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FORMERLY THE PSYCHIATRIC BULLETIN

Whistling in the wind

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The correct paradigm may be that of evolutionary psychiatry

Dr Thomas Szasz repeats his view that psychiatric illness does not exist, and that people should be held responsible for their beliefs and actions.¹ But what if we are presented with a mother who believes she has committed an unforgivable sin, and that she and her baby are infested with the devil, with the only solution being to kill herself and her child? We know that with treatment, or just with the passage of time, she will return to normal and realise that her 'sinfulness' was delusional. As I understand Dr Szasz, he would consider treating her to be 'a grave violation of her basic human rights' and he would advise us to let her 'minister to herself'. Yet does she not have a basic human right to be treated, even if she has no insight into her need for treatment?

It is likely that evolution has prepared mental states for extreme situations and that it is possible to enter one either because a person is in an extreme situation, or by mistake, on the 'smoke detector' principle that it is better to be frightened to death a hundred times thinking there is a lion in the bush rather than ignore one real clue that a lion really is there.² It may be impossible to tell whether a mental state is caused by a real danger or disaster, or is due to a psychic mistake. A depressed mother with a baby may be a member of one of those societies who try to maintain a constant population, whose surplus men go into monasteries and only one daughter per family is allowed to breed, and she may have offended against society's rules by getting pregnant outside marriage. In the *Book of Job*, Job lost his children and all his cattle and became depressed, but why did his so-called comforters not offer their condolences on the death of his children? This may suggest that the text can be as easily read as a story of a man who, owing to psychotic depression, had the delusion of loss of property and death of loved ones.³ In psychiatric practice we are often dealing with people who have entered states of depression and anxiety when there is no real cause – are we not to help them?

The paradigm here is evolutionary psychiatry.⁴ It is not necessary to view these deluded and anxious people as either sinful or responsible – whether or not we treat them as 'sick' depends on factors such as eligibility for NHS healthcare and other practical matters. We have been fashioned by evolution to suffer inappropriate extremes of mental pain and delusional ideas – it is more important to help these people back to normality than to spend time discussing whether they are sick or bad or should bear responsibility for themselves.

I must acknowledge one debt to Dr Szasz. In my long career in working age psychiatry, I was often asked by troubled patients what to say when, applying for a job, they were asked whether they had ever had mental illness. Knowing of the stigma and prejudice that a positive answer would probably arouse, I was able to say to them with a clear conscience, 'Think Szasz and say 'No!''

1 Szasz T. The myth of mental illness: 50 years later. *Psychiatrist* 2011; **35**: 179–82.

- 2 Nesse RM. Natural selection and the regulation of defences: a signal detection analysis of the smoke detector principle. *Evol Hum Behav* 2005; **26**: 88–105.
- 3 Price JS, Gardner Jr R. Does submission to a deity relieve depression? Illustrations from the Book of Job and the Bhagavad Gita. *Philosophical Paper Rev* 2009; **1**: 017–31.
- 4 Bruene M. *Textbook of Evolutionary Psychiatry: The Origins of Psychopathology*. Oxford University Press, 2008.

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Just the facts, please

Edward Shorter's riposte to 'The myth of mental illness' cuts through the redundant reasoning of Szasz, in some style.^{1,2} Shorter succeeds by contrasting the notions of mental illness in the 1960s with modern science of the brain. In doing so, he also highlights the progression of psychiatry during this period. Unfortunately, his argument is undermined by unscientific claims. How many suicides resulted from anti-psychiatry? How many are due to *One Flew Over the Cuckoo's Nest*? Shorter says 'many'. If this is based on evidence, a reference should be cited. If not, why include conjecture in an otherwise excellent commentary?

- 1 Shorter E. Still tilting at windmills: Commentary on . . . The myth of mental illness. *Psychiatrist* 2011; **35**: 183–4.
- 2 Szasz T. The myth of mental illness: 50 years later. *Psychiatrist* 2011; **35**: 179–82.

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Ill-mannered and ill-informed

It is astonishing to read in *The Psychiatrist* the coarse, ignorant and abusive screed by Edward Shorter as a commentary on the 50th anniversary of Szasz's scholarly book, *The Myth of Mental Illness*.

The book contains 'bombast', Shorter declares, and 'cock-eyed belligerence.' Portentously, Shorter explains that: 'in the way of its fraudulent notions', and those of the movie *One Flew Over The Cuckoo's Nest*, along with the anti-psychiatrist writings of Foucault, Laing and Cooper (who actually were quite unconnected with Szasz, his book, and the film) people decided not to seek psychiatric help and 'many died by suicide' instead for which the 'anti-psychiatry gurus' were therefore responsible.

Shorter cites no published evidence for this demonising of Szasz and the anti-psychiatrists and in fact there is none to cite. If this were not enough, Shorter goes on to make pronouncements about psychoanalysis, which he declares is dead. Does he mean dead in Toronto where he lives, or

worldwide? Either way his pronouncement is nonsense I am personally acquainted with psychiatrists in academe in Toronto who are very much involved with and practise psychoanalysis. Also, I live in Italy, where psychoanalysis is alive and well as ever.

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Whistling in the wind

There are reasons to be critical of Thomas Szasz's views about mental illness. For example, few would want to go as far as him in recommending that society manage without a mental health act. His definition of illness as physical lesion also unnecessarily excludes psychological dysfunction as illness.

In his commentary,¹ Edward Shorter focuses on criticising Szasz on an issue on which he is in fact correct, namely that no biological markers have been found for mental illness. Shorter seems to be using his skills as a historian to suggest that psychiatry has overlooked what he calls obvious evidence of organicity from past research in the role of panicogens in triggering panic disorder; the response of catatonia to barbiturates and benzodiazepines; and hypothalamic–pituitary–adrenal dysregulation in melancholic depression (see my Critical Psychiatry blog entry on 16 May, <http://criticalpsychiatry.blogspot.com>). The general conclusion from this research, unlike that of Shorter, is that no biological cause of mental illness has been found. Even the American Psychiatric Association admit that 'brain science has not advanced to the point where scientists or clinicians can point to readily discernible pathologic lesions or genetic abnormalities that in and of themselves serve as reliable or predictive biomarkers of a given mental disorder or mental disorders as a group'.²

Szasz has been dismissed as an anti-psychiatrist. Even 50 years later, the point of his 'myth of mental illness' has not been understood. Shorter's unscientific attack on Szasz does not promote the interests of psychiatry.

1 Shorter E. Still tilting at windmills: Commentary on . . . The myth of mental illness. *Psychiatrist* 2011; **35**: 183–4.

2 American Psychiatric Association. *American Psychiatric Association Statement on Diagnosis and Treatment of Mental Disorders*. Release no 03-39, September 25, 2003 (<http://www.psych.org/MainMenu/Newsroom/NewsReleases/2003NewsReleases/mentaldisorders0339.aspx>).

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Battling the wrong enemy!

Dr Shorter's *ad hominem* attack on Professor Szasz provides no convincing argument against Szasz's well-known position concerning what he regards as the spurious medicalisation of mental illness. Nor will there be wide agreement with Shorter that neuroscientific studies suggesting a 'neurological basis for much psychiatric illness' negate Szasz's firmly held beliefs.

It is regrettable that Dr Shorter missed the opportunity to remind our colleagues that the rampant misuse of psychiatry

50 years ago as described by Szasz is applicable to the way institutional psychiatry is practised today in many parts of the USA, Canada and the UK, and certainly in most of the other countries in the world.

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Another view of mental health tribunals

Dr Choong writes of his perception that the number of Mental Health Act Section 2 detentions is rising, and refers to 'an uncritical approach to using guidance that results in Section 2 being used much more frequently now' and the 'waste of time and resources in dealing with the inevitable extra tribunals'.¹

His perception mirrors the national picture. From 1998/9 to 2008/9, total uses of Section 2 in National Health Service (NHS) hospitals in England went from 20 874 to 23 482² and the numbers continue to rise (25 622 in 2009/10).³ Total use of Section 3 dropped slightly for the period 1998/9 to 2008/9,² from 22 738 to 21 538. There was a corresponding increase in conversions from Section 2 to Section 3 (4048 to 5145).² Data have to be examined carefully as figures may be given for England alone or England and Wales, give NHS and independent hospital figures either separately or together, and refer to total uses or admissions. Data usually refer to instances of detention, not the number of different individuals detained.

As to mental health tribunals being a waste of time and resources, I think there is room for another view. In 2007/2008, 21 849 applications were received, of which 10 380 were withdrawn before the hearing and 9137 were heard (3157 outstanding at year end); of those that were heard, 17% resulted in the section being discharged, which means over 1550 patients.⁴ It is not possible to say in how many cases the responsible clinician discharged the section in advance of the hearing because the impending hearing focused his or her attention on the question of whether continued detention was justifiable, but if this was the case in even 10% of those cases, this would amount to over 1000 patients being released from detention of doubtful legality because of a forthcoming tribunal.

If patients are first placed on Section 2 and then converted to Section 3, they will be entitled to two tribunal hearings within the first few months of detention, rather than the one they would have if Section 3 were used initially. Moreover, the first tribunal would occur within weeks of admission, instead of up to several months later. Given the substantial number of detentions that are ended by tribunals, the decision to use Section 3 rather than Section 2 initially would appear to result in a large number of people being detained on doubtful grounds for longer than necessary.

Statistics on managers' panels are not published, so it is much more difficult to make a comparable argument about their usefulness based on objective information about their decisions.

As a clinician, I believe that the discipline of having to prepare for mental health tribunals by thinking through the reasons why my patients should be detained often leads to

better decision-making and less restrictive care plans. The time it takes to write reports and attend tribunals seems a fair price to pay to ensure that those detained against their will have an effective right to challenge their situation.

- 1 Choong LS. The rise in the number of Section 2 detentions (letter). *Psychiatrist* 2011; **35**: 198.
- 2 The NHS Information Centre. *In-Patients Formally Detained in Hospitals under the Mental Health Act, 1983 and Patients Subject to Supervised Community Treatment: 1998–99 to 2008–09* (Appendix 2, Table 8). Health and Social Care Information Centre, 2009.
- 3 The NHS Information Centre, Community and Mental Health Team. *In-Patients Formally Detained in Hospitals under the Mental Health Act 1983 and Patients Subject to Supervised Community Treatment, Annual Figures, England 2009/10*. Health and Social Care Information Centre, 2010 (<http://www.ic.nhs.uk/pubs/inpatientdetmha0910>).
- 4 Administrative Justice and Tribunals Council. *Annual Report 2007/2008*. TSO (The Stationery Office), 2008 (http://www.justice.gov.uk/ajtc/docs/Annual_Report_2007_8.pdf).

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Reader feedback is helpful, but are the leaflets readable?

I was heartened to see an article evaluating the Royal College of Psychiatrists' patient information leaflets using quantitative and qualitative methods.¹ The provision of information is critical to my clinical practice and has often involved these very leaflets. I was also pleased that the authors acknowledged that 'much patient information is written in complex language and is poorly presented' as these are often barriers to patients accessing information. Disappointingly, however, they did not conduct any analysis of the language; one respondent had commented regarding one leaflet that 'It has quite a high reading age'.

The complexity of language can be assessed using a range of readability measures such as Flesch Reading Ease (FRE; a document should have a score of greater than 60, the higher the score the easier it is to read) and Flesch–Kincaid Grade Level (FKGL; refers to US school grades, so lower scores indicate better readability – a 13 year old should understand a document scoring 7). These are widely available, contained within word processing packages, and have been used to evaluate patient information leaflets in other specialties¹ and standard appointment letters in child and adolescent mental health services.² When these measures are applied to the College leaflets (Table 3 in the paper), the mean FRE is 7.81 (7.1–8.4) and mean FKGL 63.13 (58.7–69.8). This suggests the leaflets are readable as far as these computerised measures are concerned but their readability could be improved. When the top- and bottom-ranked leaflets (Table 3, which, curiously, has four highest ranked and three lowest ranked rather than four of each as described in the text) are compared, there is no statistical difference on either of the measures. This confirms that, although the language may be readable, the reader may not like the content.

I was confused by the quantitative method employed in the study. The original feedback was on a 5-point Likert scale ranging from 'strongly agree' to 'strongly disagree'. These are

ordinal variables (variables which represent categories of a feature with some inherent ordering³); however, they were converted into continuous variables (one which can take any value within a range³) and analysed as such. Unfortunately, one cannot convert discrete categories into a linear scale in this way. Given this conversion, the values could only range 1–5, and it is unsurprising that the authors found there was little variability in the feedback 'scores' assigned to each leaflet. It was also confusing to find that a correlation between modalities was included in the discussion but not presented in the results. My understanding of the analysis would have been aided to see the information presented in the original categories which those reading the leaflets had decided.

Despite these potential improvements and confusions, the conclusion remains undoubtedly true that 'reader feedback provides invaluable guidance about the substance and presentation of our public mental health information.' One can only hope that we continue to strive to produce information which is accessible to those who need it.

- 1 Briscoe M, Briscoe S, Timms P, Ramsay R. Usefulness of reader feedback on the Royal College of Psychiatrists' public information leaflets. *Psychiatrist* 2011; **35**: 175–8.
- 2 Payne S, Large S, Jarrett N, Turner P. Written information given to patients and families by palliative care units: a national survey. *Lancet* 2000; **355**: 1792.
- 3 Bennett DM, Gilchrist A. Readability of standard appointment letters. *J Ment Health Fam Med* 2010; **7**: 101–6.
- 4 Harris M, Taylor G. *Medical Statistics Made Easy* (2nd edn). Scion, 2009.

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Readability analysis?

As a trainee member of the Royal College of Psychiatrists' Public Education Editorial Board, I read with interest the review of reader feedback on the College online public education leaflets.¹ I was struck by both the popularity of the public information section of the website and the high volume of completed feedback forms. I wondered, however, whether the authors have considered further analysis of the College information leaflets, to identify potential causes for the poorly scoring leaflets that they describe in the article.

The authors refer to an analysis of free-text feedback in which they name the two highest and lowest scoring main leaflets. It is perhaps unsurprising that poorly scoring leaflets would be more likely to receive negative comments, but what interested me most was the example constructive comment in response to the cannabis and mental health leaflet that said 'It has quite a high reading age'.

If the College information leaflets aim to reach a wide audience, it would seem sensible to establish whether the comment about reading age is in fact true for all leaflets. Is their readability consistent with the recommended level? And have the authors considered analysing whether there is a correlation between the reading age of the highest and lowest scoring leaflets?

A number of papers have looked into the readability of information made available on websites^{2,3} and in patient information leaflets.^{4,5} According to the literature, a Flesch–Kincaid 6th Grade (equivalent to UK reading age of 11–12 years) is the maximum recommended level for public health information,¹ and would be consistent with the average UK reading age quoted as being between 9 and 11 years.⁴

There are, of course, a variety of different readability tests that could be used to examine the readability level of the College information leaflets, including Flesch–Kincaid and Flesch Reading Ease and Simple Measure of Gobbledygook formulae.² Whether or not a correlation exists between readability age and the leaflet scores, I would suggest it is pertinent to clarify whether all the College leaflets are written at a readability level consistent with that recommended for public health information.

- 1 Briscoe M, Briscoe S, Timms P, Ramsay R. Usefulness of reader feedback on the Royal College of Psychiatrists' public information leaflets. *Psychiatrist* 2011; **35**: 175–8.
- 2 Kalk NJ, Pothier DD. Patient information on schizophrenia on the internet. *Psychiatr Bull* 2008; **32**: 409–11.
- 3 Fitzsimmons PR, Michael BD, Hulley JL, Scott GO. A readability assessment of online Parkinson's disease information. *J R Coll Physicians Edinb* 2010; **40**: 292–6.
- 4 Clauson KA, Zeng-Triettler Q, Kandula S. Readability of patient and health care professional targeted dietary supplement leaflets used for diabetes and chronic fatigue syndrome. *J Altern Complement Med* 2010; **16**: 119–24.
- 5 Pothier L, Day R, Harris C, Pothier DD. Readability statistics of patient information leaflets in Speech and Language Therapy Department. *Int J Lang Comm Dis* 2008; **43**: 712–22.

Declaration of interest

M.B. was educational supervisor during L.M.H.'s attachment to the Public Education Editorial Board.

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Surprising discrepancy between high prevalence of suicidality and low BSI scores

I would like to congratulate Meerten *et al*¹ on their excellent paper about MedNet, a service for doctors experiencing psychological problems; and, furthermore, for setting up and running the service in the first instance.

The authors cite that doctors are a vulnerable group with high rates of psychological disorders. This is in keeping with previous work myself and colleagues conducted on junior doctors using the 12-item General Health Questionnaire, albeit at a time when they were undergoing a period of extreme stress (the MTAS fiasco).^{2,3} We found that 79% of the sample scored above the cut-off point for psychological distress and 21% for severe distress (i.e. caseness for treatment).³

What perplexed me about the paper, however, were the high rates of suicidality in the MedNet sample (nearly half) but the relatively low scores on the Brief Psychiatric Interview.

I am not sure that this discrepancy is explained sufficiently in the discussion or, indeed, why the suicidality persisted post-treatment despite the other range of outcome measures used indicating improvement.

I would like to hear more from the authors about their views about this phenomenon.

- 1 Meerten M, Bland J, Gross SR, Garelick AI. Doctors' experience of a bespoke physician consultation service: cross-sectional investigation. *Psychiatrist* 2011; **35**: 206–12.
- 2 Whelan P, Jarrett P, Meerten M, Forster K, Bhugra D. MTAS fiasco: lessons for psychiatry. *Psychiatr Bull* 2007; **31**: 425–7.
- 3 Whelan P, Meerten M, Rao R, Jarrett P, Muthukumaraswamy A, Bhugra D. Stress, lies and red tape: the views, success rates and stress levels of the MTAS cohort. *J R Soc Med* 2008; **101**: 313–8.

Declaration of interest

P.W. and M.M. know each other well.

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Psychiatry training and career conundrums – a working mother's perspective

This letter stems from an experience of the numerous problems and choices that a working mother, and a psychiatric trainee, has to face and ones that I hope that many other working mums in psychiatry training will be able to empathise and identify with. Hopefully, it will provide some food for thought and determination to continue a career with a greater conviction.

Having chosen psychiatry as one of my specialty interests as a foundation doctor, I decided to continue my further training in psychiatry, fascinated by the subject, with the work-life balance it offers and the non-resident on-calls at many places as the added attraction. Being a trainee in core psychiatry training seemed to be the right job and the right pace of work I was looking for. But that is when our little one came into our lives and things changed.

Taking time off for maternity leave and coming back to part-time working as a less-than-full-time trainee prolonged the period of training. Specialty training lasts a good number of years and thus extended led me to think about the 'quarter-life crisis'¹ that many trainees in similar circumstances might face. Full-time training helps to achieve training goals earlier but part-time training allows for a more balanced life and more free time for family and children.^{2,3} Trainees move in and out of jobs and are committed to training and flexible working.

Indeed, career goals need to be matched to individual circumstances. Many a time I struggled with swapping rotas and arranging for picking up and looking after our child. This made me think time and again whether I should just change my specialty to another interesting basic science or para-clinical subject that will help me avoid the rota headache. There is also the issue of career progression and being an

'eternal' trainee. This would be even more relevant if we plan to expand our family. Which reminds me of a situation when I have been jokingly advised not to have babies until becoming a consultant!

May I conclude that being a working mother and juggling family life as well as trying to make a successful career, and finding that right balance, is a tremendous, albeit immensely gratifying task indeed.

1 Atwood JD, Scholtz C, I Nicholls. The quarter-life time period: an age of indulgence, crisis or both? *Contemp Fam Therapy* 2008; **30**: 233–50.

2 NHS Medical Careers. Less than full time training. NHS Medical Careers, 2011 (http://www.medicalcareers.nhs.uk/career_options/less_than_full_time_training.aspx).

3 Modernising Medical Careers. *A Reference Guide for Postgraduate Specialty Training in the UK – The Gold Guide, Fourth Edition*. Modernising Medical Careers, 2010 (http://www.mmc.nhs.uk/specialty_training/specialty_training_2011_final/gold_guide.aspx).

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