Letters to the Editor

Recent advances in the epidemiological study of minor psychiatric disorder

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Dear Sir, The editorial by Bebbington *et al.* (May *Journal*, p 315) raises some important issues about case definition in psychiatric epidemiology that call for further discussion.

Since there is no observable or objective representation of psychiatric illness, its presence or absence is entirely a matter of consensus clinical opinion. However standardized this opinion may be, the threshold between what does and does not constitute a case must be arbitrary. Thus, some case-identifying instruments would include as cases individuals who would not be so regarded according to other strategies of case identification.

This being so, it is a matter of considerable importance that the definition of a case and, in particular, the threshold, be appropriate and relevant to the aims of any enquiry. As psychiatric epidemiology has developed, the focus has shifted away from the hospital and severer forms of morbidity, towards the community and the investigation of lesser degrees of morbidity. There is, however, evidence to indicate that concepts and methods of case definition have not similarly changed, and that epidemiologists are still preoccupied with methods of measurement derived from hospital psychiatry (Williams *et al.* 1980).

The problem is exemplified in the editorial by Bebbington *et al.* One of their requirements for defining a case is that 'symptoms should be used to build up specific classes which conform to accepted clinical practice'. This raises two questions: whose clinical practice, and which specific classes? The answers clearly implied by the content of their paper are 'the psychiatrist's' and 'psychiatric diagnosis'.

However, it is well known that psychiatrists are acquainted with only a small proportion (5–10%) of the total morbidity in the community, and a grossly atypical proportion at that. Psychosis, for example, is common in hospital but rare in general practice and community samples (Shepherd *et al.* 1966). Thus it is questionable whether conceptual frameworks derived from such samples are appropriate to the community. Shepherd (1977) has pointed out the doubtful utility of psychiatric diagnosis in relation to much minor psychiatric morbidity. He observed that most 'cases' in the community are characterized by 'such features as depression, anxiety, preoccupation with health, irritability and insomnia . . . to include them with the neurotic depressive disorders . . . can serve to extend an outworn concept to breaking point'.

A common problem in present-day community psychiatric research is the classification of individuals who cannot clearly be assigned to any one diagnostic category, yet who should clearly be regarded as cases. For example, many respondents who are annoyed by aircraft noise exhibit psychological reactions and symptoms, yet only a minority merit a psychiatric diagnosis (Tarnopolsky *et al.* 1978). Clinically, patients with such features are well known to general practitioners and even psychiatrists, and often receive treatment. Many of them can be regarded as suffering from 'transitory difficulties in living that beset individuals in the ordinary course of their lives' (Bradburn 1969), and they are variously given the label of 'subclinical neurosis' (Taylor & Chave 1964), 'dysthymia' (Foulds & Bedford 1975), or simply 'nervous tension' (Wing 1976). Surprisingly, many case definitions are framed so as to exclude such conditions, which results in an incomplete picture of community morbidity.

Clearly, measuring instruments (i.e. the methods of identifying cases) should be 'appropriate to the types of psychiatric disturbance commonly encountered in the community' (Goldberg *et al.* 1970). The Present State Examination (Wing *et al.* 1974) was used in much of the work described by Bebbington and his colleagues. Yet the content of this instrument is derived almost exclusively from hospital patients; for a symptom to be rated as present it must be 'clinically fairly severe' (Wing *et al.* 1974); the standardization training is done on inpatients. It yields community prevalence estimates of about 10%, as compared with estimates of 15–25% obtained with the General Practice Research Unit Standardised Interview Schedule (Goldberg *et al.* 1970), an instrument designed on the basis of, and specifically for, community research.

Elsewhere, we have argued that the 'yardstick' for 'caseness' should be shifted from hospital psychiatry to general practice (Williams *et al.* 1980). Such a shift will mean that epidemiologists must face up to the problems involved in conceptualizing and measuring forms of morbidity more relevant to the distressed person in the community. The solution of these problems will result in a more realistic, comprehensive and humane view of mental functioning than has been achieved so far.

Yours faithfully

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A copy of this letter was shown to Dr Bebbington *et al.*, whose reply follows:

Sir, The first point made by Drs Williams, Tarnopolsky and Clare is that there can be no single definition of 'a case' in psychiatric community surveys. It is difficult to understand why they think we would disagree with so self-evident a proposition. The particular definition used must depend on the purpose for which the study is undertaken. Our editorial was concerned with the use of methods which enable us to move from the relatively familiar (psychiatric conditions in outpatients and inpatients, for which there are theories that have already to some extent been tested) towards the relatively unknown (approximately equivalent conditions found in samples of the general population, i.e. in people who have not been selected because of recent contact with a general practitioner or specialist). This approach, which requires the use of identical methods of symptom measurement and classification in clinical and community settings, seems likely to be very fruitful. Its use does not exclude interest in conditions defined as sub-threshold for diagnosis nor, of course, does it imply that such conditions are not worth investigating in their own right (Wing 1980).

The second point concerns the extent to which special instruments are required for investigating sub-threshold conditions. This again depends on one's prior knowledge of what the conditions are. Someone who is annoyed by aircraft noise may or may not exhibit some of the symptoms that psychiatric outpatients experience. The only way to find out is to use some form of general list of symptoms in addition to any specific items that earlier work suggests may be appropriate. No one method will suit all circumstances. Dr Williams and his colleagues are here confusing the diagnoses made in outpatients and inpatients with the symptoms they display. An interview designed for referred patients will cover most of the symptoms found in general population samples. A total score based on ratings of the symptoms in the Standardised Interview Schedule used by Dr Williams and colleagues correlated very highly ($r=0.89$) with the total score derived from the Present State Examination (Orley & Wing 1979). The latter score also correlates highly with scores on the General Health Questionnaire. If further research demonstrates that there are symptoms unique to non-referred individuals, these can easily be added to the general list.

The question of classification, e.g. into 'case' and 'non-case', raises different issues. We use a computerized technique, the Index of Definition, based on type and severity of symptom present, which provides eight levels of confidence that a disorder is present. Levels 5-8 can be tentatively diagnosed using the CATEGO program. Levels 1-4 are sub-threshold. An extra value of such techniques is their flexibility. It is simple to modify them, or to provide alternative programs, in order to compare different techniques of classification. This is just as applicable at sub-threshold levels. Our current analyses may well indicate hypotheses which can be tested in this way. The research of Dr Williams and his colleagues and of other workers will also suggest such advances. The Present State Examination is in its ninth revision, the CATEGO program in its fourth, and the Index of Definition is still in its first. All three will continue to develop in the light of research experience.

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10 July 1980

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Metachronous carcinomas of the large and small bowel

From Dr W M Castleden
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Dear Sir, The case report of the patient with metachronous carcinomas of the large and small bowel from Lewisham Hospital (April *Journal*, pp 299-300) is of very great interest to researchers involved in the dietery aetiology of colon cancer.