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The International Classification and the Diagnoses of English Psychiatrists 1968-1980

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Summary: The diagnoses given to samples of 1,000 first admissions to English mental hospitals in 1977 and 1980 were compared in order to find out how much influence the 9th revision of the International Classification and its glossary had had on the diagnostic habits of English psychiatrists since its introduction in January 1979. Although the differences between 1977 and 1980 diagnoses were modest they were greater than those found in an earlier comparison of 1968 and 1971 diagnoses, before and after the introduction of the 8th revision. Comparison of all four sets of diagnoses, from 1968 to 1980, revealed some serial changes in the categorization of depressive illnesses and a slowly increasing familiarity with the ICD. Although a higher proportion of diagnoses used the nomenclature of the ICD in 1980 than in previous years, this was mainly because the ICD had adapted itself to the habits of English psychiatrists rather than the other way about.

Every decade, after extensive international consultations, the World Health Organisation publishes a new revision of the International Classification of Diseases (ICD). In the 1940s and 1950s little interest was taken in the Mental Disorders section of this, but in the 1960s WHO made great efforts to persuade health ministries and national psychiatric associations throughout the world to use its classification, and since then most member countries have adopted the successive revisions of the ICD for statistical purposes and also recommended them to physicians for general use. The United Kingdom was one of the few countries to use the Mental Disorders section of the early post-war revisions, and influential English psychiatrists like Lewis and Stengel played a leading part in the campaign to persuade other countries to do likewise. They were also instrumental in persuading the General Register Office to produce a glossary to the nomenclature of the 8th revision (ICD-8) (General Register Office, 1968).

Sufficient copies of this glossary for every consultant and senior registrar were circulated to all psychiatric hospitals and units in England and Wales shortly before the nomenclature of ICD-8 came into use in January 1970. In spite of this publicity and official encouragement a comparison of two samples of 1000 diagnoses, one taken in 1968 before the advent of ICD-8 and the other in 1971 a year after its introduction, revealed almost no differences between the two (Kendell, 1973). The diagnoses on which this comparison was based were obtained from the Mental Health Enquiry cards returned to the Department of Health for every psychiatric admission. In both years over a third of these diagnoses could not be translated into any ICD category, old or new. Moreover, in 1971 only eight patients out of 1000 were allocated to any of the seven new diagnostic categories introduced for the first time in the nomenclature of ICD-8, suggesting that neither the glossary nor the nomenclature had had much influence on the diagnostic habits of the majority of English psychiatrists.

The ninth revision of the International Classification was published in 1978 and this time WHO provided its own glossary to the mental disorders section as a separate booklet available in time for the formal introduction of the new nomenclature (WHO, 1978). The adoption of this ninth revision the following year provided an opportunity to carry out a similar comparison to the previous one, partly to find out whether this revision with its international glossary had had any greater impact on the diagnoses of English psychiatrists than its predecessor, and partly to see whether longer term changes in diagnostic behaviour could be detected by comparing diagnoses made in 1977 and 1980 with those made in 1968 and 1971.

Method and Results

To facilitate this second objective the procedure used was almost identical to that of the original

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1968/1971 comparison. As before, the diagnoses were obtained from the Mental Health Enquiry (HMR1 (Psych I/P)) forms of first admissions over the age of 15 to mental illness hospitals or units throughout the country. These forms are returned to the Department of Health a few weeks after the patient's admission to hospital. Samples of 1000 were withdrawn from the files for two years, one before and one after the date on which the new nomenclature was introduced (1 January, 1979). As before, the two years (1977 and 1980) were twenty-four months apart in order to avoid the change-over period, and the diagnoses were transcribed onto separate sheets, verbatim and anonymously, before being released to the author. Neither sample was a true random sample, partly because many of the 1977 Mental Health Enquiry forms had already been destroyed at the time of the study, but both were geographically representative. They were, however, drawn from England alone, whereas the 1968/71 comparison had been based on England and Wales. A further minor complication was that, in patients with more than one diagnosis, the instructions for deciding which should be coded as the main diagnosis and which as secondary were changed between 1977 and 1980, but in practice this seemed to make little difference.

Although administrators and records officers were briefed before the change-over in January 1979, copies of the WHO glossary were not available until April. Hospital administrators were then urged to make copies available 'to all grades of psychiatric staff' but the extent to which they did so varied and it was not until December 1979 that the College asked its Members and Fellows to use the new nomenclature and try to ensure that their junior staff were issued with copies of the glossary.

Several new diagnostic terms were introduced in the nomenclature of ICD-9. Their appearance for the first time in 1980 would therefore have provided convincing evidence that this new nomenclature was being used. The frequency with which eight such terms appeared in the 1977 and 1980 samples is shown in Table I. Three of the new terms did not appear at all, though this might have been because of the comparative rarity of the syndromes in question. The diagnoses of confusional state and depressive illness were frequently used in 1980, but they had been used equally frequently in 1977 despite the fact that they had never figured in ICD-8 or any of its predecessors. The only good evidence, therefore, was provided by the term alcohol dependence syndrome, which was never used in 1977 but appeared seventeen times in 1980. Other terms which had been present in the nomenclature of ICD-8 were not retained by ICD-9. The frequency with which six of these were used in 1977 and 1980 is shown in Table II. Although the combined use of these six diagnoses was significantly less in 1980 than it had been in 1977 ($\chi^2 = 4.98$ and $P < .05$) the difference is marginal, partly because none had been widely used in the first place.

TABLE I

Frequency of use of diagnostic categories present in ICD–9 but not in ICD–8

	1977	1980
Acute or subacute confusional state 293.0 or .1	50	44
Depressive disorder, not elsewhere classified 311	117	134
Alcohol dependence syndrome 303	0	17
Induced psychosis (Folie à deux) 297.3	0	0
Adjustment reaction 309	2	1
Acute reaction to stress 308	0	3
Frontal lobe syndrome 310.0	0	0
Postconcussional syndrome 310.2	0	0

Total sample n = 1,000 each year

TABLE II

Frequency of use of diagnostic categories present in ICD–8 but not in ICD–9

	1977	1980
Involutional melancholia 296.0	3	0
Involutional paraphrenia 297.1	0	0
Episodic or habitual excessive drinking 303.0 or .1	4	2
Alcoholic addiction 303.2	4	1
Transient situational disturbance 307	17	9
Borderline mental retardation 310	0	1

Total sample n = 1,000 each year

The proportion of all diagnoses which could not be allocated without very arbitrary assumptions to any ICD category fell from 37 per cent in 1977 to 8.5 per cent in 1980. However, this was due to changes in the nomenclature rather than to changes in diagnostic usage. In fact, it was largely due to the provision in ICD-9 of a category 'Depressive disorder not elsewhere classified' (311), which for the first time made it possible to code the frequently used terms 'Depression' or 'Depressive Illness', and to the provision of categories (293.0 and 293.1) for confusional states of uncertain aetiology.

As the two sets of 1000 diagnoses on which the earlier 1968/1971 comparison had been based were still available, it was possible to compare four large samples of diagnoses spanning a period of thirteen years and three successive revisions of the International Classification (ICD-7, ICD-8 and ICD-9).

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When these four were compared the most obvious changes were simply a reflection of gradual changes in incidence and admission policies—increasing numbers of patients with a diagnosis of dementia (30 in 1968 and 125 in 1980) and anorexia nervosa (2 in 1968 and 14 in 1980), for example, and a corresponding reduction in the proportion of patients with depressive illnesses. But there were other serial changes as well. A comparison of the 1977 and 1980 diagnoses with those from 1968 and 1971 showed that there had been a modest but statistically significant fall in the proportion of depressive illnesses described simply as 'depression' or 'depressive illness' (χ^2 = 11.44 and P <.001), and a matching rise in the proportion described as manic depressive (χ^2 = 13.45 and P <.001), agitated or retarded (χ^2 = 11.68 and P <.001) or neurotic (χ^2 = 7.91 and P <.01) (see Table III). Presumably this reflects a gradually increasing conviction that it is worth distinguishing between one type of depression and another; though the increasing usage of the terms retarded or agitated as well as the term manic depressive implies that there is still no agreement on which method of subdividing depressions is the most useful.

Partly because the seven diagnostic terms introduced for the first time in the nomenclature of ICD-8 were only given to eight patients out of a thousand in 1971, the earlier 1968/71 comparison concluded that most English psychiatrists 'had paid little attention' to either the nomenclature of ICD-8 or the Registrar General's glossary. However, comparison of the 1971 and 1977 diagnoses shows that some psychiatrists did begin to adopt the terminology of ICD-8 in the course of the decade. The diagnosis of transient situational disturbance, for example, appeared 17 times in 1977 compared with only once in 1971. There was also a progressive replacement of the ICD-7 term drug addiction by the ICD-8 term drug dependence; the proportion of drug abuse diagnoses using the word dependence rising from 18 per cent in 1968 to 48 per cent in 1971 and 69 per cent in 1977/80. On the other hand, many of the new terms introduced by ICD-8 were hardly ever used, even in 1977. This is perhaps understandable in the case of involutional paraphrenia, reactive depressive psychosis, reactive excitation and reactive confusion. It is more surprising, though, where alcoholic addiction and residual schizophrenia are concerned. Although both these terms are applicable to common conditions and neither involves alien theoretical assumptions, the former was used only seven times and the latter only once in either 1971 or 1977. To all intents and purposes they were ignored.

TABLE III
Terms used for describing depressive illnesses

	1968	1971	1977	1980
Total number of depressive illnesses	347	368	256	285
Percentage unspecified	57	60	50	48
Percentage called endogenous	10	8	8	5
Percentage called manic depressive	5	2	5	12
Percentage called agitated or retarded	3	2	7	7
Percentage called reactive	17	16	18	16
Percentage called neurotic	4	6	10	9

Total sample in each year 1,000 cases.

Another puzzling development was an increasing use of '? diagnoses' which cannot be coded and have always been discouraged for that reason. In 1968 and 1971 there were five of these, but the number rose to 29 in 1977 and 1980, a highly significant increase (χ^2 = 15.50 and P <.001) for which there is no obvious explanation. This was accompanied, however, by an increasing tendency for psychiatrists to quote an ICD code number alongside, or instead of, a written diagnosis. This was done on 13 occasions in 1968 and 1971, and on 102 occasions in 1977 and 1980, again a highly significant increase (χ^2 = 68.56 and P <.001). Although no one is asked to do this and it often serves no purpose it is perhaps the strongest evidence of all of an increasing familiarity with the international classification.

Changes in the official nomenclature may not be the only, or even the main cause of changing terminology. Fashion and the influence of contemporary research may influence usage at a much earlier stage, and only produce changes in the official nomenclature after the new terms have become familiar and accepted. However, there was surprisingly little evidence of such influences in these four sets of diagnoses. The terms Alzheimer's disease and multi infarct dementia which have figured prominently in the research literature in recent years were conspicuously absent even in 1980, and the term schizoaffective was used less often in that year than it had been in 1968. Indeed, the only hint of response to contemporary research interests was an increasing use of the term manic depressive, from twelve in 1977 to 35 in 1980 (χ^2 = 10.38 and P <.01).

Discussion

Like the earlier comparison of 1968 and 1971 diagnoses, this comparison of 1977 and 1980 diagnoses shows that the introduction of a new revision of the International Classification, in this case the 9th, does not immediately lead to any major change in the diagnoses English psychiatrists give to their patients.

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It is also apparent that some ICD terms, such as alcoholic addiction and residual schizophrenia, are never used by the majority of psychiatrists even after they have been in the official nomenclature for several years and despite a plentiful supply of suitable patients. On the other hand, there is some evidence that English psychiatrists are slowly beginning to take a greater interest in, and to become more familiar with, the International Classification. Although the differences between the 1977 and 1980 diagnoses were modest, there was more response to the introduction of ICD-9 in 1979 than there had been to the introduction of ICD-8 in 1970, despite the delayed and incomplete distribution of the WHO glossary. At least one of the new ICD-9 terms, alcohol dependence syndrome, was used in 1980 for over a quarter of the patients to whom it might have been applied, and other terms which had been dropped from the international nomenclature were used less frequently in 1980 than in 1977. It must also be recognized that most of the innovations in ICD-9 involved disorders which are not often encountered in adult in-patients. Greater changes in usage might have been demonstrable if the study had been based on out-patient or children's diagnoses.

The most convincing evidence of increasing familiarity with the International Classification is provided not by the immediate response to new revisions but by the increasing use of ICD code numbers as part of the diagnosis (rising from 11 in 1968 and 2 in 1971 to 61 in 1980), and by the way in which use of a term like transient situational disturbance (which figured in the nomenclature of ICD-8, but not of ICD-7 or ICD-9) started for the first time in 1971, rose to a maximum in 1977 and then fell in 1980. Even so, the most widely used diagnoses were the same in 1980 as they had been in 1968—depression, schizophrenia, dementia, alcoholism, personality disorder and confusional state—all broad syndromes whose many official subcategories were largely ignored. Indeed, senile dementia was the only commonly made diagnosis corresponding to a four-digit rather than a three-digit ICD category. The diagnoses of English psychiatrists were closer to being based on the International Classification in 1980 than they had been in 1968, but this was mainly because the International Classification had adapted itself to them, rather than because they had adapted to it.

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