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Psychiatric Epidemiology

DEFINITION

The study of the incidence and prevalence of mental disorder in time and space.

KEY POINTS

- Psychiatric epidemiology is described.
- Its weakness compared to traditional medical epidemiology is discussed.

In medicine, incidence refers to the number of new or first cases diagnosed. Prevalence refers to the total number of cases present in a population at a point in time or for a specified period of time. Epidemiology is the study of incidence and prevalence of diseases in space and time. Estimates of both prevalence and incidence of mental disorders are not easy for the following reasons:

- 1 Some critics argue that it is inappropriate to count cases, other than those with true organic conditions, which are associated with psychological abnormality (Szasz, 1961);

- 2 Critics who, in principle, accept the legitimacy of functional psychiatric diagnoses concede that particular diagnostic categories suffer from validity problems (Wakefield, 1999). These validity problems undermine our confidence in what is being counted;
- 3 In the absence of a consensus about the aetiology of most functional mental illnesses, the best that can be achieved by psychiatric epidemiology is to map the number of cases. It cannot achieve a causal map. This can be contrasted with the stronger tradition of medical epidemiology, in which causes not just cases are mapped. An example would be mapping the geographical spread of the incidence or prevalence of an infectious disease, such as tuberculosis. Psychiatric epidemiology is thus *descriptive* at best. It may be able to describe correlations between social variables (say social class, gender and race) and mental disorder. However, correlations may not imply causality and even if they do, as in the case of social class position, the direction of causality may be disputed.

The problems of valid and reliable case identification in psychiatric epidemiology are summed up well here:

Epidemiology is a branch of medicine and thus the assumptions of the medical model of disease are implicit. The most important assumption is that the disease under study actually exists. In psychiatry, this assumption is assuredly more tenuous than in other areas of medicine, because psychiatric diseases tend to be defined by a failure to locate a physical cause, and a validation of a given category of disease is therefore more subtle and complex. (Eaton, 1986)

With this type of caution in mind, what estimates are given by the psychiatric literature? The criticisms are confirmed by quite large variations in published estimates. For example, a review of eight US studies of prevalence estimates of personality disorder (all types) found a range of 6–15% in the general population and up to 50% in clinical psychiatric populations (de Girolamo and Dotto, 2000). Some studies find that borderline and histrionic personality disorders are more common in women but others find no sex differences. Much of this variation seems to reflect differences in diagnostic measures.

Variable estimates are also found in anxiety-based disorders. For example, community samples suggest a one-year prevalence of 7% for women and 9% for men of social phobia but clinical samples suggest no sex differences (Kessler et al., 1994). In the latter study, much larger sex differences were found in community samples for panic disorder (1.3% for men and 3.2% for women). Although most studies show a lifetime prevalence of obsessive-compulsive disorder of around 2%, estimates vary in different parts of the world from 1–3% (Weissman et al., 1994).

Of course, variations may represent real differences rather than artefacts of measurement. The problem is that it is not easy to resolve which of these two possibilities is most likely, given the concerns about the validity of particular diagnoses noted earlier from the likes of Szasz, Eaton and Wakefield.

If the validity of diagnoses of schizophrenia and bi-polar disorder is accepted then variations are still found. The lifetime risk of bi-polar disorder ranges from 0.3% to 1.5% with no discernible sex differences (Kessler et al., 1997). When those with a diagnosis of schizophrenia have been studied, the annual incidence lies between 0.017 and 0.54%, with a one-year prevalence ranging from 0.14% to 0.46% (Jablensky, 2000). Within these figures, large racial differences appear (for example, with a higher incidence in young Afro-Caribbean men in Britain).

A final question about psychiatric epidemiology relates to its social administrative role. Given its descriptive character, it has been largely used by psychiatrists and some policy makers to define *need for services*. That is, by estimating the prevalence of disorders separately and together, mental health service provision can be planned. The apparently benign role of service planning is not without its critics, given that mental health services are linked to coercion, stigma and social exclusion. This can lead to people with mental health problems evading services rather than demanding them.

See also: coercion; mental health; psychiatric diagnosis; race; social exclusion; stigma; the myth of mental illness.

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