Beyond the Layman's Madness

The Scientific Basis of Medicine

Based on the 14th Sir Geoffrey Vickers Lecture for the Mental Health Foundation.
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Black-and-white
Duration: 00:39:09:13

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<Opening titles>

<Professor Shepherd to camera>

Fifteen years ago in a paper entitled *Mental Disorder in British Culture*, Sir Geoffrey Vickers stated that the *layman's madness* is only a small part of mental disorder. He didn't go on to indicate what constitutes the larger part, and in this lecture, I should like to take up the issue by considering a triad of simple sounding questions.

<Shepherd narrates over series of slides specifying questions>

First, what types of mental disorders do we encounter? Secondly, how much illness is subsumed by these categories? And thirdly, where and how are the patients suffering from such disorders to be identified?

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<Shepherd to camera>

None of these questions can be approached without some sort of agreement on definition. For heuristic purposes, the layman's madness would seem to be broadly synonymous with the psychiatrist's psychosis. And this in the words of the World Health Organization's glossary of mental disorders includes those conditions in which impairment of mental functions has developed to a degree that interferes grossly with insight, ability to meet some of the ordinary demands of life, or adequate contact with reality. As the glossary goes on to concede, psychosis is not an exact or well-defined term. Nonetheless, it does serve to cover the various organic and functional disorders making up the first of the three large groups of conditions incorporated in section 5 of the International Classification of Diseases, […]

<Shepherd narrates over slide showing table>

<Table>

International Classification of Diseases – 8th edition
Section V Mental Disorders

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1. Psychoses
2. Mental retardation
3. Neuroses, personality disorders and other non-psychotic mental disorders

[…] which traditionally incorporates all forms of mental illness. The psychoses can be excluded from further consideration here. And with only minor modifications, the same definition can be extended to cover many of the forms of mental retardation, the second of the groups which falls outside our purview. We're left with a third group comprising a large heterogeneous collection of categories under the heading of neuroses, personality disorders and other non-psychotic mental disorders.

<Shepherd narrates over series of slides showing tables>

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<Table>

‘Minor’ mental disorders

300 Neurosis

301 Personality disorders

302 Sexual deviation

308 Behaviour disorders of childhood

Its ten subcategories may be sub-grouped naturally into four, namely, first the so-called minor mental disorders, namely neurosis, personality disorders, sexual deviation, and behavioural disorders of childhood.

<Table>

Drug associated disorders

303 Alcoholism

304 Drug dependence

Secondly, drug associated disorders: alcoholism and drug dependence.

<Table>

Associated with somatic disease

305 Physical disorders of presumably psychogenic origin

309 Mental disorders not specified as psychotic associated with physical conditions

Thirdly, mental illness associated with somatic disease, that’s to say, physical disorders of presumably psychogenic origin, and mental disorders not specified as psychotic associated with physical conditions.

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Other conditions

306 Special symptoms not elsewhere classified

307 Transient situational disturbances

And lastly, other conditions, including a ragbag of special symptoms not elsewhere classified, and transient situational disturbances.

<Shepherd to camera>

This list is still far from complete, but it does help provide a partial answer to the first of our three questions. The other two questions, how much and where, call for empirical studies of a type which have been well established in Britain since the Second World War. Much information about the quantitative aspects of mental illness in this country is now contained in the published national statistics. It's natural therefore to turn first to the data collected for the mental health enquiry of the Department of Health and Social Security which utilises the International Classification of Diseases for the purpose of classification.

00:05:01:04

I've adapted some of the data furnished by the report for 1971 […]

<Shepherd narrates over chart>

[…] excluding institutions for the mentally handicapped. And a number of points emerge at once. First, it is apparent that the estimate of madness, defined as the proportion of patients suffering from psychotic illnesses, varies with the type of institution, and that it's most frequently encountered in the traditional mental hospitals. Secondly, the minor mental disorders assume increasing numerical significance as we look to the general and teaching hospital as a source of information. Thirdly, the drug-associated disorders appear to be numerically less prominent than the neuroses. Fourthly, mental disorder associated with somatic

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disease does not figure independently at all as it comes under other psychiatric conditions. Fifthly, among all other conditions, which make up more than one fifth of the total, it's been estimated that about 90 % are classified as: depression not specified as neurotic or psychotic, epilepsy, undiagnosed cases, and admissions for other psychiatric disorder.

<Shepherd to camera>

Clearly, however, such figures cannot be taken at their face value without regard to the possibility that cases are being admitted to other types of institution. Data from the hospital inpatient enquiry, which is conducted under the aegis of the Department of Health and Social Security and the Office of Population Censuses and Surveys, provide us with relevant information. Based, as these records are, on inpatient protocols from National Health Service Hospitals in England and Wales, excluding those hospitals confined to the treatment of psychiatric diseases and the psychiatric departments of general hospitals, the enquiry, constructed on a 1 in 10 sample of inpatient records, furnishes facts and figures relating to discharges in deaths, which were estimated in 1971 as numbering more than 42,000 for all forms of mental disorder covered by section 5 of the ICD.

<Shepherd narrates over chart>

The breakdown into the simplified groups presented earlier is set out here and demonstrates the marked shift towards a preponderance of minor mental disorders, although the number of psychiatric illnesses associated with somatic disease are still surprisingly few. In large measure, however, this finding turns out to reflect the unsatisfactory nature of the two relevant categories in the ICD.

<Shepherd to camera>

One of these, physical disorders of presumably psychogenic origin, accounted for only 1351 cases, of which the largest single subgroup was made up by young women with anorexia nervosa. As the expression 'presumably psychogenic origin'

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implies however, this category, as a whole, reflects a view of so-called psychosomatic illness which is already outdated so that the relatively small number of cases in the first somatic category is more readily understandable.

The second category, mental disorders not specified as psychotic associated with physical conditions, is at first sight remarkable in claiming no cases at all. The explanation here resides in the fact that, in accord with a long-standing rule, the cases are classified primarily by the physical condition leading to admission. This process, however, must result in an underestimate of the psychiatric correlates of physical illness, and in particular of depressive reactions although their detection calls for a clinical awareness not always present among general physicians.

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In 1960, when we first took a close look at the psychiatric disorders calling for consultation in the wards of a general hospital, we found that about two thirds of the cases, most of them suffering from clear-cut medical disease, were associated with a significant form of non-psychotic illness, some half of these being clinically depressed. Subsequent more intensive studies have examined more representative samples of the inpatient populations. Recently, for example, it's been estimated by direct examination that one quarter of medical inpatients are morbidly depressed during their stay in hospital. And another group of workers have shown that almost a quarter of 170 medical inpatients, suffering from coincidence psychiatric disability, showed that the large majority were depressed.

While the collection of such large scale figures are clearly useful in themselves for administrative purposes, their value is much enhanced if a more detailed examination can be made of diagnostic subgroups over time, although the marked change in the pattern of psychiatric care over the past 20 years in this country makes it difficult to collate data from so many different sources. For such purposes, the more precise and reliable the clinical diagnosis, the better. And consequently, it's most instructive, if possible, to assess the relevant information concerning psychiatric

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morbidity associated with an unequivocally causal factor, namely the ingestion of chemical substances and one obvious example is alcohol.

In 1949, when figures were first published, fewer than 500 patients were admitted to National Health Service Hospitals and Units. Of these, about one half were said to be suffering from an alcoholic psychosis, and one half from alcoholism. Nearly a generation later in 1973, the number of admissions had risen more than 20 times to over 12 000. This sharp increase in numbers does not, of course, necessarily reflect incidence rates. We know, for example, that these rates exhibit regional variations which are positively correlated with the existence of special units for alcohol dependence, and that only about 30 % of cases, admitted in 1970 to 1972, were first admissions. More directly relevant to my present theme is the fact that over the years the ratio of alcoholism to alcoholic psychosis has risen to almost 6 to 1. Moreover, since a diagnosis of alcoholism is in the opinion of most authorities incomplete, it is significant that since 1964, alcoholism has been sub-classified as a primary and secondary diagnosis; the latter accounting for about a quarter of all cases, and including a substantial number of patients diagnosed as depressive not otherwise stated.

The hospital inpatient enquiry supplements these data by revealing a comparable state of affairs in non-psychiatric beds, the numbers having risen at about the same rate to nearly 5000 in 1972. Of this population, only 300 were classified as alcoholic psychosis. There is a substantially higher proportion of women and a disturbingly large number of admissions under the age of 15. And further, though three quarters of these cases were treated in departments of general medicine, the figures do not include the various physical conditions related to excessive drinking, such as malnutrition, polyneuritis, myocarditis, gastrointestinal disorders, accidents, and most overtly – hepatic cirrhosis, of which 5000 cases were treated in 1972, about one quarter being recorded specifically as due to alcohol. At present such cases will be classified outside section 5 of the International Classification of Diseases.

<Shepherd narrates over slide showing table>

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<Table>

Section IX Disease of the digestive system

570	**Necrosis of the liver**
571	**Cirrhosis of the liver**
571.0	**with alcohol**
571.9	**without alcohol**
572	**Suppurative hepatitis and liver**

Cirrhosis of the liver, for example, will appear in section 9 under category 571. In practice, therefore, it becomes necessary to adopt a system of double coding if one is to identify the psychiatric component of a physical disorder.

<Shepherd to camera>

And this principle, it may be noted, has been underlined in the 9th edition of the International Classification of Diseases in which combination categories are to be eliminated so that only the psychiatric syndrome is to appear elsewhere.

We must also go outside section 5 to record the importance of suicide in the general hospital. This issue needs to be emphasised less as it's received more attention. Its outlines, at least in part, can be readily traced from the published statistics which have demonstrated a sharp rise in attempted suicide over the past 20 years. Here, I would only observe that though both suicide and attempted suicide are associated with mental disorder, in a high proportion of cases the information published by the Registrar General again falls outside section 5 of the ICD and appears under two separate sections: […]

<Shepherd narrates over slide showing table>

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<Table>

I.C.D. 8

Section XVII Accidents, poisonings and violence

Alternative classifications of accidents, poisonings and violence

EXVII External cause

NXVII Nature of injury

[…] the E code, recorded as the external cause of death; and the N code, recorded as the nature of the injury. The N coding shows that four fifths of the drugs employed are analgesics, psychotropic substances or hypnotics, all of them drugs often used for self-poisoning.

00:16:14:22

<Shepherd to camera>

So much for inpatient statistics which, with all their limitations, take us some way towards an awareness of the extent of non-psychotic illness leading to institutional care; for time has long since passed, however, when bed occupancy could be regarded as an index of psychiatric morbidity. And the expanded forms of ambulant care for the mentally ill, provided by the health service, might be expected to furnish a rich source of data, particularly from the outpatient departments wherever patients are seen. Unfortunately, large scale statistics on this population are still lacking, but outlines of the picture are clear enough from the few studies of individual centres or areas which have been undertaken by individual workers. All of them show the numerical weight of the case load, carried by the mental health services of this level, tilted sharply towards neurotic illness and personality disorder.

<Shepherd narrates over slide showing table>

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	In patients	Out patients
Psychoses	**39**	**14**
Neuroses and Personality disorders	**55**	**77**
Other	**6**	**9**
	100 %	**100 %**

By way of example, this table shows the situation at the Maudsley Hospital, where outpatient statistics have been available for a number of years. But if, in addition, the psychiatric aspects of illness referred to non-psychiatric patient departments are to be given due recognition, more elaborate enquiries will clearly be required.

<Shepherd to camera>

Some years ago, for example, we were able to assess psychiatric morbidity in a sample of 200 consecutive outpatients in a general hospital, 100 of them referred to medical and 100 to surgical clinics. Over a 12 month period, it had been recorded that the outpatient physician, surgeons and gynaecologists of the hospitals had requested psychiatric opinions on 3.4 % of all new patients in their clinics; on which basis, 1 patient in 30 would be recognised as suffering from a psychiatric disability. This estimate, however, rises tenfold when the figures from an intensive outpatient survey were examined […]

<Shepherd narrates over slide showing statistics>

[…] for a closer study of these findings proved to be revealing since about 40 % of the 100 patients attending the medical clinic and 5 % of those referred to the surgeons exhibited no evidence of any form of physical disease, although somatic complaints were prominent. The majority of psychiatric illnesses among these patients were depressive and neurotic reactions and personality disorders. No more than 1 in 3 of the psychiatric patients suffered from a coexisting physical disorder.

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And when this was present, the symptoms were those of exaggerations or of morbid reactions to organic disease.

<Shepherd to camera>

In essence then, these patients were suffering from the same types of disorder as those referred for psychiatric opinion, differing principally in the severity of their symptoms. What stood out with equal force was the significance of domestic and social problems in the genesis of their complaints. And we were compelled to acknowledge that patients attending medical and surgical clinics of a general hospital present a relatively large number of minor psychosocial problems, the majority being found among the medical cases. Their management need not be elaborate; a great majority of these patients did not require more expert attention than could be expected reasonably from the combined resources of a general physician and a social worker.

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This conclusion bears directly on the mounting body of information which indicates that hospital statistics, however complete they may become, cannot do justice to the dimensions of the problems of mental disorders in the community at large. Within the structure of the National Health Service, the most compelling evidence has undoubtedly come from studies directed at the level of primary care. An overall view of the situation is provided by the two national morbidity surveys conducted by the Royal College of General Practitioners in 1955 and 1970 to ’71 respectively. The first of these, in collaboration with the Registrar General, the second with the Office of Population Censuses and Surveys and the Department of Health and Social Security.

A comparison of the results of these surveys reveals an apparently striking increase in the amount of mental disease presenting to the general practitioner, the rate having more than doubled from the 50 patients per 1000 population, consulting at least once annually, to about 109, a figure which puts it in the forefront of disorders

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with which the practitioner has to deal. It cannot be maintained, however, that this statistic represents a true rise in the incidence of psychiatric morbidity for a closer analysis of the figures shows the greater part of the increase to have been attributable to the much greater frequency with which the diagnosis of depressive illness has been made.

<Shepherd narrates over chart>

Independent confirmation of these findings has furnished by our own more intensive studies of psychiatric illness in general practice carried out over a 1 year period over a sample of patients attending more than 50 practitioners. The findings have since been confirmed by surveys which have been carried out in comparable fashion in places as far apart as Australia, the USA, Austria and Iran. Among what we call the formal disorders, derived as simplified and collapsed categories from section 5 of the ICD, the neurotic and personality disorders again loom largest. But it was the affective illnesses with depression and anxiety or mixtures thereof, which assumed the greatest prominence among them. However, it became clear that such formal labels were quite inadequate to cover all the psychiatric conditions.

<Shepherd to camera>

To incorporate these symptomatic complaints and problems in the total picture of morbidity, it is necessary to invoke section 16 of the ICD, […]

<Shepherd narrates over slide showing table>

<Table>

I.C.D. 8

Section XVI Symptoms and ill defined conditions

790.0 Nervousness

790.1 Debility and undue fatigue

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790.2 Depression

791 Headache

[…] where, under the label of symptoms and ill defined conditions, we find such items as nervousness, debility, headache and the ubiquitous depression to which a formal diagnostic label cannot be applied with sufficient accuracy to justify inclusion in section 5.

<Shepherd narrates over table>

In our own study, for example, we looked at consulting rates per 1000 at risk and compared disorders classified by formal ICD categories with complaints labelled 'psychiatric associated conditions'; a group which increased the reported 1 year consultation rate by almost 50 %.

<Shepherd to camera>

Even these figures do not, of course, do justice to the whole range of extramural psychiatric illness which comes to medical care. Alcoholism, for example, is recognised much less often than it occurs though it's recently been suggested that it might be screened effectively by the general practitioner. And if the interest in what was called 'industrial neurosis' forty years ago appears to have waned, the published figures do not suggest that it has decreased substantially as may be seen from the next chart.

00:25:06:11

<Shepherd narrates briefly over chart and then to camera>

In going then beyond the layman's madness so far, we've remained close to the identification of mental disorder at different levels of medical care. This task is much facilitated in Britain by the knowledge that more than 97 % of the population is

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registered with a general practitioner, and there is some evidence indicating that sooner or later most sick people make contact with representatives of the primary care system.

<Shepherd narrates over graph>

Nonetheless, in terms of general morbidity, the situation can be depicted diagrammatically like this, from which it may be seen that a large segment of illness remains undetected by routine records. This schema may be extended legitimately to incorporate mental disorder. In assessing psychiatric morbidity which fails to come to the attention of or is not recognised by the medical services, however, some form of population enquiry is usually required since the chain which leads from awareness of symptoms […]

<Shepherd to camera>

[…] to recognition of illness can be a long one; the links comprising an awareness of the stress or discomfort, the identification of this state as morbid, the belief in the need and value to seek medical treatment, the overcoming of possible obstacles to such a step – for example, fear, expense or inconvenience. And further account must be taken of private and public attitudes towards health and the health professions.

In the sphere of public health and clinical epidemiology, the spur to such investigations is customarily designated ‘screening’, but as several authors have pointed out, many so-called screening programmes would be better described as morbidity surveys. All too often, the strategy of screening becomes identified with the concepts and techniques of case identification, which in the field of mental disorder presents particular difficulties. While these are not, in some respects, different from those which confront the investigator of, say, diabetes or hypertension, the lack of relatively objective criteria has proved a major stumbling block to a number of strenuous but largely misdirected ventures. As Taylor and Chave have commented, the over-enthusiastic diagnostician can find evidence of psychiatric ill health in most

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human beings; such findings perhaps tell us more about the observer than about those observed.

It would, I think, be more accurate to direct this charge at the instruments employed by the observers; for the definition and detection of the psychiatric case has turned in large measure on issues concerning the techniques employed, which in medical hands consist principally in psychiatric interviews, psychological tests and scales, and assessments of symptoms, illness and disability. Yet, whatever method be chosen, an obvious practical difficulty resides in the need to interview large numbers of people in a standardised manner. To overcome this hurdle, there is much to recommend a two-stage approach using a relatively simple questionnaire to identify vulnerable individuals who can then be interviewed as a whole group or in samples. This is the procedure which we've followed in our own studies. And a number of investigations have been carried out along these lines. The results show an uncomfortably large proportion of people demonstrating abnormal responses, most of them characterised by dysthymic mood states, comprising such features as depression, anxiety, preoccupation with health, irritability, and insomnia. The designation of these phenomena has raised, and continues to raise, problems of classification. For to include them with the neurotic depressive disorders of section 5 of the ICD can serve to extend an outworn concept to breaking point. They're more adequately described by the description of depression in section 16 as a decrease of functional activity not amounting to psychosis or psychoneurosis. The same conclusion has found some theoretical support from a recent analysis of the classification of psychiatric disorder in hierarchical terms. According to this schema, dysthymia takes its place as a category of reaction below neurotic depression, and the existence of a large pool of individuals with dysthymic states in the general population is of potential clinical significance.

00:30:37:17

It is, however, possible to approach case finding in quite another way as was pointed out by Bloom several years ago. In practice, he said, the psychiatric evaluation remains the primary means for making judgements for the purposes of case

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identification. It will probably continue as the ultimate criterion until either a more reliable, demonstrably valid and practical alternative is developed, or until confidence wanes in the value of medically orientated investigations into those kinds of human behaviour which, when labelled as psychiatric disorder, are now considered to fall within the medical domain.

Since those words were written, there has been not so much a waning of medically orientated studies as the emergence of alternative frameworks inspired by the social sciences related to medicine. A charter for this approach was provided as early as 1960 by the proposal of a World Health Organization Committee that a case be defined as a manifest disturbance of mental function, specific enough in clinical character to be consistently recognisable as conforming to a clearly defined standard pattern and severe enough to cause loss of working or social capacity, or both, to a degree which can be specified in terms of absence from work, or the taking of legal or other social action.

Now, this statement appears to imply that a social dimension must be deemed indispensable to the definition of mental diseases. This has acted as an open sesame for the many social investigators who have tended to incorporate ill health into their framework of enquiry.

<Shepherd narrates over slide showing table>

<Table>

I.C.D. 8

Supplementary classifications

Y11	**General psychiatric examination**
Y11.0	**Social maladjustment without manifest psychiatric disorder**
Y11.9	**Other**

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In fact, however, they have often ignored that the ICD can still cover the situation adequately through its Y code of supplementary classifications, in particular category Y11.0, namely social maladjustment without manifest psychiatric disorder.

<Shepherd to camera>

And despite this trend, most of the large scale surveys which have been conducted by non-medical investigators to furnish facts about mental health retain a medical framework. The most ambitious enquiry in this country has been the British Survey of Sickness, which ran from 1943 to 1952. It was initiated because of the interest developed in minor ailments and general ill health as an index of national wellbeing in the Second World War. The information was derived extensively from questionnaires administered to samples of about 2500 people, who were asked about illnesses during the preceding trimester. The essentially subjective nature of this judgement, however, is contained in the expressed view that a person is ill if he feels ill. Accordingly, the amount of formal mental disorders recorded is much less prominent than the rubric of nervousness and debility and headache, which were consistently exceeded in frequency by only muscular and unspecified rheumatism and the common cold.

Much of the methodological experience acquired during the period of the Survey of Sickness has been incorporated more recently into the health section of the multipurpose General Household Survey conducted by the Office of Population Censuses and Surveys. Here the questionnaire has been expanded to cover the limitations of activity caused by illness, the use of health and personal social services, consultations with doctors, and visits to hospitals. As the authors of the report take pains to emphasise, morbidity information obtained from sample surveys is not equivalent to clinical diagnosis, and they are correspondingly cautious in presenting diagnostic data. Nonetheless, their tabulation of the rate per 1000 persons reporting conditions leading to consultation with a National Health Service general practitioner, in a 2 week period, shows mental disorders at 10.5 per 100 to rank third in frequency, following behind only diseases of the upper respiratory tract and symptoms and ill-defined diseases.

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The proportion of mental disorders is, in fact, rather smaller than that recorded in the National Morbidity Survey. The reasons, say the authors, is that they are typically disorders which a doctor may ascribe to a category without telling the patient, or which in the case of the informant who has been told, she may not confide to the interviewer.

00:36:00:05

In the United States, the health examination survey of the National Health Survey has yielded further information about the mental health of the general population in the 1960s, derived from a probability sample of almost 8000 persons aged 18 to 79 years.

<Shepherd narrates over slide showing table>

The data relating to reported nervous breakdown, from which almost 5 % of the adult population were reported to have suffered, is shown in this table. The term nervous breakdown was ascertained as an extreme emotional reaction to various factors, most prominently an illness of the respondent or a close friend or relative, an enforced separation, occupational or financial difficulties and interpersonal problems. Significantly, almost 3 times as many adults complained of feelings of an impending nervous breakdown defined in these terms, numbering almost 15 million people in toto.

<Shepherd to camera and then over slide>

So, in conclusion, the argument emerging from this attempt to tackle my questions rests on three principle points. First, it is apparent that in going beyond madness or psychosis, it becomes necessary to go beyond section 5 of the International Classification of Diseases to incorporate categories from the section on symptoms and ill-defined disorders, from the sections on accidents, poisonings and violence, and from the supplementary classifications.

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<Shepherd to camera>

Secondly, in numerical terms, dysthymic mood states represent the largest clinical category to which full justice can only be paid by taking account of both biological and psychosocial factors. And lastly, much, if not most, mental disorder is to be detected extramurally. It therefore escapes the attention of the specialised mental health facilities and constitutes a major public health problem, which is closely involved with physical illness, on the one hand, and social dysfunction, on the other. As such it merits serious consideration along a much broader front than it usually receives.

<End credits>

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