English Psychiatry's Revolution

Vera Norris

Mental Illness in London. (Maudsley Monographs, No. 6.) Pp. 317. 35s.

Michael Shepherd


 Reviewed by Joseph Zubin

Dr. Zubin is Chief of Psychiatric Research in Biometrics of the New York State Department of Mental Hygiene and also Professor of Psychology at Columbia University. He is the author of many articles and several books: with H. Hoch, Psychopathology of Childhood (Grune & Stratton, 1953; CP, Mar. 1957, 2, 63f.). Experimental Psychopathology (idem, 1957; CP, Apr. 1958, 3, 106f.), Psychopathology of Communication (idem, 1958; CP, Oct. 1959, 4, 334f.), and, with 8 others, Current Trends in Description and Analysis of Behavior (Univ. Pittsburgh Press, 1958; CP, July 1959, 4, 214f.). He has reviewed Washington University's symposium on Theory and Treatment of the Psychoses (Washington Univ., 1956; CP, July 1957, 2, 185f.).

Modern hospital psychiatry may be said to have begun in the nineteenth century with the ushering in of 'moral therapy' under the leadership of such men as Pinel in France, Rush in the U. S., and William Tuke in England. Just why moral therapy declined is difficult to fathom unless one looks to such obvious factors as the industrial revolution, urbanization, and, in the U. S., immigration which overwhelmed the economy as well as the hospitals during the latter half of the nineteenth century. At the beginning of the third decade of the twentieth century, the tide turned again. The rise of the somatic therapies was heralded by Wager-Jauregg's malaria treatment for general paresis in 1917. The shock therapies followed in the '30s and '40s, but the introduction of these therapies in England was gradual. Not until the end of the Second World War did the new trend become apparent. The two books now under discussion ring out the old era of static psychiatry and ring in the new postwar period. The changes are documented with statistical data gathered in mental hospitals in England since the early '30s.

Shepherd, in a tersely written but
meaty book, examines hospitalized cases of mental illness in a small, prosperous, and stable county with a population of 400,000, served by only one hospital and evenly balanced between urban and rural residents. He contrasts the admissions from 1931–33 with those from 1945–47, following both groups for 5 years. The periods were selected so as to compare the 5 years preceding World War II with the five years following World War II, with the war period itself eliminated.

Norris, in her posthumous book, describes the story of mental disorder from the period 1947–1949 up to 1951, permitting an overview of the initial impact of the National Health Act which began in July, 1948. She studied admissions to two observation (or receiving) units and three mental hospitals in three areas of London. The patients were drawn from a population of 450,000 to 600,000. Both Shepherd and Norris suggest that their samples were representative of the national picture in hospitalized mental illness.

It is fortunate that these studies focus on the above periods since they mark the end of an area in the statistics of mental disease. These studies have special significance for the United States, for England appears to be about ten years ahead of America, not only in experience with the open hospital policy, but also in the application of new policies of admission and release. Thus in England the trend of increasing admission rates and declining resident rates, which we in the States are just beginning to experience, began about a decade ago. Hence the established British pattern might very well represent what we can expect in care, cost, and distribution of mental illness in this country in the next decade.

Before making such comparisons we had, however, better realize that comparative psychopathology, like comparative anatomy, can not be dealt with in an offhand fashion. It was not until anatomists began to compare organs with reference to their functions rather than their forms that comparative anatomy became meaningful. Although the amount of basic psychopathology may be biologically invariant from culture to culture, the characteristic behavior may be more fully elicited in some cultures, occulded to some degree in others, while in still others it may even be exploited to the benefit or detriment of the individual or the group. For this reason the drawing of comparisons between incidence figures in different cultures, even though the cultures are as closely alike as those of Great Britain and the United States, is hazardous.

What are some of the conclusions emerging from these two studies? They are of two types: (1) those dealing with such specific aspects as admission policies and management, which are largely dependent upon changes in law and in available facilities, and (2) more general conclusions about intrinsic relationships among sociocultural factors, diagnoses, outcome, etc.

Shepherd found, for the period prior to the introduction of the National Health Act, a marked increase in admissions and in releases for all conditions but schizophrenia, but no increase in hospital beds. This could only have happened as a result of shortening the stay of the average patient. Whether the increase in release rates was occasioned by the new therapies, by changes in community attitudes, or by change in type of patients admitted is difficult to determine. Probably each of these factors contributed its share. The new therapies alone could not explain the change because the most frequently used new therapy in Shepherd's hospital was continued narcosis, a technique which is now known not to be highly efficacious. There is some evidence of a change in the character of the inmates. During the second period the population was older and included higher proportions of females, of married persons, of voluntary patients, and of readmissions. There was an increase in the number of diagnoses of functional psychosis, in particular of affective disorders. All of these changes in population bring in patients with somewhat better prognosis. It is likely, therefore, that the changes in release rates are due, at least in part, to the better prognosis of the newly admitted patients. But why did this new influx of patients occur? Perhaps there was a change in attitude towards hospitalization for mental illness even before the passage of the National Health Act.

One of the most surprising findings in Shepherd's study is the reduction absolute numbers of first admissions of schizophrenia, as well as in rate, in second period. Whether this difference represents a change in diagnosis, a change in the type of facility to which schizophrenics first came, or some statistical artifact—such as variability due to small numbers—is difficult to determine. The number of readmissions per schizophrenic patient, however, rose, while the total duration of residence in the hospital during the follow-up period declined. It seems that a change in policy, at least, with regard to schizophrenia had occurred. Instead of resembling a prison, as it did earlier, the hospital during the second period became more like a subway train—always full but never with the same people, although the same passengers get in and out at various time periods. Apparently the English hospitals became not so much open-door as revolving-door hospitals, recycling their populations in and out.

A good way to study such a revolving population is by applying an index of retention in which the number of days of actual hospital residence is related to the total number of possible days of residence during the period beginning with the admission of the patient and ending with the conclusion of the follow-up period—with some weight also given to the number of readmissions for each patient. Examples of such indices are the Immobility Index (Cran dell et al., 1956) and the Outcome Index recently developed by Burdock (Zubin, 1960a).

Norris' is one of the best studies on the treatment of mental disease because it starts off with specific definitions of terms and uses standard actuarial and statistical methods. She developed several new indices, including a "follow-up success rate" for the proportion of time following admission to the hospital during which the patient was followed. Patients who were followed continuously up to end of the survey were rated at 100% success in follow-up, while those
who were lost to observation either because of death or release before the end of the follow-up period were rated proportionately less successful in follow-up. About half of the patients remained in the hospital throughout the period of follow-up, thereby attaining a score of 100% follow-up success. The follow-up success rates of the rest varied; seventy percent was arbitrarily selected as a satisfactory rate. It should be noted that much more reliable information was available for the patients who failed to leave the hospital than for those who were released.

As data for the period previous to July 5, 1948, are unavailable, it is difficult to measure the impact of the National Health Service on the utilization of admission wards and hospital beds. However, it is interesting to note that the number of individuals referred to the authorized officer at County Hall for mental conditions rose from 4,500 in 1946, to 7,800 in 1952 while the proportion of such persons against whom no action was taken under the Lunacy Act rose from approximately zero before the introduction of the National Health Act, to 22% in 1952. Apparently more individuals were taking advantage of the availability of mental-health facilities, with larger proportions of those wishing admission referred to places other than a mental hospital or being found not in need of treatment.

A rather striking contrast between England and the U. S. A. is found in the frequency of manic-depressive psychosis. Far from being a vanishing condition, as is the case apparently in many parts of the United States, it is quite common in England. Although the prognosis in manic-depressive psychosis seems to be more hopeful than in schizophrenia, it is, nevertheless, a severe condition. About half of those admitted with this diagnosis spend less than 16 weeks continuously in the hospital, while 9% spend at least 41 years continuously in the hospital. Whether these last would continue to be labeled manic-depressives in the U. S. is doubtful. The others have one or more recurrences of the illness in the course of their lives, so that on any one day in England, one in every 1,000 persons aged 16 or over is resident in a mental hospital on account of manic-depressive psychosis. The ratio of number of cases in the hospital on a given day to the total number of patients in the country is unknown, but according to Scandinavian estimates hospitalized manic-depressives are only 14% of the total number.

As for the mental disorders of old age, the expectation at birth of being admitted to a mental hospital at least once after the age of sixty is 2% for men, 3% for women. For those admitted the outlook is gloomy; early death being the usual outcome. The presence of affective symptoms is correlated with an increased chance of being discharged to the home. The mortality rates are higher for men than for women, the greater proportion of women remaining in the hospital as long-term patients.

The mortality rates for the diagnostic groups indicate that schizophrenics, who are usually regarded as psychologically immature, age much faster than the general population. The average age of the schizophrenics was 33 for males and 38 for females, but their mortality rates corresponded to those of ages 54 and 65, respectively. That is a disadvantage of from 21 to 27 years vis-à-vis their age-peers in the general population. Manic-depressives similarly show a 20-year handicap in mortality rates, while those suffering from old-age psychoses have a 15-year disadvantage. Perhaps all three of these disorders have a common organic factor. In this connection, it is interesting to note that interference with oxygen metabolism has been implicated in the aging process, while it has also been repeatedly alleged that the mentally ill have some metabolic deficit.

In England and in the European countries generally the diagnoses of manic-depressive psychosis and schizophrenia have a high degree of adherence, whereas old-age psychoses seem to have less adherence. The organic psychoses have the highest degree of adherence, while the neuroses have a rather low degree. In general, diagnostic labels in the United States are not so firmly adhesive as elsewhere. This, of course, raises an issue which ought to be looked into more carefully. In a recent Work Conference on field studies in mental disorders (Zubin, 1960b) steps were proposed for increasing the consensus on diagnosis. It was concluded that further conferences about differences in diagnosis would not lead far, but that an actual field investigation in which psychiatrists, psychologists, social workers, anthropologists, and biometricians from the various cultures would participate, might be useful. One suggestion was for surveys of the registrants of military service in the various countries.

The comparison of incidence figures is impeded by another difficulty. In many instances the figures are for first admissions to mental hospitals, not for true incidence in the population. It is even difficult, however, to compare first admissions because they are defined differently in various places. For example, in the studies being reviewed, the patients who formerly had treatment for mental illness in places not recognized as mental hospitals were not counted as readmissions but as first admissions, even though in other countries they would have constituted readmissions.

One of the most striking features of Norris' book is its rather pessimistic note about the outlook for mental patients once they enter mental hospitals. In the major categories, only one-fifth or one-fourth of the patients were released permanently, whereas the majority had at least one readmission during the four years following first admission. It is important to delve further into this problem by providing better base lines from which to make prognoses for the variety of patients entering our hospitals. It is possible that if we were to make a biometric assay of each patient as he came in and to follow his career through treatment,
we might discover that certain types of patients are more suited for certain types of treatment than others. Such a refinement in treatment procedure might lead to greatly improved outcomes. The battle of prognosis would, moreover, be greatly advanced, were it attacked simultaneously on three levels: pre-morbid, morbid, and course of illness. These three types of information in combination might lead to a more accurate prediction of outcome. Moreover, outcome on follow-up cannot be based merely on in-or-out-of-hospital status. There must be definite attempts at finding the patient in the community and seeing how well he has adjusted. With the marked increase in release rates, the number of former patients adjusting or not can not be determined by the fact that they are out of the hospital. Only follow-up observations with techniques and tools specially developed for evaluation of degree of adjustment can answer this question. This is the greatest need of the moment and efforts to meet this need are almost certain to be rewarding.

The two studies end in 1952, just prior to the discovery of chlorpromazine and the introduction of drug therapy on a large scale. Here again, it is noteworthy that England has not used the drug therapies as extensively as the U.S. Perhaps the open-door policy and the smaller hospitals made the universal use of drugs unnecessary. Whether the American experience with drugs will nullify the poor prognosis described by Norris remains to be seen.

Another current problem raised in these volumes is that of providing more facilities for the care of mental patients. On this point Norris has the following to say:

In the Annual Reports of the Board of Control the gravity of the situation is stressed yearly, as in the Report for 1953 in which is stated:

“...The hospitals were overcrowded to the extent of 18,923 patients. References have been made in previous Reports to the expedients adopted to cope with this overcrowding and with the deteriorated conditions which have resulted.”

Such a situation obviously calls for more facilities and more efficacious methods of treatment and prevention. The former lies in the hands of the Ministry of Health, responsible for hospitals and specialist services; the latter is the function of research workers who need the support of relevant organisations but who ultimately succeed or fail, contribute much or little, according to their gifts and experience in this complex field of inquiry. It is not for the medical statistician to draw up a programme of psychiatric research or to tell Governments how to find the money and materials for building new mental hospitals and how to recruit sufficient nurses and other staff. He may, however, properly draw attention to the urgent and in some ways alarming picture which his investigations uncover—a picture which many psychiatrists would suppose overdrawn, because of their clinical impressions regarding the effects of modern treatment, and which others would prefer to minimize for fear of undermining the confidence that the public has been developing during the last decade or two in the benefits of mental hospital care. Public confidence in mental hospitals is valuable, but it is not secure and likely to be retained if with the proof of the many demonstrable benefits of treatment, serious evidence of our general deficiencies in preventive and therapeutic knowledge is honestly stated and frankly discussed. The findings of this survey are intended to contribute to the objective appraisal of the present position, broadly in respect of the course and outcome of illness requiring mental hospital care, and the strength of some factors which evidently influence it.

If the English trends are truly predictive of what will happen in this country, the proposed contraction or expansion of mental-health facilities—in mental hospitals, day hospitals, clinics, general hospitals, and community agencies—ought to be reviewed cautiously.

REFERENCES

