Diagnostic Criteria of American and British Psychiatrists

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Videotapes of diagnostic interviews with eight patients, three American and five English, were shown to large audiences of trained psychiatrists in the eastern United States and in different parts of the British Isles. The diagnoses made by these audiences were compared and for some patients there were major disagreements between them. The overall pattern of diagnostic differences between the American and British raters indicates that the American concept of schizophrenia is much broader than the British concept, embracing not only part of what in Britain would be regarded as depressive illness, but also substantial parts of several other diagnostic categories—manic illness, neurotic illness, and personality disorder. These serious differences in the usage of diagnostic terms have important implications for transatlantic communication, and indeed for international communication in general.

THERE ARE striking differences between the diagnostic contributions of first admissions to the mental hospitals of the United States and those of England and Wales,[1] but these differences are greatly reduced when cohorts of patients admitted to hospital in the two countries are examined by a single team of psychiatrists using consistent diagnostic criteria.[2,3] These findings imply that there are systematic differences between the diagnostic criteria used by American and British psychiatrists and that, in particular, the former have a broader concept of schizophrenia and the latter a broader concept of manic depressive illness. If this is so, one would expect American and British psychiatrists to make different diagnoses when both are confronted with the same patients, and there is indeed some evidence that this occurs.

Sandifer et al[4] showed films of diagnostic interviews of a series of American patients to small groups of psychiatrists in London, Glasgow, and North Carolina and found systematic differences between the three centers. The British psychiatrists tended to diagnose manic depressive illness more readily, and the North Carolina psychiatrists tended to diagnose depressive neurosis more readily, and all within national differences were overshadowed by these cross-national differences. In a similar study Katz et al[5] showed a videotape of a diagnostic interview of a young woman, an aspiring actress, to two different audiences—42 American psychiatrists at the 1964 annual meeting of the American Psychiatric Association and 32 English psychiatrists at the Maudsley Hospital in London. A third of the American audience regarded this woman as schizophrenic, a third regarded her as neurotic, and the remainder regarded her simply as having a personality disorder. By contrast 60% of the English audience made a diagnosis of personality disorder and no one diagnosed schizophrenia.

The studies described here were conceived against this background. Our intention was to define more closely the areas in which the diagnostic criteria used by American and British psychiatrists differ from one another by showing videotapes of diagnostic interviews with varying types of patients, both British and American, to large representative audiences of psychiatrists on both sides of the Atlantic.

Method

Eight videotapes were used. Each was an unstructured diagnostic interview lasting between 20 and 50 minutes. Five of the patients (A, B, C, D, and E) were English and three (F, G, and H) American. Some were chosen in the expectation that they would highlight diagnostic differences between the two countries, others were chosen because their symptomatology was typical of a well-known stereotype. Together they portrayed a wide range of symptoms and a variety of different clinical problems.

In the British Isles five of the tapes were rated by an audience of 30 to 40 psychiatrists mainly from the Maudsley Hospital, London, and the other three (patients A, B, and F) were seen by 200 psychiatrists drawn from all over the country. This large group was obtained by holding a series of all-day meetings in different regions —two in London, two in Scotland, two in Ireland, and one each in Birmingham and Manchester. Apart from some overrepresentation of clinicians trained at the Maudsley Hospital, and the inevitable problem that only those with an interest in diagnosis offered to participate, this group can reasonably be regarded as broadly representative of British psychiatry. In the United States it proved harder to obtain a representative sample and eventually raters were obtained mainly from the New York Psychiatric Institute and the staffs of other state, city, and private hospitals supplying the New York metropolitan area. Audiences were also assembled, though, in Baltimore, Boston, and New Jersey and a few raters were obtained at the 1968 annual meeting of the American Psychiatric Association. Altogether over 450 psychiatrists participated; two tapes (patients A and F) were rated by over 120 psychiatrists and the others were rated by between 30 and 60.

All British raters were required to possess a Diploma in Psychological Medicine and American raters to have completed a psychiatric residency. Both were also required to have a minimum of four years experience of psychiatry and the average for both groups was between 12 and 15 years experience. Nearly all the British raters had received both their medical and their psychiatric training in the British Isles. Half the American raters, however, had obtained their initial medical qualification abroad (mostly in Central Europe), but over 90% had received their psychiatric

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training in the United States. A higher proportion of the British raters were from university departments or the psychiatric departments of general hospitals, and a correspondingly higher proportion of the Americans were from state hospitals. These differences are probably due to the different manner in which raters were obtained in the two countries. More of the American raters, on the other hand, had received a formal training in psychotherapy, and more were currently in private office practice. These latter differences probably reflect, or even underreflect, genuine differences between the two countries.

Apart from explanations of a few slang phrases and allusions that might have been unfamiliar on the far side of the Atlantic, raters were given no information other than that provided by the videotapes. After seeing each tape every audience was required to complete three sets of ratings. The first, Lorr's Inpatient Multi-dimensional Psychiatric Scale (IMPS)[6] consists of a series of 89 ratings, mainly on 9-point scales, which are defined in nontechnical language and cover most of the varieties of abnormal behavior likely to be manifested in an interview. The second was a check list of 116 technical terms, culled from both American and British sources and including most of the terms, like retardation, blocking, flattening of affect, and so on, commonly used by psychiatrists to describe abnormalities of speech and behavior. Lastly, raters were required to make a diagnosis. As the main purpose of the study was to compare the two sets of diagnoses it was necessary for a common nomenclature to be used. For this reason every rater was provided with the psychiatric section of the 8th edition of the *International Classification of Diseases* and asked to restrict himself to terms included therein. (*ICD* 8 is very similar to the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*, ed 2 which was in fact modelled on *ICD* 8). In addition to this main diagnosis, provision was made for a subsidiary diagnosis, and also for an alternative diagnosis, if either or both were felt to be needed by the rater. Finally, raters were invited to make a personal diagnosis, using whatever terminology they wished. Because the information that can be included in a 40-minute videotape is necessarily limited it was anticipated that raters might often feel that some vital piece of information was lacking, and so be unable to make a confident diagnosis. For this reason a 5-point confidence scale was attached to the main diagnosis. In fact, these fears proved to be largely unjustified; over all eight tapes 84% of American raters and 85% of British raters made confidence ratings of either 1 ("the patient's behavior or description of his subjective experience is pathognomonic") or 2 ("on the evidence provided this is by far the most likely diagnosis").

Results

This communication is concerned primarily with Anglo-American diagnostic differences. An account of the relatively minor differences between psychiatrists within the British Isles is published elsewhere,[7] and an analysis of the IMPS and checklist ratings is to be published shortly.

PATIENT A.—This 34-year-old English housewife had a long history of mild depressive symptoms and had recently developed a florid psychotic illness in which both schizophrenic and affective elements were prominent. She described feeling wonderfully happy and feeling that she was being forced to dance and sing and that radio programs were purely for her benefit; and then a few days later feeling "dirty and nasty" and thinking people were laughing at her because she was in hell. Table 1 lists the diagnoses given to her by 128 American and 211 British psychiatrists. In each country the majority regarded her illness as schizophrenic, mostly either as paranoid schizophrenia or as a schizo-affective psychosis. However, a significant minority (27%) of British clinicians regarded her illness as an affective disturbance and a further 11%, by listing an affective psychosis as an alternative diagnosis, implied that they regarded this as a serious possibility. The corresponding American figures were lower (7% and 9%, respectively).

PATIENT B.—This patient was a 33-year-old Londoner with more straight forward symptoms. He had heard voices (talking about him and plotting to kill him) intermittently for several years and had had frequent admissions to hospital. He was also a heavy drinker and commented that he could always get rid of his voices by having a few drinks. For this man the American and British diagnoses were very similar (Table 2). The majority, 83% of the British group and 76% of the smaller American audience, regarded him as a schizophrenic. In each case, however, there was a dissenting minority who regarded his illness as an alcoholic psychosis. Eleven percent of the American and 6% of the British audience made a diagnosis of alcoholic hallucinosis or alcoholic paranoia and a further 15% of the American audience and 21% of the British listed one of these as an alternative diagnosis.

PATIENT C.—This was a 37-year-old Cockney laborer who, like patient A, had both schizophrenic and affective symptoms. At the time of interview he was euphoric and talkative and revealed an elaborate series of grandiose delusions, centered on the belief that he was "King David," but he was prone to marked fluctuations of mood and had had periods of deep depression in the past. Again, most raters in both countries regarded him as a schizophrenic but again a significant minority (20%) of the British raters regarded him as a manic depressive and a further 17% gave this as an alternative diagnosis (Table 3). By comparison, only 8% of the American raters even considered an affective illness as an alternative to schizophrenia.

PATIENT D.—This patient was an unhappy 50-year-old woman who felt, with some justification, that her family were treating her as a servant. She had been admitted after a suicidal attempt and wept during the interview. She also had a longstanding fear of crowds and enclosed spaces and always spent much of her time cleaning and polishing her house. There was almost universal agreement that she had a depressive illness (Table 4) but less agreement over what kind of depression it was. The majority (79%) of American raters favored a diagnosis of involutional melancholia. Forty-two percent of the British raters did likewise, but nearly as many (39%) regarded her as a manic depressive while the remaining 19% thought she had a depressive neurosis. In addition, about 40% of both American and British raters made a subsidiary diagnosis of either a neurotic illness or an anankastic personality disorder.

PATIENT E.—The last of the five English patients presented a less familiar problem. She was a married woman of 25 years of age who described herself with some accuracy as having "gone back to being six." She

Table 1.—Diagnoses Given to Patient A

	American Psychiatrists (N = 128)	British Psychiatrists (N = 211)
Schizophrenia	112 (88%)	148 (70%)
Hebephrenic	5	25
Catatonic	2	1
Paranoid	60	43
Acute schizophrenic episode	7	28
Latent	0	1
Residual	1	1
Schizo-affective	26	42
Unspecified	11	7
Affective Psychoses	9 (7%)	56 (27%)
Involutional melancholia	2	1
Manic depressive, manic	1	16
Manic depressive, depressed	2	9
Manic depressive, circular	4	17
Reactive depressive psychosis	0	1
Unspecified	0	12
Other Diagnoses	7	7
Alternative Diagnosis of Affective Psychosis	11 (9%)	23 (11%)

Table 2.—Diagnoses Given to Patient B

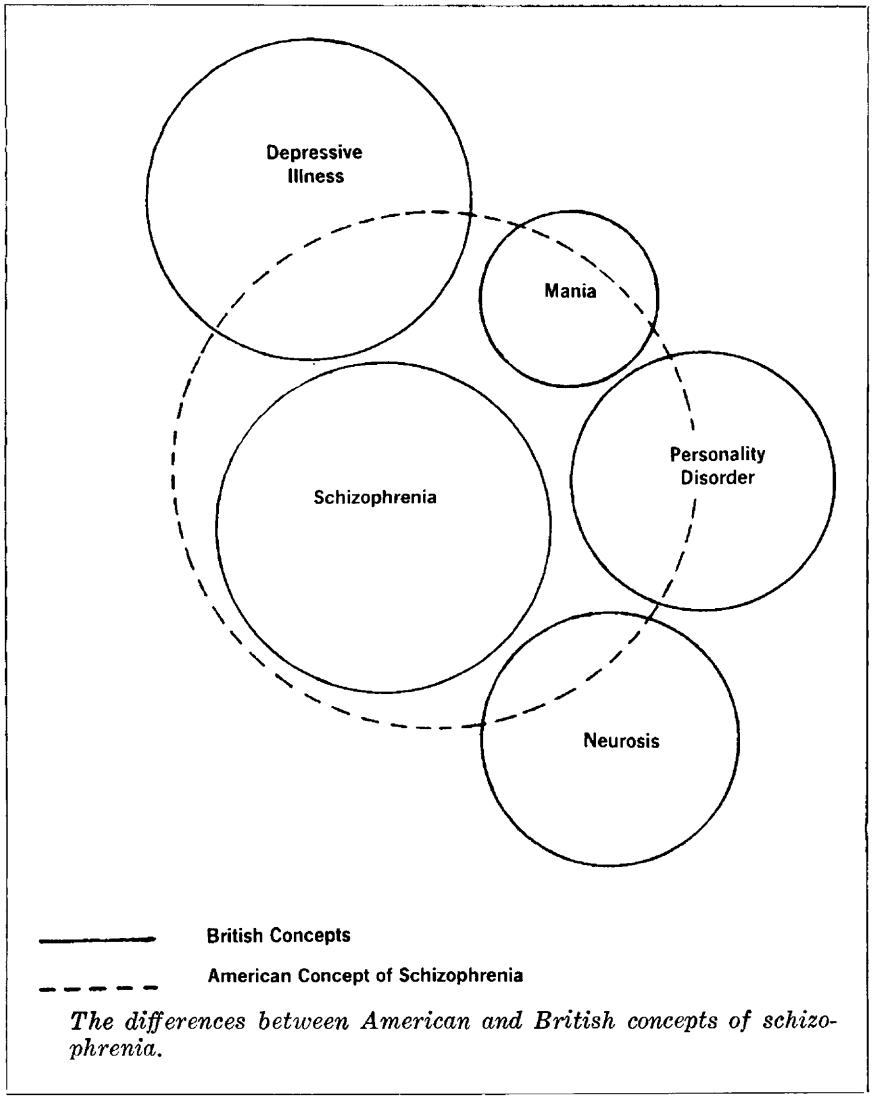
	American Psychiatrists (N = 46)	British Psychiatrists (N = 205)
Schizophrenia	35 (76%)	171 (83%)
Hebephrenic	0	5
Paranoid	32	159
Acute schizophrenic episode	0	3
Latent	1	0
Residual	0	1
Schizo-affective	2	3
Paranoid State	5 (11%)	15 (7%)
Paranoia	4	9
Involutional paraphrenia	0	1
Unspecified	1	5
Alcoholic Psychosis	5 (11%)	12 (6%)
Alcoholic hallucinosis	4	9
Alcoholic paranoia	1	3
Other Diagnoses	1	7
Alternative Diagnosis of Alcoholic Psychosis	7 (15%)	44 (21%)

denied knowing the date or how old she was and behaved and spoke in an absurdly childlike manner, clutching an empty egg carton and asking only to be allowed to sit on her husband's knee and be cuddled. She described how this remarkable behavior had been precipitated by the threat of her husband's arrest on a criminal charge and also gave a history of an earlier "breakdown" when, as a nursing student, she had been required to assist at a delivery. The attitudes of the American and British audiences to this problem were very different. Eighty-five percent of the American raters regarded her as a schizophrenic (Table 5) though there was no consensus on the type of schizophrenia involved. Only 7% of the British audience agreed with this diagnosis. Fifty-two percent of them thought that she had a personality disorder and 38% thought that she had a neurotic illness. In fact, the most common diagnoses were hysterical neurosis and hysterical personality, so 76% of the British raters were agreed that she was a hysteric. In contrast, only one American rater mentioned the term hysteria.

PATIENT F.—This 30-year-old bachelor from Brooklyn had been hospitalized briefly several times, had no close friends, and had rarely held a steady job. He described having once had a hysterical paralysis of his arm and gave a vivid account of the fluctuations in his mood and morale and of his willingness to abuse alcohol or drugs whenever the opportunity arose. Table 6 shows the diagnoses made by 133 American and 194 British psychiatrists. Again, there is a striking difference between the two. Sixty-nine percent of the American audience, but only 2% of the British audience, diagnosed some form of schizophrenia. The most common American diagnoses were schizo-affective psychosis and paranoid schizophrenia, but many of the psychiatrists concerned indicated that pseudoneurotic schizophrenia, a term not recognized in the International Classification, was the diagnosis they would normally have made. Only three British psychiatrists even mentioned this term. Instead, 75% of the British audience made a diagnosis of personality disorder, and the majority specified that this was of hysterical type. By comparison, only 8% of the American group diagnosed a personality disorder of any kind.

The striking differences between the American and British diagnoses for the previous patient (E) might perhaps be discounted on the grounds that her behavior, and the situation that had precipitated it, were both unusual and that, in any case, the diagnostic discrepancy summarized in Table 5 was derived from a comparatively small number of raters. But neither of these pleas can be made here. The general tenor of the patient's history and his behavior in the interview were familiar enough to psychiatrists on both sides of the Atlantic and both groups of raters were large. For this reason the discrepancy was studied in more detail.

If the patient's account of his problems had been vague and incomplete, or if the interviewer had left important areas uncovered, the raters would not have been able to make confident diagnoses and the discrepancy would lose much of its significance. But this does not seem to have been the case. Eighty-three percent of both the American and the British audiences made ratings of 1 or 2 on the 5-point confidence scale and when the two audiences were compared again after excluding all those who had rated 3, 4 or 5, the discrepancy was as great as ever. Sixty-eight percent of the Americans, but only 2% of the British, diagnosed schizophrenia; 79% of the British, but only 6% of the Americans, diagnosed a personality disorder. An examination of the alternative diagnoses offered pointed to the same conclusion. Fifty-nine percent of the American audience and 62% of the British audience offered no alternative diagnosis, a further indication of their



The differences between American and British concepts of schizophrenia.

confidence in their main diagnoses. Of the 92 American psychiatrists who regarded the patient as schizophrenic, only three offered a personality disorder as an alternative; and of the 146 British psychiatrists who regarded the patient as having a personality disorder, only three mentioned schizophrenia as an alternative. In short, the majority of American psychiatrists was confident that the patient was schizophrenic and did not seriously consider any other diagnosis; the majority of British psychiatrists, on the other hand, insisted that he simply had a personality disorder and that there was really no question of his having a psychotic illness.

Because of this persisting discrepancy, the personal information provided by all participating psychiatrists was analyzed in an attempt to identify types of psychiatrists particularly prone to make a diagnosis of schizophrenia rather than personality disorder, or vice versa. Age, length of psychiatric experience, country of medical qualification, and formal psychotherapeutic training exerted no significant influence. In the United States there was a significant ($P < 0.05$) tendency for raters who had either been trained in, or were currently working in, state hospitals to diagnose schizophrenia more commonly than those from university departments or other settings, but by far the most important variables were which country the rater worked in, Britain or America, and which he had received his psychiatric training in. The two could not be distinguished because they were nearly always the same.

PATIENT G.—This patient was a 26-year-old American who spent most of the interview describing his illogical and incomprehensible schemes for world domination. He rocked in his chair, giggled repeatedly, and twice stopped speaking in midsentence and stared blankly for several seconds before continuing. This tape was seen by 34 psychiatrists in each country and their diagnoses are listed in Table 7. Nearly everyone agreed that he was schizophrenic but there was much poorer agreement on the type of schizophrenia involved. Eight of the nine subtypes recognized in the International Classification were mentioned and none commanded a majority of either American or British raters.

PATIENT H.—The last patient was an American woman of 47 who regarded herself as the queen of England. She was flippant and preoccupied with her sexual needs and her speech was full of puns and clang associations. Her symptomatology had prominent schizophrenic and manic components and she gave rise to a similar pattern of diagnoses to patient A. That is, in both countries the majority diagnosis was schizophrenia, of either paranoid or schizo-affective types, and in both there was a dissenting minority who felt she had a manic-depressive illness (Table 8). Again, like patient A, the proportion of American raters diagnosing schizophrenia was higher than that of the British raters (78% vs 66%), and the proportion diagnosing an affective psychosis correspondingly lower (22% vs 34%).

Comment

Three different patterns of diagnostic agreement or disagreement are portrayed by these eight patients. Patients B, D, and G all exhibited symptoms which were fairly typical of classical stereotypes and for all three there was substantial agreement between American and British psychiatrists. For patient B agreement was very close, not only for the main diagnosis of paranoid schizophrenia but also for the alternative diagnosis of an alcoholic psychosis. Similarly, there was almost complete agreement that patient D had a depressive illness and that patient G had a schizophrenic ill-

Table 3.—Diagnoses Given to Patient C

	American Psychiatrists (N = 39)	British Psychiatrists (N = 30)
Schizophrenia	37 (95%)	23 (77%)
Hebephrenic	0	1
Paranoid	32	15
Acute schizophrenic episode	1	3
Residual	1	0
Schizo-affective	2	3
Unspecified	1	1
Manic Depressive Psychoses	0	6 (20%)
Manic depressive, manic	0	2
Manic depressive, circular	0	4
Other Diagnoses	2	1
Alternative Diagnosis of Affective Psychosis	3 (8%)	5 (17%)

Table 4.—Diagnoses Given to Patient D

	American Psychiatrists (N = 29)	British Psychiatrists (N = 31)
Involutional melancholia	23 (79%)	13 (42%)
Manic depressive, depressed	1	12 (39%)
Reactive depressive psychosis	2	0
Depressive neurosis	2	6 (19%)
Schizophrenia, schizo-affective type	1	0
Subsidiary Diagnoses		
Anxiety, phobic or obsessive compulsive neurosis	5	6
Anankastic personality	6	6

Table 5.—Diagnoses Given to Patient E

	American Psychiatrists (N=27)	British Psychiatrists (N=29)
Schizophrenia	23 (85%)	2 (7%)
Simple	1	0
Hebephrenic	2	1
Catatonic	2	0
Paranoid	2	0
Acute schizophrenic episode	4	0
Residual	1	1
Schizo-affective	7	0
Unspecified	4	0
Neuroses	1 (4%)	11 (38%)
Anxiety neurosis	0	1
Hysterical neurosis	1	10
Personality Disorders	1 (4%)	15 (52%)
Schizoid	1	0
Hysterical	0	12
Antisocial	0	1
Unspecified	0	2
Other Diagnoses	2	1

ness. There was poor agreement, however, both between and within countries, on the variety of depression or schizophrenia involved. Patients A, C, and H all exhibited a mixture of schizophrenic and affective symptoms and had been chosen for that reason. All three were regarded as schizophrenic by the majority of both American and British raters, but for each between 20% and 34% of the British audience made a diagnosis of an affective psychosis (mainly manic-depressive illness) and a further 15% or so suggested this as a serious alternative to schizophrenia. A few American psychiatrists did the same, but in each case the proportion was much lower. Patients E and F had originally been included to offset a preponderance of psychotic patients rather than to highlight any particular diagnostic problem but, in the event, it was these two who gave rise to the most serious disagreement. For both, the majority of American psychiatrists diagnosed some form of schizophrenia while British psychiatrists diagnosed either a personality disorder or a neurotic illness.

The differences between the American and British diagnoses for patient A, C, and H are consistent with the many other indications[1-3,8] that American psychiatrists have a broader concept of schizophrenia and British psychiatrists have a correspondingly broader concept of manic depressive illness, and are not of sufficient magnitude to prevent the majority diagnosis from being the same on both sides of the Atlantic. The problem is familiar, and of manageable proportions. The same cannot be said of the almost total disagreement revealed by patients E and F, which has more serious implications. The basic design of the study ensured that all raters were provided with exactly the same information and it has already been shown that both sets of raters had confidence in their conflicting diagnoses. The different interpretations placed on patient E's behavior might perhaps be discounted, for reasons that have been discussed previously, but the same cannot be done for patient F. The essential features of his problem—a long history of failure to develop lasting relationships or to cope with the demands of everyday life, but without florid psychotic symptoms—were commonplace. Perhaps significantly, Katz's aspiring actress[5] showed these same general characteristics and the majority of English raters considered that she had a personality disorder; while a third of the American audience regarded her as schizophrenic.

In a situation such as this, where two groups of equally experienced psychiatrists, both provided with the same data, disagree as to whether or not a patient is schizophrenic there is a natural temptation to ask who is right. It is important to

Table 6.—Diagnoses Given to Patient F

	American Psychiatrists (N = 133)	British Psychiatrists (N = 194)
Schizophrenia	92 (69%)	4 (2%)
Simple	0	1
Catatonic	1	0
Paranoid	27	1
Latent	8	0
Residual	3	0
Schizo-affective	33	1
Unspecified	20	1
Personality Disorder	10 (8%)	146 (75%)
Paranoid	1	2
Affective (cyclothymic)	1	8
Explosive	0	2
Hysterical	4	105
Asthenic	0	2
Antisocial	1	8
Unspecified	3	19
Affective Psychosis	10 (8%)	7 (4%)
Neurosis	19 (14%)	37 (19%)
Alcoholism or Drug Dependence	2	0

Table 7.—Diagnoses Given to Patient G

	American Psychiatrists (N = 34)	British Psychiatrists (N = 34)
Schizophrenia	33 (97%)	32 (94%)
Simple	0	1
Hebephrenic	11	12
Catatonic	0	8
Paranoid	15	7
Acute schizophrenic episode	3	0
Residual	0	1
Schizo-affective	1	0
Unspecified	3	3
Other Diagnoses	1	2

Table 8.—Diagnoses Given to Patient H

	American Psychiatrists (N = 60)	British Psychiatrists (N = 41)
Schizophrenia	47 (78%)	27 (66%)
Hebephrenic	5	6
Catatonic	1	0
Paranoid	17	10
Residual	1	0
Schizo-affective	12	11
Unspecified	11	0
Affective Psychoses	13 (22%)	14 (34%)
Manic depressive, manic	8	7
Manic depressive, depressed	1	0
Manic depressive, circular	1	5
Unspecified	3	2
Alternative Diagnosis of Schizophrenia	6 (10%)	8 (20%)
Alternative Diagnosis of Affective Psychosis	7 (12%)	5 (12%)

realize, though, that in our present state of knowledge such a question is not only unanswerable, it is inherently meaningless. Schizophrenia, like all other varieties of functional mental illness recognized in our nomenclature, is defined in terms of its clinical picture. In Scadding's terminology,[9] its defining characteristic is its syndrome, and so the decision whether or not an individual patient has schizophrenia can only be made by the 'Hippocratic procedure' of comparing his symptoms with those of the illness and deciding whether the resemblance is adequate. In consequence, though one may discuss whose concept of schizophrenia is more useful, or closer to Bleuler's original description, one cannot meaningfully discuss which is right, for we have no external criterion to appeal to—no morbid anatomy, no etiological agent, no biochemical or physiological anomaly.

But disagreements as glaring as this have serious implications. Diagnoses are the most important of all our technical terms because they are the means by which we identify the subject matter of most of our research. They identify the types of patients who received the drug we were assessing, or whose family dynamics or sodium metabolism we were studying. If these terms are used by different groups of psychiatrists in widely differing ways, the two will, at best, fail to communicate with each other, and may well actively mislead one another.

The fact that these Anglo-American differences have arisen in spite of a common language and numerous cultural and professional ties has unhappy implications for international communication in general. Certainly the opportunities for groups of psychiatrists who lack these advantages to diverge from one another without realizing it must be much greater. Only recently have attempts been made to study differences in diagnostic criteria on this wider stage, and so far only two multinational comparisons have been reported, both based on written case histories rather than on films or videotapes. In the first of these,[10] a World Health Organization pilot study involving a small number of distinguished psychiatrists from eight different countries, cross-national differences were no worse than those within a group of British psychiatrists. However, in the second,[11] which involved larger groups of psychiatrists from the United States, the United Kingdom, and the Scandinavian countries, several systematic differences were de-

tectable. American psychiatrists had a propensity for diagnosing schizophrenia where Europeans diagnosed a depression or a paranoid psychosis: Scandinavian psychiatrists used the term psychogenic psychosis to describe patients others regarded as neurotic; and American and Swedish psychiatrists diagnosed cerebral arteriosclerosis and their British, Norwegian, and Danish counterparts diagnosed an affective disorder. Significantly, these differences emerged in spite of the fact that the study was based solely on written transcripts, and these eliminate one of the most important sources of variation, the observer's own perception of psychopathology.

There is probably no easy way of removing entrenched differences in diagnostic usage of the kind that have been demonstrated here. If psychiatrists detected the same abnormalities in patients to whom they attributed different diagnoses the problem would be relatively simple. Patients could be identified by their symptoms instead of by diagnosis, and different schools of psychiatry might even be persuaded to agree on common definitions for their diagnoses. But in this study at least the evidence (to be reported in detail elsewhere) is that American and British psychiatrists often detect quite different symptoms in patients whom they diagnose differently. Patient F, for instance, was rated by 67% of the American audience as having delusions, by 63% as having passivity feelings, and by 58% as showing thought disorder. The corresponding percentages for British raters were 12%, 8%, and 5%, a contrast every bit as striking as the difference in diagnosis. Even the IMPS ratings, which are couched in nontechnical language and purport to be straightforward descriptions of deviations from normal behavior, showed several significant differences, with American raters perceiving more symptomatology in all areas, particularly in those with a strong schizophrenic connotation. Whether clinicians make different diagnoses because they perceive different symptoms, or whether they perceive different symptoms because they have already recognized a familiar illness is an important and intriguing issue. But either way the fact that serious perceptual differences are involved makes it very difficult for someone who has been trained in one frame of reference to change to another.

Probably the most important cause of the Anglo-American discrepancies revealed here is that the American concept of schizophrenia has expanded greatly in the last 30 years without any corresponding enlargement of the British concept. The reasons for this divergence are complex, but the greater influence of the psychoanalytic movement in North America, and influential teachers on both sides of the Atlantic, have probably been more important than any factual discoveries. The evidence provided by these and earlier videotape studies[4,5] and comparisons of hospital populations in London and New York[2,3,8] make it clear that the concept of schizophrenia held on the east coast of the United States now embraces not only part of what in Britain would be regarded as depressive illness but also substantial parts of several other diagnostic categories—manic illness, neurotic illness and personality disorder (Figure).

Other less important differences can also be seen. The diagnoses given to patients E and F (Tables 5 and 6) indicate that British psychiatrists are more prone to use the term hysteria than their American counterparts, a finding presumably related to the omission of hysteria from the American Psychiatric Association's 1952 classification (DSM 1). Similarly, the diagnoses given to patient D (Table 4) and the results of the hospital population comparisons referred to above[2,3] indicate that American psychiatrists diagnose involutional melancholia in middle-aged women whom many British psychiatrists would regard as manic depressives. Of all these differences, the overlap between the American concept of schizophrenia and the British concept of manic depressive illness is the most widely recognized, but the additional overlap with the British concept of personality disorder probably represents the most serious problem, particularly where ambulant patients are concerned.

Although, as was stressed above, no concept of schizophrenia can be either right or wrong it does seem, at least to a European observer, that the diagnosis is now made so freely on the east coast of the United States that it is losing much of its original meaning and is approaching the point at which it becomes a synonym for functional mental illness. Seven of the eight patients in this study were diagnosed as schizophrenic by over two thirds of the American psychiatrists, although between them they presented a variety of different symptoms and problems. Similarly, in a recent random sample of 192 patients below the age of 60 admitted to public mental hospitals in New York City, 82% of those with nonorganic conditions were diagnosed as schizophrenic by the hospital psychiatrists.[3,8] But doubtless the situation looks very different when seen through North American eyes and any major changes in either the British or American concepts of schizophrenia will probably occur only after, and as a consequence of, therapeutic innovations or biochemical or physiological discoveries. Changes currently taking place in the American concept of mania illustrate this quite well. The diagnosis of mania was in danger of disappearing, at least in New York, until lithium salts were introduced as a specific treatment of manic illnesses. The interest aroused by this new drug has, however, caused patients who five years ago would have been regarded as schizophrenics to be diagnosed now as manic depressives in order that they may be given lithium salts.[12,13]

Finally, one last issue needs to be raised. Although the British raters, at least of tapes A, B, and F, can reasonably be regarded as geographically representative of British psychiatry, the same is not true of the American raters, the majority of whom worked in or near New York. At present we do not know

how representative New York psychiatrists are of American psychiatry as a whole, but there are a number of indications that their concept of schizophrenia may be broader than that of their colleagues elsewhere. The 1968 tables of first admissions to public mental hospitals compiled by the Biometry Branch of the National Institute of Mental Health show that, for the whole of the United States, 18% of admissions are diagnosed as schizophrenics, or 31% of all admissions other than organic brain syndromes and addictive states. For California and Illinois, two large states of similar size and population distribution to New York state, the corresponding proportions are very similar. For New York state, though, they are considerably higher—25% and 52%. These high percentages might, of course, be due to a higher prevalence of schizophrenia in New York, but they certainly raise the possibility that schizophrenia is diagnosed more readily there. The preliminary results of videotape comparisons between New York and other centers on the Pacific coast and in the Midwest suggest the same. It is probably also significant that several of the ideas that have been instrumental in enlarging the American concept of schizophrenia, like the introduction of the concept of pseudoneurotic schizophrenia[14] and the dictum that "even a trace of schizophrenia is schizophrenia"[15] originated in New York, and so can be expected to have been more influential there than elsewhere.

It is possible, therefore, that future work will show that these comparisons between predominantly New York psychiatrists and British psychiatrists have given a misleadingly alarming picture of overall Anglo-American differences. It is important to realize, though, that if this does happen an equivalent communication difficulty will necessarily be revealed between New York psychiatrists and their colleagues elsewhere in the United States. The magnitude of the diagnostic disparity, and hence of the communication problem, would not be affected, only its geographical location—within the United States instead of between the United States and Britain. In view of the confusion which inconsistent diagnostic criteria can cause, the sooner this question is answered the better.

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