Programs
(Interviews)
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Interviews with Pioneers

Michael Shepherd

On Epidemiology in Psychiatry

Leonardo Tondo

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Biographical sketch

Michael Shepherd (1923–1995) was born in Cardiff to a Jewish family originating in Odessa and Poland. He married Margaret Rock in 1947, who died in 1992, after a long illness. They had four children.[1] He obtained his bachelor medical degree at the Oxford University, where he was influenced by John Ryle,[2] a professor of social medicine, to pursue the social implications of mental disorders. In 1952, he started his career at the Maudsley Hospital and Institute of Psychiatry[3] and obtained a doctorate in medicine from Oxford University, in 1954.

In 1955–56, he trained at the Johns Hopkins School of Public Health in Baltimore and visited several psychiatric centers in the United States to obtain material for a critical survey of American psychiatry.[4] He documented a major difference in psychiatry in the US and UK as an emphasis on public services in the UK and dominant private office practice in the US. He noted

that "nearly 3,000 of the 7,500 recognised [American] psychiatrists in 1951–1952 listed private practice as their major activity…one-quarter of them were engaged in the practice of psychotherapy and were not considered to meet the traditional criteria of the practice of medicine." Moreover, he found that American psychiatrists seemed to have a "distaste for the tracts of detailed knowledge dismissed as 'descriptive psychiatry'; an antagonism to many of the facts and concepts associated with the study of heredity; a neglect of much biological investigation; and…in many centers, a biased ignorance of the evolution and the historical roots of modern psychiatry." He also pointed out the "frosty reception… for the 'tranquilizing' drugs" by US psychiatrists, along with the dominance of psychoanalysis, noting that many US centers, "ingested the whole system, python-like, into the body of academic opinion," This dominance led to "an interest in mental health only in the individual and much less for the society in which he lives," as he further noted in a report on the use of psychotherapies in Britain.[5]

In 1961, he became Reader in psychiatry at the Institute of Psychiatry, where in 1967, he was conferred a chair in epidemiological psychiatry. He remained there for the remainder of his professional career. He became Fellow of the *Royal College of Physicians* in 1970, and in the following year, he was among the founders of the *Royal College of Psychiatrists*. Later, he was also named Fellow of both the *American Public Health Association* and the *American Psychological Association*. He was the founding editor of the journal *Psychological Medicine,*[6] in which he invested an enormous amount of energy until 1993, when he resigned from his position of editor-in-chief.

Michael Shepherd's interest in social issues associated with mental problems was stimulated by the teaching at the Maudsley Institute of Aubrey Lewis,[7], who insisted that the collection of social data was more important than personal details about individual patients. Shepherd had a special respect for Lewis as his mentor, to whose qualities he aspired for himself.[8] He described Lewis as, "the style of a man," referring to the richness of Lewis' writing. It has been suggested that Shepherd's style of writing was even better, lighter, more vivid, and amusing.[9]

Shepherd was one of the most influential and internationally respected psychiatrists of his time. He was Professor of Epidemiological Psychiatry at the Maudsley Institute of Psychiatry. He was the author of 30 books, among which, *Psychiatric Illness in General Practice* (1966), and of more than 200 scholarly articles. He masterminded the development and production of the monumental, five-volume *Handbook of Psychiatry* (1982). His main interests certainly were in

the epidemiological approach in psychiatry and on the effects of social issues in the lives of individuals.[10]

Shepherd also was convinced that better mental health care could be achieved by better training and support for general practitioners in the British National Health System. This position was not entirely appreciated by his psychiatric colleagues and it stirred a debate that lasted many years before eventual acceptance of his opinions.[11]

Among his works, his collection of biographical essays, including on John Ryle, Aubrey Lewis[12] and Jean Starobinski[13] have received special praise. He was described as the *Hammer of Psychoanalysis* owing to his critical view of the Freudian approach as a scientific method.[14] He brilliantly expressed his perspective in the essay *Sherlock Holmes and the case of Dr Freud*, in which he coined the neologism *mythod* to describe a combination of method and myth with minimal scientific value. This essay demolished psychoanalysis as a scientific discipline, and incidentally relegated Conan Doyle to the category of very minor writers.

He was not an enthusiastic supporter of Kraepelin's classification of mental disorders. According to the German psychiatrist, major functional mental disorders fell into two main groups: dementia præcox and manic-depressive insanity. Shepherd considered this scheme to be "a primitive exercise … with so many methodological flaws as to render it unacceptable to any editor of a peer-review journal."[15] Shepherd's view of Kraepelin's work had a strongly political cast: "At the same time attention is drawn to the limitations of his general outlook and to his political views, which in their historical context carry disturbing overtones of proto-fascism. It does not detract from the value of his work as a clinical scientist to conclude that his philosophical amblyopia, allied to an ineradicable chauvinism that was shared by many Germans of his class and status, resulted in a failure to demarcate the boundaries of his professional expertise and distorted his judgment on the wider implications of his own achievements."[16] The accusation of "*proto*-fascism" reflects the fact that Kraepelin died, in 1926, before the tragedy of Nazism emerged, whereas Shepherd wrote in 1995 from a very different historical perspective that included having lived through World War II and the Holocaust.

According to many colleagues who knew him well, Shepherd was highly cultivated, as witnessed by a pleasant and startling paper on psychohistory.[17] He was fluent in several European languages and familiar with German and French, as well as Anglo-American psychiatry. His legacy certainly is tied to understanding the social origins and the political context of psychiatry. "No other individual in British psychiatry could move with such felicity

and wisdom from an analysis of the racism inherent in the thinking of Emil Kraepelin to an exposition on the Sherlock Holmes-type fantasy at the heart of the great Freudian mythology."[18]

About the Interview

I met Professor Michael Shepherd on May 30, 1987, during the 16th Congress of the Italian Association of Psychiatry, held in Cagliari, Sardinia, where he had been invited to give a lecture titled *Psychogeriatrics and the Neo-Epidemiologists*. The venue was the Forte Village, a posh sea resort in the south of Sardinia. We dined together the night before the congress, along with his wife, a gentle and affable lady. Professor Shepherd struck me for the tranquility he communicated; he had a peaceful expression, with the subtle smile of people who practice irony diligently and eyes that hardly left the prey. The next day, on a sunny and warm morning, during which he never thought of taking off his winter jacket, we spoke for nearly an hour.

The interview

LT: What do you think about the current importance of epidemiology for affective disorders? I have read that epidemiology is considered the most important aspect of health organization in your country.

MS: As you know, there are several different dimensions of investigation which are covered by the one word 'epidemiology.' It is a word with several meanings, although probably for most people the principal significance of epidemiology in the field of mental disorder has been as a method of making an accurate assessment of the amount of mental illness which exists in a defined population and providing the necessary information on the extent of the disease, the strategy for screening, and the resources for effective intervention. It is what we call 'head-counting,' and what it has done for the psychiatric profession is to demonstrate that psychiatrists see very little mental illness because they know nothing about the existence of mental disorder in the general population. If you take a public-health point of view—and epidemiology is the science of public health—then you ask not how many patients are in the hospital, but how many patients and illnesses you find in the whole population. And in descriptive terms, the most important category has been affective disorders. We have discovered through epidemiological enquiry that affective illnesses constitute easily the largest group of disorders in the general population, and this [conclusion] has come almost entirely from epidemiological research.

However, a major obstacle in the way of epidemiological inquiry has been the dominance of subjective phenomena, always difficult to measure accurately.

LT: Have affective disorders changed in prevalence from the beginning of this century when a kind of objectification of psychiatry started with the work of Kraepelin? I am interested particularly in the possible change of prevalence of affective disorders considering that this century has seen two world wars. Do you think that these major events changed the prevalence of affective disorders in any way?

MS: I think that unfortunately you cannot answer this question on the basis of published information because what you call 'objective' enquiry in psychiatry was almost exclusively confined to hospital conditions. Kraepelin knew nothing about the general distribution of illness.[19] He, like most of the older clinicians, appears to have been virtually innumerate. What has emerged by the epidemiological studies is that the less severe forms of depression far exceed in number the major variants which come to hospital and that they are identified and managed chiefly by non-psychiatrists, particularly by general practitioners. This would mean that the role of general practitiners needs to be reinforced, as well as the collaboration with the psychiatrists as recommended by the World Health Organization (WHO) and the Committee for the Prevention & Treatment of Depression. However, the contributors nowhere acknowledge the epidemiological foundations of which their discussions are based. The function of the psychiatrist was to deal with severe mental disorder and I think it has been only since the end of the Second World War that people have begun to make systematic observations on affective disorders and insufficient time has elapsed to give you a time trend.

LT: What is your own opinion on the possibly increased need for psychiatric consultation on affective disorders? Is this because affective disorders have increased dramatically in the last forty years or because there are simply many more psychiatrists now?

MS: I do not believe in personal opinions except for general discussion. But for what it is worth, I would say that there have been two factors: the first is the increase in epidemiological studies everywhere which makes people understand that many members of the general population suffer from what we call 'minor' affective disorders, and do not go to psychiatrists. They see their general practitioners or they ask their mothers what they should do. And now we understand that there are many such subjects. During a meeting in 1974, one speaker remarked that possibly in 40%–50% of all patients consulting a general practitioners for any reason, no organic causes for their symptoms can be found. That raises the question as to whether all these patients should be

regarded as psychiatric cases. The answer is ‘no’. The second reason has been the arrival of drugs which are used widely for this purpose. And if you describe a drug as an antidepressant, for example, and the patient or an individual takes the drug, then he becomes ‘depressed’ — because he is taking an antidepressant.

LT: The Oedipus Effect?

MS: I think it is more than the Oedipus Effect. It is an Oedipus effect with commercial implications. And it is true in every country. I have a colleague who likes to say that the diagnosis is benzodiazepine and the treatment is anxiety and one knows what he means. You make the diagnosis through the drug and because there are now so many drugs which are supposed to be used for affective illness, we have apparently an increase.

LT: Might it be possible that in thirty years we will not talk about anxiety but rather about benzodiazepine plus or minus something?

MS: Yes. Certainly I think that we will learn a great deal about neural transmission and about the pharmacological activities of centrally-acting drugs. But whether we learn about depression, well let's wait thirty years and see![20] Even the concept of depression is quite scattered, appearing as it does, in the categories of psychosis, neurosis, personality disorder, alcoholism. The patterns or syndromes in terms of the phenomena of the illnesses, their outcome and their response to treatment is a sore need for the elucidation of depressive states.

LT: Can psychiatric epidemiology give an answer to the contributions of environment in causing affective disorders?

MS: It is not possible to provide an answer to that at the moment, but it may help to make observations, which will enable one to make more accurate statements than are made at the present time, by selecting populations which differ in their environmental conditions. For example, if you have two populations, which differ in their environmental conditions, two populations where one is subject to a lot of stress and the other is not, where one is urban and one is rural, you can use a comparison of the prevalence rates of affective disorder to outline the environmental component. By exclusion, because you cannot do this directly with the epidemiological method, you can introduce the element of constitutional factor. I mean a recent example of an American genetic study[21] of depression is a very good example of using a special population with a biological technique, which could not have been possible if the environment

had not been as stable as it was. So, that in theory, yes. But at the moment, it is only in limited areas has this been done.

LT: Do you think that in the United Kingdom epidemiological psychiatry is more important than in other European countries or the United States?

MS: I do not know whether it is important but I think it has a different emphasis. And I think there are several reasons for this. The first is the existence of a national health service, which makes it possible to carry out enquiries more easily than in other countries and the second is that there is a tradition in the United Kingdom which makes epidemiology part of clinical activity, so that many of the people who work in this field, for example myself, are also clinicians. It is possible to be an epidemiologist in psychiatry without being medically qualified. Statisticians, sociologists, psychologists, stenographers, geneticists, all use the epidemiological method. But what has happened in Britain is that it has become part of the clinical teaching and the importance of this is that many of the hypotheses of epidemiology arise from clinical observation. If you don't see patients, you have no opportunity to know what type of hypothesis to examine. I think that gives the subject some distinguishing features in the United Kingdom.

LT: I seem to understand that you make use of somatic treatments, but it would appear that you are in some way skeptical about long-acting drugs. You mentioned that these medicines can cover spontaneous remissions for a disease due to the fact that 25% of the population can go into spontaneous remission. Do you agree with this?

MS: You are now speaking of schizophrenia, not affective disorders.

LT: I am speaking of long-acting drugs.

MS: But of course the example concerns schizophrenia and the study which I described was based on the claim that intramuscular injections of fluphenazine were most effective because they avoided the problem of non-compliance. And we were struck by the number of patients who seemed to be receiving these injections unnecessarily because once you begin to receive it, it is very difficult to stop. It was suggested that fluphenazine for schizophrenia is like insulin to diabetes. You MUST continue. We thought that there was no pharmacological evidence to support this and so we did a comparative study. From the results, I think we were right to do this because other people have since made similar observations. But it is not so much the study itself I was trying to emphasize, as the approach to answering a question about treatment. And I think

that one could generalize from this small study, although it took five years to do, to every branch of psychiatry.[22]

LT: Do you think the same speaking of affective disorders, for example, using treatment with lithium salts?

MS: Oh yes. Of course we have published material on this matter, as well as with lithium and other forms of antidepressant medication. The method is exactly the same. And it seems to me that until this type of study has been carried out, it is unjustifiable to suggest that patients should receive drugs indefinitely. And as you know, there are now very grave doubts about lithium being expressed in several centers. You probably know that some years ago, I unintentionally caused problems about this; we wrote a paper[23] questioning the evidence before lithium was widely introduced, and Dr. Schou was very agitated. And I see more and more reports in the clinical literature raising doubts about the long term efficacy of lithium. I think it would have been better to do this type of study before it became generally the practice to give patients with manic depressive disease lithium for a long period of time.[24]

LT: Do you suggest withdrawal of the treatment from time to time?

MS: In some cases, I think that is certainly justified. The difficulty, of course, is that from a purely clinical point of view, it is not always easy to do this because the patient has become dependent partly on the lithium and partly on the ritual of lithium administration. And it is not always easy to persuade the patient that he does not need the drug. Because he may need the injection and the attention and everything that goes with it. It is a little like the treatment of long-term hypertension. But, in principle, my answer would be that all cases should be carefully looked at.

LT: What is your concept of normality in psychiatry and in affective disorders? Do you have something more than a personal opinion of normality?

MS: I can only answer this in general terms. There are two radically different notions of normality. One is a statistical matter, which would require quantitative information of a large population; the other is the type of question that arises if you ask what is a normal blood pressure, You cannot answer this without taking the blood pressures of 10,000 people and giving the normal range. You have a range, which is regarded as normal in purely quantitative terms. And the other is to ask simply whether or not the person in the end develops morbid affective phenomena. And that is using the same notion of normal/abnormal but in a different way. I think

that the first is what a chemical epidemiologist would imply and the second is the way you function as an ordinary clinician.

LT: Thank you very much.

MS: Thank you.

Notable comments:

Kraepelin knew nothing about the general distribution of illness.

I would say that there have been two factors: the first is the increase in epidemiological studies everywhere which makes people understand that many members of the general population suffer from what we call 'minor' affective disorders, and do not go to psychiatrists. They see their general practitioners or they ask their mothers what they should do.

And if you describe a drug as an antidepressant, for example, and the patient or an individual takes the drug, then he becomes 'depressed' —because he is taking an antidepressant.

It is an Oedipus effect [about the use of more psychotropic medications] with commercial implications. And it is true in every country. I have a colleague who likes to say that the diagnosis is benzodiazepine and the treatment is anxiety and one knows what he means.

And, as you know, there are now very grave doubts about lithium being expressed in several centers. You probably know that some years ago, I unintentionally caused problems about this; we wrote a paper questioning the evidence before lithium was widely introduced and Dr. Schou was very agitated.

You have a range which is regarded as normal in purely quantitative terms. And the other is to ask simply whether or not the person in the end develops morbid affective phenomena. And that is using the same notion of normal/abnormal but in a different way. I think that the first is what a chemical epidemiologist would imply and the second is the way you function as an ordinary clinician.

Endnotes

[1] Biographical information from Russell G.: Michael Shepherd, Obituary in: Psychiatric Bulletin 1996; 20: 632–637; Clare Anthony: Michael Shepherd, Obituary. The Independent August 30, 1995 (access: September 21, 2015).

[2] John Alfred Ryle (1889–1950), British physician and epidemiologist, Fellow of the Royal College of Physicians since 1924, became the chair of the Institute of Social Medicine at the University of Oxford in 1943. He was also physician of the King George V.

[3] The Maudsley Hospital in South London and is the largest mental health training institution in the UK; it is partnered with the Institute of Psychiatry of King's College. It was founded in 1907 when the Victorian psychiatrist Henry Maudsley offered London County Council the sum of £30,000 to help found a new mental hospital that would be exclusively for early and acute cases rather than chronic cases, have an outpatient clinic, and provide for teaching and research (Wikipedia 2015).

[4] a. Shepherd M. An English view of American psychiatry. Am J Psychiatr 1957; 114: 417–420.

b. Shepherd M. A critical appraisal of contemporary psychiatry. Compr Psychiatry 1971; 12: 302–320.

[5] Shepherd M. Psychoanalysis, psychotherapy, and health services. Br Med J 1979; 15: 1557–1559. The paper introduces the issue with an amusing quotation from *Time* magazine (Psychiatry on the couch, April 2, 1979, p.74) in which psychoanalytical psychiatry is presented in the role of a patient with the following clinical aspects:

History: European born. After sickly youth in the US, travelled to Vienna and returned as Dr. Freud's Wunderkind. Amazing social success for one so young. Strong influence on such older associates as Education, Government, Child Rearing and the Arts, and a few raffish friends like Advertising and Criminology.

Complaint: Speaks of overwork, loss of confidence and inability to get provable results. Hears conflicting inner voices and insists that former friends are laughing behind his back.

Diagnosis: Standard conflictual anxiety and maturational variations, complicated by acute depression. Identity crisis accompanied by compensatory delusions of grandeur and a declining ability to cope. Patient averse to the therapeutic alliance and shows incipient overreliance on drugs.

Recommended treatment: requires further study.

Prognosis: problematic

[6] The journal was established in 1969 by Michael Shepherd who remained its editor in chief until 1993. Shepherd insisted on the the term 'psychological' instead of 'psychiatric' apparently in continuity of the *Journal of Psychological Medicine* founded by Forbes Benignus Winslow (1810–1874) in 1848.

[7] Sir Aubrey Julian Lewis, (1900–1975) was born in Australia. In 1946, he became the first Professor of Psychiatry at the Institute of Psychiatry in London. He was a great supporter of the unitarian view of depression following Adolf Meyer's ideas. Lewis was pragmatic in his approach to diagnosis: "if clinical differences did not make a difference in practice, then there was no difference" and very little interested in classification of mental disorders. (see also interview with Sir Martin Roth).

[8] Rawnsley K. *The Contribution of Michael Shepherd. In The Scope of Epidemiological Psychiatry: Essays in Honour of Michael Shepherd*. London: Routledge; 1989, pp. 509-21.

[9] See Russell in note 1.

[10] Several publications are devoted to this main research theme for which a small but prestigious selection is provided:

a. Shepherd M, Cooper B. Epidemiology and mental disorders: A review. J Neurol Neurosurg Psychiatry 1964; 27: 277–290.

b. Shepherd M. Epidemiology and clinical psychiatry. Br J Psychiatry 1978; 133: 289–298.

c. Shepherd M. The application of the epidemiological method in psychiatry. Acta Psychiatr Scand Suppl 1982; 296: 9–16.

d. Shepherd M. Psychiatric epidemiology and the classification of mental disorder. Int J Epidemiol 1982; 11(4): 312–313.

e. Shepherd M. Psychiatric epidemiology and epidemiological psychiatry. Am J Public Health 1985; 75(3): 275–276.

f. Shepherd M. Urban factors in mental disorders – an epidemiological approach. Br Med Bull 1984; 40: 401–404.

g. Shepherd M. Historical epidemiology and the fucntional psychoses. Psychol Med 1993; 23: 301–304.

[11] a. Shepherd M. The prevalence and distribution of psychiatric illness in general practice. J R Coll Gen Pract 1973; 23(Suppl 2): 16–22.

b. Shepherd M. General practice, mental illness, and the British National Health. Am J Public Health 1974; 64: 230–232.

c. Shepherd M. Who should treat mental disorders? Lancet 1982; 1(8282): 1173–1175.

d. Shepherd M. Mental illness and primary care. Am J Public Health 1987; 77: 12–13.

[12] a. Shepherd M. A representative psychiatrist: the career and contribution of Sir Aubrey Lewis. Am J Psychiatry 1977; 134: 7–13.

b. Shephard M. Aubrey Lewis: the making of a psychiatrist. Br J Psychiatry 1977; 131: 238–242.

c. Shepherd M. From social medicine to social psychiatry: the achievement of Sir Aubrey Lewis. Psychol Med 1980; 10: 211–218.

d. Shepherd M. A representative psychiatrist: the career, contributions and legacies of Sir Aubrey Lewis. Psychol Med Monogr Suppl. 1986; 10: 1–31.

[13] Jean Starobinski (1920–), Swiss literary critic.

[14] See note 5.

[15] See Russell in note 1.

[16] a. Shepherd M. Kraepelin and modern psychiatry. Eur Arch Psychiatry Clin Neurosci 1995; 245:189–195.

b. Shepherd M. The two faces of Emil Kraepelin. Br J Psychiatry 1995; 167:174–183.

[17] Shepherd M. Clio and Psyche: the lessons of psychohistory. J R Soc Med 1978; 71: 406–412.

[18] See Clare in note 1.

[19] See notes 16 a and b

[20] Thirty years are almost passed and we still know very little about biological mechanism of depression.

[21] Cadoret RJ, O'Gorman TW, Heywood E, Troughton E. Genetic and environmental factors in major depression. J Affect Disord 1985; 9: 155–164.

[22] Several studies by Shepherd indicate that treatments with long-term injections are not superior to oral treatments. In particular, in one there was no difference between the two treatments (Falloon I, Watt DC, Shepherd M. A comparative controlled trial of pimozide and fluphenazine decanoate in the continuation therapy of schizophrenia. Psychol Med 1978; 8: 59–70); one more showed that patients on pimozide were significantly more favourably rated on aspects of sociability, use of leisure, warmth of personal relationships, household tasks and child-rearing. (Falloon I, Watt DC, Shepherd M. The social outcome of patients in a trial of long-term continuation therapy in schizophrenia: pimozide vs. fluphenazine. Psychol Med 1978; 8: 265–274), and a last one showed that the use of pimozide was associated with improvement in various

measures of social outcome (Shepherd M. Medico-social evaluation of the long-term pharmacotherapy of schizophrenia. Comparative study of fluphenazine and pimozide. Prog Neuropsychopharmacol 1979; 3: 383–389).

[23] A. Blackwell B, Shepherd M. Prophylactic lithium: another therapeutic myth? An examination of the evidence to date. Lancet 1968; 1(7549): 968–971.

b. Shepherd M. A prophylactic myth. Int J Psychiatry. 1970-1971; 9: 423–425.

c.Glen IA, Johnson AL, Shepherd M. Continuation therapy with lithium and amitriptyline in unipolar depressive illness: a randomized, double-blind, controlled trial. Psychol Med 1984; 14: 37–50.

The controversy is going on still at these days and can be followed in *Lithium Controversy* in Controversies in INHN's website.

[24] The rather harsh, dismissive, and highly critical paper by Blackwell and Shepherd on the prophylactic effect of lithium actually encouraged another controlled study by Mogens Schou on the prophylactic effect of lithium in mood disorders in which the efficacy of this treatment well demonstrated. Since then, several other studies have confirmed the efficacy of lithium.

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