disorders</td>
<td></td>
</tr>
<tr>
<td>Mood disorders†</td>
<td>247 (35.7)</td>
</tr>
<tr>
<td>MDDs‡</td>
<td>148 (21.4)</td>
</tr>
<tr>
<td>Bipolar disorders§</td>
<td>15 (2.2)</td>
</tr>
<tr>
<td>Anxiety disorders</td>
<td>120 (17.3)</td>
</tr>
<tr>
<td>Substance-induced disorders</td>
<td></td>
</tr>
<tr>
<td>Other diagnoses</td>
<td>59 (8.5)</td>
</tr>
<tr>
<td>Diagnosis deferred</td>
<td>18 (2.6)</td>
</tr>
<tr>
<td>No diagnosis</td>
<td>143 (20.7)</td>
</tr>
<tr>
<td>All subjects¶</td>
<td>692</td>
</tr>
</tbody>
</table>

Abbreviation: MDDs, major depressive disorders.
*Includes nonaffective and affective psychotic disorders, substance-induced psychotic disorders, and psychotic disorders due to general medical condition.
†Includes MDDs, depressive disorder not otherwise specified, dysthymia, bipolar disorders, and mood disorder not otherwise specified.
‡Includes single-episode and recurrent MDDs.
§Includes bipolar II disorder, bipolar disorder not otherwise specified, and cyclothymia.
||Includes alcohol and other substance abuse or dependence.
¶Some subjects had more than 1 diagnosis.
noses of psychotic disorders. The different screening methods and the best-estimate diagnoses assessed by a physician were good, but the last 2 had low sensitivity.

Discharge Register, self-reported psychoses, and psychiatric registers and lower for other screens. Registers were the most comprehensive general population survey of the prevalence of psychotic disorders, whose reliability is questionable. In our study, the LTPs of nonaffective psychoses and schizophrenia were higher than in most recent general population studies that have used modern community sampling techniques and operational diagnostic criteria. The LTP of schizophrenia has varied from 0.12% to 1.6%. Older studies have found even higher prevalences, but comparison with them is difficult owing to changes in diagnostic criteria. Concordance between diagnoses made using DSM-III and more recent operational criteria and those using more historical definitions are only modest. Previous Finnish studies, all including register data, have found comparably high prevalences of schizophrenia, and have found considerably higher if the authors had had access to register and case note information.

Table 6 presents the concordance between the different screening methods and the best-estimate diagnoses of psychotic disorders. The $\kappa$ values were best for registers and lower for other screens. Registers were the most sensitive screens, whereas the sensitivity of other screens was rather poor. The specificity and negative predictive value of all of the screens were comparably high. The positive predictive values of the National Hospital Discharge Register, self-reported psychoses, and psychoses assessed by a physician were good, but the last 2 had low sensitivity.

The PIF Study is, to our knowledge, the most comprehensive general population survey of the prevalence of psychotic disorders, in terms of diagnostic assessment and diagnostic coverage. Our study is also the first to report the prevalences of specific psychotic disorders separately. Finally, we were able to compare the different screening methods of psychotic disorders.

The LTP of all psychotic disorders was high, at 3.06% and 3.48% when register diagnoses of nonresponders were included. Only 1 survey has obtained a higher estimate, but this was based on CIDI diagnoses of possible psychotic disorders, whose reliability is questionable. In our study, the LTPs of nonaffective psychoses and schizophrenia were higher than in most recent general population studies that have used modern community sampling techniques and operational diagnostic criteria. The LTP of schizophrenia has varied from 0.12% to 1.6%. Older studies have found even higher prevalences, but comparison with them is difficult owing to changes in diagnostic criteria. Concordance between diagnoses made using DSM-III and more recent operational criteria and those using more historical definitions are only modest. Previous Finnish studies, all including register data, have found comparably high prevalences of schizophrenia, and have found considerably higher if the authors had had access to register and case note information.

Consistent with the review by Saha et al, there was no sex difference in the prevalence of schizophrenia, which is discordant with the higher incidence and morbid risk of schizophrenia in men. However, the age at onset of schizophrenia is lower for men and their mortality is higher, particularly during the first years after the onset of the disorder. On the other hand, most of the late-onset cases are female. Thus, it seems that in our study the inclusion of older women has raised the prevalence in this group, whereas higher mortality among men has lowered the prevalence in men. Congruent with this, the mean age of subjects with schizophrenia was 50 years for men and 56 years for women. Nevertheless, the incidence and prevalence of schizophrenia among men and women have also been equal in many previous Finnish studies.

There are only a few general population studies of the prevalence of schizoaffective and delusional disorders.
Delusional disorder was found only in the group of women. The LTP of delusional disorder was approximately half of that for schizophrenia, and, as in previous studies, it was more common in women. The LTP of schizoaffective disorder was approximately half of that for schizophrenia. Delusions in this disorder while they still have a relatively well-preserved functional capacity. Because delusions in this disorder are nonbizarre, it is extremely difficult to assess in a single interview whether they are genuine delusions if no other source of information is available.

Delusional disorder was found only in the group of women. The LTP of delusional disorder was approximately half of that for schizophrenia, and, as in previous studies, it was more common in women. The LTP of schizoaffective disorder was approximately half of that for schizophrenia. Delusions in this disorder while they still have a relatively well-preserved functional capacity. Because delusions in this disorder are nonbizarre, it is extremely difficult to assess in a single interview whether they are genuine delusions if no other source of information is available.

Schizoaffective disorder and brief psychotic disorders were rare. With a long enough follow-up, most subjects with a psychotic episode experience relapse. This accords with a 3-year follow-up of subjects with ICD-10 acute and transient psychoses in which the diagnosis remained unchanged in only 34% of the subjects. The LTP of BPI disorder was 0.24%, lower than in most previous studies in which the LTP has varied from 0.2% to 0.04%. Delusional disorder was found only in the group of women. The LTP of delusional disorder was approximately half of that for schizophrenia, and, as in previous studies, it was more common in women. The LTP of schizoaffective disorder was approximately half of that for schizophrenia. Delusions in this disorder while they still have a relatively well-preserved functional capacity. Because delusions in this disorder are nonbizarre, it is extremely difficult to assess in a single interview whether they are genuine delusions if no other source of information is available.
disorder based on fully structured interviews such as the CIDI should be interpreted with caution.19

We screened BPI disorder from multiple sources. However, the LTP may still be conservative. There were probably previously undiagnosed subjects who denied having had manic symptoms in the CIDI.19 Previous manic episodes among subjects with a major depressive episode may also be underdiagnosed in clinical practice.20,57 Those with a diagnosis of nonpsychotic depression in hospitals were not selected for our reassessment, but all subjects with a disability pension or reimbursed medication for MDD were reassessed. Manic symptoms were sometimes poorly described in the case notes. If all previously undiagnosed subjects who denied having manic symptoms in the CIDI.19 Previous manic episodes among subjects with a major depressive episode may also be underdiagnosed in clinical practice.20,57 Those with a diagnosis of nonpsychotic depression in hospitals were not selected for our reassessment, but all subjects with a disability pension or reimbursed medication for MDD were reassessed. Manic symptoms were sometimes poorly described in the case notes. If all subjects who received a diagnosis of bipolar disorder not otherwise specified because of insufficient information had BPI disorder, its prevalence would rise to 0.39%. The inclusion of register diagnoses of BPI disorder for the nonresponse group would lift the prevalence to 0.42%. However, our low prevalence accords with previous Finnish studies.38,61

The LTP of MDD with psychotic features also fell in the lower range of the few previously published studies.62-63 There were no differences between the sex and age groups, which was unexpected because MDD was less common in men and in older age groups.31 Substance-induced psychotic disorders were frequent in men aged 30 to 54 years. Most had alcohol-induced psychotic disorders; the prevalence of other substance-induced psychoses was only 0.03%. Comparisons with previous studies are difficult to make, because substance-induced psychotic disorders are not included in recent general population studies of psychoses. Of first-admission patients with psychotic disorders in the study by Cantwell et al.,84 8.4% were substance induced. The

### Table 5. Subjects With a Diagnosis of Psychotic Disorder Found by Specific Screens in the PIF Study

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Hospital Discharge</th>
<th>Other*</th>
<th>Self-reported Psychosis</th>
<th>Physician-Assessed Psychosis</th>
<th>CIDI Section</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nonaffective psychotic disorders (n = 153)</td>
<td>124 (81.0)</td>
<td>111 (72.5)</td>
<td>51 (33.3)</td>
<td>37 (24.2)</td>
<td>47 (30.7)</td>
</tr>
<tr>
<td>Affective psychoses (n = 49)</td>
<td>37 (75.5)</td>
<td>28 (57.1)</td>
<td>7 (14.3)</td>
<td>2 (4.1)</td>
<td>9 (18.4)</td>
</tr>
<tr>
<td>Substance-induced psychotic disorder (n = 32)</td>
<td>19 (59.4)</td>
<td>5 (15.6)</td>
<td>2 (6.3)</td>
<td>1 (3.1)</td>
<td>10 (31.3)</td>
</tr>
<tr>
<td>Psychotic disorder due to a GMC (n = 23)</td>
<td>11 (47.8)</td>
<td>10 (43.5)</td>
<td>1 (4.3)</td>
<td>1 (4.3)</td>
<td>1 (4.3)</td>
</tr>
<tr>
<td>Any psychotic disorder (n = 249)</td>
<td>186 (74.7)</td>
<td>149 (59.8)</td>
<td>61 (24.5)</td>
<td>41 (16.5)</td>
<td>66 (26.5)</td>
</tr>
</tbody>
</table>

### Table 6. Concordance Between the Screens and the DSM-IV Diagnoses of Any Psychotic Disorders in the PIF Study

<table>
<thead>
<tr>
<th>Screen</th>
<th>No. of Subjects by Findings*</th>
<th>Sensitivity</th>
<th>Specificity</th>
<th>PPV</th>
<th>NPV</th>
</tr>
</thead>
<tbody>
<tr>
<td>National registers†</td>
<td>214 35 125 7138</td>
<td>0.72 (0.68-0.76)</td>
<td>86.1</td>
<td>98.3</td>
<td>63.8</td>
</tr>
<tr>
<td>Psychotic disorder in National Hospital Discharge Register</td>
<td>186 63 25 7238</td>
<td>0.80 (0.76-0.84)</td>
<td>75.3</td>
<td>99.7</td>
<td>88.4</td>
</tr>
<tr>
<td>Psychotic disorder in other registers§</td>
<td>149 100 106 7157</td>
<td>0.58 (0.52-0.63)</td>
<td>60.9</td>
<td>98.5</td>
<td>58.2</td>
</tr>
<tr>
<td>CIDI section</td>
<td>60 91 232 5582</td>
<td>0.25 (0.19-0.30)</td>
<td>43.5</td>
<td>95.1</td>
<td>19.7</td>
</tr>
<tr>
<td>All sections</td>
<td></td>
<td></td>
<td>66 95 165 5699</td>
<td>0.32 (0.25-0.38)</td>
<td>41.5</td>
</tr>
<tr>
<td>G, psychotic symptoms</td>
<td>19 142 100 5764</td>
<td>0.12 (0.06-0.17)</td>
<td>12.1</td>
<td>98.3</td>
<td>16.0</td>
</tr>
<tr>
<td>F, manic symptoms</td>
<td>36 125 55 5809</td>
<td>0.27 (0.20-0.35)</td>
<td>22.4</td>
<td>99.1</td>
<td>40.0</td>
</tr>
<tr>
<td>P, other symptoms related to psychosis</td>
<td>41 130 4 6165</td>
<td>0.37 (0.29-0.45)</td>
<td>24.5</td>
<td>99.9</td>
<td>91.0</td>
</tr>
<tr>
<td>Baseline study</td>
<td>61 161 14 7107</td>
<td>0.38 (0.31-0.44)</td>
<td>26.7</td>
<td>99.9</td>
<td>81.8</td>
</tr>
</tbody>
</table>

Abbreviations: CI, confidence interval; CIDI, Composite International Diagnostic Interview; FN, false negative; FP, false positive; NPV, negative predictive value; PIF, Psychoses in Finland; PPV, positive predictive value; TN, true negative; TP, true positive.

*Includes the Medication Reimbursement Register of the Finnish Social Insurance Institution and the Pension Register of the Finnish Centre for Pensions.

†Includes the National Hospital Discharge Register, the Medication Reimbursement Register of the Finnish Social Insurance Institution, and the Pension Register of the Finnish Centre for Pensions.

§Includes CIDI sections G, F, and P.

||Includes CIDI sections G, F, and P.

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higher prevalence of alcohol-induced psychoses in men 
daconds with the higher prevalence of alcohol dependence in men. The low prevalence of psychotic disorders caused by substances other than alcohol reflects the low frequency of their use in the Finnish population who are 30 years or older.65

The LTP of psychotic disorders due to a GMC began increasing in the group 65 years or older and was 1.71% among subjects 80 years or older. Most subjects (92.9%) with psychotic disorder due to GMC in the group 80 years or older had dementia. The LTP of psychotic disorders due to a GMC is clearly an underestimation because many somatic diseases are associated with psychotic symptoms that are rarely diagnosed and reported separately. Overall, the prevalence of psychotic disorders was highest in the elderly. This accords with previous studies of the population who were older than 65 years66 or older than 80 years.26

Screening based on multiple sources was essential to achieve the highest possible coverage of subjects with psychotic disorders. Registers were the most important and reliable source of information, as in a previous Finnish study.12 The κ value of 0.80 for the National Hospital Discharge Register, similar to that in a previous Finnish study,67 indicates that, although register information on psychotic disorders is good, it is not excellent for case ascertainment. The lower concordance of other registers was the result of different coding of diagnoses and their inclusion of subjects with MDD. In this study, all other screens added only 25.0% and 13.7% of the subjects with psychotic disorders to those selected by the National Hospital Discharge Register, or all the registers, respectively. Using all other screens except the registers would have located only 52.4% of subjects with psychotic disorders.

Section G of the CIDI has been used to screen for psychotic disorders in recent general population studies of nonaffective psychoses.2-4 Besides producing false-positive results, the section G screen produced a large number of false-negative results. Only 26.6% of subjects with psychotic disorders would have been recognized if the only screen had been CIDI section G, and the prevalence of schizophrenia would have been 0.28%, which is quite similar to that of other studies using the same method.2-4 Thus, the CIDI alone is not sufficient for screening psychotic disorders. The CIDI mania section was equally unreliable, finding only 25.0% of the subjects with BPI disorder. A self-reported or psychotic disorder assessed by a physician produced only a few false-positive cases, i.e., the specificity was excellent, supporting previous results.68 However, the sensitivity of these screens was poor.

Obtaining case notes was important for making diagnoses in subjects who did not participate in the SCID-I, but also for accurately making diagnoses in subjects who did participate in it. Previous incidence and family studies of psychoses with access to case notes or to other longitudinal information in addition to semistructured interviews have also been able to ascertain more subjects with psychotic disorders than studies using only interview information.56,69-72

In this study, we were able to overcome many of the methodological problems inherent in general population studies of psychotic disorders. Register information enables estimation of nonresponse to be included in prevalence rates. Although the response rate in the Health 2000 Study was exceptionally high, the prevalence estimate was 12% higher when subjects with a registered diagnosis of psychosis in the nonresponse group were included in the calculations. Our study also included homeless subjects. Homelessness is very rare in Finland; our screen identified 2 of the 25 subjects without a permanent address in the entire Health 2000 Study population. Institutionized persons, another subpopulation often excluded from general population surveys, were included in our study. Being institutionalized was defined as staying in an institution longer than 3 months, and only 14 (5.7%) of the subjects with any psychotic disorder diagnosis fulfilled this definition. However, these findings cannot be generalized to other studies because rates of nonresponse, institutionalization, and homelessness are highly variable.

The exclusion of adults younger than 30 years limits the comparison with previous studies. Among young adults, the incidence of schizophrenia and bipolar disorders is high,71,72 but the prevalence could be lower in other groups. In terms of overall prevalence, this was probably compensated for by the higher mortality of subjects with psychotic disorders.66,67 However, the inclusion of older groups and exclusion of young adults might also have affected the observed sex differences in disorders other than schizophrenia: patients with late onset, who were predominantly female, raised the prevalence of delusional disorder, psychotic disorder not otherwise specified, and MDD with psychotic features, whereas exclusion of young men lowered the prevalence of substance-induced psychotic disorders.

One particular problem related to the inclusion of the oldest group is that the subjects might not have remembered psychotic symptoms if they had had them decades ago. This recall bias was partially overcome by register data and case notes, which we obtained on a lifetime basis.

The number of cases in many disorders was small and the CIs were large. Our LTP estimates are still conservative because there were probably undetected cases among those nonresponders without a registered diagnosis of psychotic disorder and also among Health 2000 Study participants with screen-negative findings. This particularly concerns the milder forms of psychotic disorders. There were also subjects in the diagnosis-deferred category for whom a psychotic disorder was suspected but could not be confirmed. Moreover, the LTP of psychotic disorder not otherwise specified was high, indicating insufficient information to assign a specific diagnosis for some of these subjects. However, our prevalence estimates are high, which suggests that our screen was able to detect most of the subjects with psychotic disorders.

The exact prevalences we report apply only to Finland, a Nordic country with a relatively low immigration rate and no large cities. However, we believe that our prevalence estimates are more accurate than those in previous studies and that screening from nationwide health care registers and use of case note information would have increased the case detection substantially in other general population studies as well.
In conclusion, our results support previous suggestions that multiple sources of information are essential to estimate the LTP of psychotic disorders. Psychotic disorders are among the most severe and impairing conditions; with an LTP exceeding 3%, these disorders are a major public health concern.

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