

**A LEVEL**  
*Teacher Guide*

# PSYCHOLOGY

H567  
For first teaching in 2015

## Issues in Mental Health Key Research Guide

Version 1



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This Core Studies guide is just a starting point for teachers and students. It is important that students understand the studies in-depth in order to answer any assessment questions. The assessment questions may ask them to extrapolate information from the studies or take their understanding of the studies and what they have taught us further.

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# On being sane in insane places

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## 1. Theory/ies on which the study is based

- Benedict (1934) suggested that normality and abnormality are not universal. What is viewed as normal in one culture may be seen as quite aberrant in another.
- Abnormality can be seen as any of: a deviation from the average, a deviation from the norm, a deviation from ideal mental health, personal distress, others' distress, maladaptiveness, unexpected behaviour, highly predictable/unpredictable behaviour, mental illness (Gross, 2010)
- The belief has been strong that patients present symptoms, that those symptoms can be categorised, and, implicitly, that the sane are distinguishable from the insane. Emil Kraepelin developed the first comprehensive classification system for mental disorders, believing they could be diagnosed from observable symptoms, just like physical illness.
- Two major western classification systems exist today - the American Psychiatric Association's 'Diagnostic and Statistical Manual of Mental Disorder' (DSM) and the World Health Organisation's 'International Classification of Diseases' (ICD). The two systems in use at the time of this study were the DSM IV and the ICD 10.
- The classification of mental disorder involves the identification of groups or patterns of behaviour or mental symptoms that reliably occur together to form a type of disorder. Techniques of assessment include the use of: behavioural observations, clinical interviews, psychological tests, and physiological tests.
- The DSM defines a mental disorder as a clinically significant syndrome associated with distress, a loss of functioning, an increased risk of death/pain, or an important loss of freedom. The manual emphasises that the problem should stem from within the individual, but does not specify whether it is biological, behavioural or psychological in nature. The manual describes diagnostic categories for mental disorder and lists the specific diagnostic criteria that have to be met for a diagnosis to be made. Assessment is usually made on five axes (which rates the highest level of social, occupational, and psychological functioning on a scale of 1 – persistent danger – to 90 – good in all areas – currently and during the past year) to provide a more complete picture of the individual.

# On being sane in insane places

Rosenhan, D. L. (1973) *Science*, Vol 179, (4070), 250–258

## 2. Background to the study

- Notions of normality and abnormality are not quite as accurate as people believe they are. However there is no question that some behaviours are deviant or odd e.g. murder, hallucinations and that the personal anguish associated with mental illness and psychological suffering exist e.g. anxiety and depression.
- Research has shown that the reliability of early classification systems e.g. DSM were very poor. Beck et al. (1962) found that agreement on diagnosis for 153 patients (where each patient was assessed by two psychiatrists from a group of four) was only 54%. This was said to be due to vague criteria for diagnosis and inconsistencies in the techniques used to gather data. Cooper et al. (1972) found New York psychiatrists were twice as likely to diagnose schizophrenia as London psychiatrists, who were twice as likely to diagnose mania or depression, when shown the same video-taped clinical interviews.
- Other studies have also shown the belief that symptoms can be easily categorised to allow a diagnosis of 'sane or insane' may be questioned e.g. Szasz (1961), Grove (1970), Sarbin (1972). Based in part on theoretical and anthropological considerations, but also on philosophical, legal, and therapeutic ones, the view has grown that psychological categorization of mental illness is useless at best and downright harmful, misleading, and pejorative at worst. Psychiatric diagnoses, in this view, are in the minds of the observers and are not valid summaries of characteristics displayed by the observed.
- The question of whether the sane can be distinguished from the insane (and whether degrees of insanity can be distinguished from each other) is a simple matter: do the salient characteristics that lead to diagnoses reside in the patients themselves or in the environments and contexts in which observers find them?
- Rosenhan believed that gains could be made in deciding which of these (the individual's disposition or the situation he is placed in) is the best explanation by getting normal people (that is, people who do not have, and have never suffered, symptoms of serious psychiatric disorders) admitted to psychiatric hospitals and then determining whether they were discovered to be sane and, if so, how. If the sanity of such pseudo-patients were always detected, there would be prima facie evidence that a sane individual can be distinguished from the insane context in which he is found. Normality (and presumably abnormality) is distinct enough that it can be recognized wherever it occurs, for it is carried within the person. If, on the other hand, the sanity of the pseudo patients were never discovered, serious difficulties would arise for those who support traditional modes of psychiatric diagnosis. Given that the hospital staff was not incompetent, that the pseudo patient had been behaving as sanely as he had been outside of the hospital, and that it had never been previously suggested that he belonged in a psychiatric hospital, such an unlikely outcome would support the view that psychiatric diagnosis betrays little about the patient but much about the environment in which an observer finds him.
- This research therefore set out to answer the question, can we tell the sane from the insane? Eight sane people gained admission to 12 different psychiatric hospitals. Their diagnoses and experiences are described by Rosenhan in this study.
- Rosenhan's study had three main aims:
  - To extend the efforts of previous researchers who had submitted themselves to psychiatric hospitalisation but who had commonly remained in hospitals for only short periods of time, often with the knowledge of hospital staff.
  - To test the diagnostic system in use at the time of the study (DSM IV) to see if it was valid and reliable. To do this he and seven other individuals got themselves admitted to psychiatric hospitals.
  - To observe and report on the experience of being a patient in a psychiatric hospital.

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## 3. Research method

- This is a field study in which Rosenhan uses a field experiment, participant observation and self-report.
- There are four main parts to Rosenhan's study:
- (a) The admission of the pseudo patients to the hospitals was studied as a field study. Rosenhan controlled the pseudo patients' procedure for gaining admission to hospital. Once admitted, pseudo patients became covert participant observers and gathered data regarding the experience of being a patient in a mental hospital through observing behaviours of staff and genuine patients and recording observations in notebooks. There was a field experiment component when patient or student (IV) went up to someone on campus to see how they responded (DV).
- (b) Once the pseudo patients were in the hospitals, the self-report method was also used. Pseudo patients asked specific questions of staff. He instructed his pseudo patients to ensure that any one member of staff was never approached more than once a day. Pseudo patients observed and recorded responses.
- (c) Rosenhan again used the *self-report* method and controlled six questions asked of Stanford University staff by a young lady. The young lady observed and recorded responses.
- (d) Rosenhan once again used the *self-report* method by asking staff to rate prospective patients on the likelihood they were a pseudo patient. A 10point scale was used with 1 and 2 reflecting high confidence that the person was a pseudo patient.
- Results were then analysed to produce both quantitative and qualitative data.

## 4. Sample

- The pseudo patients were eight sane people (five men, three women) who were a psychology graduate in his 20's, three psychologists, a paediatrician, a psychiatrist, a painter and a housewife.
- Once in the hospitals, the pseudo patients became participant observers with the psychiatrists, doctors, nurses and other members of staff at the hospitals together with the genuine patients also becoming participants.

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## 5. Outline of the procedure/study

### Part (a)

- Eight sane people / pseudo patients (five men, three women) - a psychology graduate student in his 20's, three psychologists, a paediatrician, a psychiatrist, a painter, and a housewife. All used fake names and those in mental health professions also used fake occupations. No other alterations of person, history or circumstances were made. The significant events of the pseudo patient's life history were presented as they had actually occurred. Relationships with parents and siblings, with spouse and children, with people at work and in school, consistent with the aforementioned exceptions, were described as they were or had been. Frustrations and upsets were described along with joys and satisfactions. These facts are important to remember. If anything, they strongly biased the subsequent results in favour of detecting sanity, since none of their histories or current behaviours were seriously pathological in any way.
- With the exception of Rosenhan who was one of the pseudo patients, the presence of pseudo patients and the nature of the research program were not known to hospital staffs. Rosenhan's presence was known to the hospital administrator and chief psychologist and, so far as he knew, to them alone)
- They sought admission to 12 hospitals (of varying ages, resources and staff ratios) across five states in the USA.
- Pseudo patients called the hospital and arranged an appointment at the hospital. On arrival they reported they had been hearing voices which were unclear, unfamiliar, of the same sex as themselves, and said, "empty", "hollow" and "thud".
- Once admitted, pseudo patients immediately behaved normally. They interacted with staff and patients and participated in ward activities. When asked by staff how he was feeling, he indicated that he was fine, that he no longer experienced symptoms. He responded to instructions from attendants, to calls for medication (which was not swallowed), and to dining hall instructions. Beyond such activities as were available to him on the admissions ward they observed the behaviour of staff and genuine patients and recorded their observations in a notebook. Initially these notes were written "secretly," but as it soon became clear that no one much cared, they were subsequently written on standard tablets of paper in such public places as the dayroom. No secret was made of these activities.
- Pseudo patients had the responsibility of persuading hospital staff that they were sane and could therefore be discharged.

### Part (b)

- In four of the hospitals pseudo patients approached members of staff and asked, "Pardon me Mr/Dr/Mrs X, could you tell me when I will be eligible for grounds privileges / ...when will I be presented at the staff meeting / ...when am I likely to be discharged?"
- While the content of the question varied according to the appropriateness of the target and the pseudo patient's (apparent) current needs the form was always a courteous and relevant request for information. Care was taken never to approach a particular member of the staff more than once a day, lest the staff member become suspicious or irritated.
- Pseudo patients observed the responses and recorded them in their notebooks.

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## 5. Outline of the procedure/study . . . continued

### Part (c)

- A young lady approached individual faculty members who seemed to be walking purposefully to some meeting or teaching engagement and asked them the following six questions: 1) "Pardon me, could you direct me to Encina Hall?" (at the medical school: "... to the Clinical Research Center?"), 2) "Do you know where Fish Annex is?" (there is no Fish Annex at Stanford), 3) "Do you teach here?", 4) "How does one apply for admission to the college?" (at the medical school: "... to the medical school?"), 5) "Is it difficult to get in?", 6) "Is there financial aid?"

### Part (d)

- Staff at a research and teaching hospital who were aware of the findings of the first study but doubted that such an error could occur in their hospital were warned that one or more pseudo patients would present themselves over the next three months attempting to be admitted to the psychiatric hospital. None actually did so.
- Each member of staff was asked to rate each patient who arrived at admissions / the ward according to the likelihood they were a pseudo patient. A 10 point scale was used, with one and two reflecting high confidence that the patient was not genuine.

## 6. Key findings

### Part (a)

- ALL the pseudo patients were admitted to the hospitals where they remained for between 7 and 52 days (mean length of stay = 19 days). seven out of the eight pseudo patients were diagnosed as schizophrenic, the other as manic-depressive psychosis, and when these were finally discharged, they left with the diagnosis of 'schizophrenia in remission'.
- None of the staff asked them what the notes were, they just assumed the behaviour was part of their illness and made comments in their records such as 'Patient engages in writing behaviour'. Other normal behaviours were also misinterpreted e.g. pacing the hospital corridors through boredom was a sign of anxiety, queuing early for lunch was observed by one psychiatrist as a characteristic of the oral-acquisitive nature of their syndrome.
- If anything went wrong and a patient became upset or distressed by the behaviour of the staff, the response was seen to be because of their illness not due to the situation (an extreme case of making dispositional not institutional attributions).
- Rosenhan noted there was a tremendous overlap between normal and abnormal behaviours. Everyone gets angry or upset and sometimes there appears to be no apparent reason for the reaction when it is considered as a proportion of the whole. However, if someone has been labelled insane, those behaviours will be perceived in a totally different way because the label distorts the interpretation of even the most normal activity or event. This seems to be what happened when medical practitioners made notes about the pseudo patients. One of them talked about his childhood and family which seemed to be a typical example of how individuals experience changes in relationships with parents as they grow up. Sometimes we are closer to one parent when we are young, but when we reach adolescence, we find we become closer to the other. This may be due to one of the parents finding it harder to relate to small children, but enjoy a new found closeness as the child matures. Similarly with marital relationships, they do not always run smoothly and occasionally minor rows can develop which are relatively meaningless. However, the case notes of this particular pseudo patient talked about him having a 'long history of considerable



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## 6. Key findings . . . *continued*

ambivalence in close relationships, which begins in early childhood! The notes continue by saying that his relationship with his father changes from being distant to becoming 'very intense. Affective stability is absent.' This last sentence means that his feelings have no stability – implying he has emotional swings. The report goes on to describe the fact that his efforts to 'control emotionality with his wife and children are punctuated by angry outbursts and, in the case of the children, spankings'.

- Pseudo patients' visitors said they saw no changes in their behaviour as a result of being hospitalised.
- Many real patients detected the pseudo patients' sanity – 35/118 genuine patients voiced their suspicions in the first three hospitalisations recognising they were fakes, making such comments as, 'You're not crazy, you're a journalist or a professor. You're checking upon the hospital,' probably as a result of the fact that they were making notes.
- Rosenhan reports that 2100 pills were handed out to the pseudo patients during their stays in the hospitals although all but two were flushed down the toilet. As long as the behaviour of the patients was acceptable whilst on the wards, such actions were not noticed.
- The staff tended to keep themselves away from the patients except for administrative or practical duties (inside the glass quarters, called by the pseudo patients 'the cage'). On average attendants spent 11.3% (range 3-52%) of their time outside the cage. Daytime nurses emerged from the cage, on average, 11.5 times per shift whilst late afternoon and night nurses emerging on average 9.4 times per shift.
- The doctors were even more remote and seemed to maintain the greatest distance except on admission and discharge. On average, physicians emerged on the ward 6.7 (range 1-17) times per day. Surely it should have been the other way round with these senior members of staff who wield the most power being the most familiar with the patients' case histories, and yet these doctors tended to see the patients on arrival and departure only.
- Personal hygiene and waste evacuation were often monitored. Many water closets had no doors.
- The other major impact on the pseudo patients was their complete lack of power in the psychiatric wards. Their movements were watched and restricted, they had virtually no contact with staff, their quarters and possessions could be entered and examined by any staff member, for whatever reason and their notes were available to all members of staff. They also suffered from a minimum of personal privacy, for example some hospitals had no toilet doors, examinations were conducted in semi-public rooms and on one occasion a nurse was observed adjusting her bra in full view of the patients. It was also found that there were instances of serious physical abuse to patients. Sometimes these were observed by other patients who were presumably considered to be irrelevant, but such instances of abuse of power were immediately stopped when another member of staff appeared.
- All pseudo patients experienced powerlessness and depersonalisation.

### Parts (b) and (c)

- Responses received by the pseudo patients versus a female student asking simple questions.

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## 6. Key findings . . . continued

### Parts (b) and (c)

- Responses received by the pseudo patients versus a female student asking simple questions.

	Psychiatric hospital	Psychiatric hospital	University campus	University medical centre	University medical centre
Responses(%)	Psychiatrists	Nurses	Faculty	'Looking for a psychiatrist'	'Looking for a doctor'
Moves on, head averted	71	88	0	0	0
Makes eye contact	23	10	0	11	0
Pauses and chats	2	2	0	11	0
Stops and talks	4	0.5	100	78	100
Mean number of questions answered(out of six)	*	*	6	3.8	4.8
No. of respondents	13	47	14	18	15
No. of attempts	185	1283	14	18	15

The most common response was either a brief response offered whilst they were 'on the move', with head averted, or no response at all.

Few staff made eye contact with pseudo patients.

Note also the lack of responses towards the pseudo patients compared with controls in both eye contact and conversation. Students were talked to 100% of the time whereas the pseudo patients were only talked to 4% of the time by psychiatrists and 0.5% by nurses. Another notable thing about these findings is that when the student asked where she could find a psychiatrist, the per cent response she got decreased to 78% indicating that people in general find mental illness quite hard to deal with.

### Part (d)

Although no pseudo patients actually presented themselves, out of 193 genuine patients who attended for psychiatric treatment, 41 were judged, with high confidence, to be pseudo patients by at least one member of staff. 23 were considered suspect by at least one psychiatrist and 19 one psychiatrist and one other staff member!

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## 7. Possible conclusions

- Psychiatric diagnosis is extremely inaccurate and that Rosenhan's claim 'we cannot distinguish the sane from the insane in psychiatric hospitals' is actually given considerable support / the sane cannot be distinguished from the insane in psychiatric hospitals.
- Hospitals seem to be special environments where behaviour gets easily distorted and patients are treated in such a way as to perpetuate any problems they may have rather than providing the kind of environment which would help and support them.
- Patients in psychiatric hospitals experience powerlessness and depersonalisation.
- Significant labelling can be in producing expectations and influencing behaviour; once a patient has been labelled 'insane', all subsequent behaviour is seen in the light of the label given. This was shown by the fact that patients were discharged with the label 'Schizophrenia in Remission'.
- Institutionalisation in psychiatric hospitals has negative effects on interred patients.
- Mental health workers are insensitive to the feelings and emotions of psychiatric patients.
- The DSM IV had poor reliability.
- The diagnosis of mental illness can be influenced by the situation an individual finds themselves in.

# Severe mental disorders in offspring with two psychiatrically ill parents Gottesman, I. I., Laursen, T. M., Bertelsen, A. & Mortensen, P. B. (2010) *Archives of General Psychiatry*, 67, (3), 252–257

## 1. Theory/ies on which the study is based

- A mental disorder, also called a mental illness or psychiatric disorder, is a mental or behavioural pattern or anomaly that causes either suffering or an impaired ability to function in ordinary life (disability), and which is not a developmental or social norm. Mental disorders are generally defined by a combination of how a person feels, acts, thinks or perceives. This may be associated with particular regions or functions of the brain or rest of the nervous system, often in a social context. Mental disorder is one aspect of mental health. ([http://en.wikipedia.org/wiki/Mental\\_disorder](http://en.wikipedia.org/wiki/Mental_disorder))
- Signs and symptoms of mental illness can vary, depending on the particular disorder, circumstances and other factors. Mental illness symptoms can affect emotions, thoughts and behaviours. Examples of signs and symptoms include: feeling sad or down; confused thinking or reduced ability to concentrate; excessive fears or worries, or extreme feelings of guilt; extreme mood changes of highs and lows; withdrawal from friends and activities; significant tiredness, low energy or problems sleeping; detachment from reality (delusions), paranoia or hallucinations; inability to cope with daily problems or stress; trouble understanding and relating to situations and to people; alcohol or drug abuse; major changes in eating habits; sex drive changes; excessive anger, hostility or violence; suicidal thinking. Sometimes symptoms of a mental health disorder appear as physical problems, such as stomach pain, back pain, headache, or other unexplained aches and pains. (<http://www.mayoclinic.org/diseases-conditions/mental-illness/basics/symptoms/con-20033813>)
- Schizophrenia is a severe mental disorder, characterized by profound disruptions in thinking, affecting language, perception, and the sense of self. It often includes psychotic experiences, such as hearing voices or delusions. It can impair functioning through the loss of an acquired capability to earn a livelihood, or the disruption of studies. Schizophrenia typically begins in late adolescence or early adulthood. There are effective treatments for schizophrenia and people affected by it can lead a productive life and be integrated in society. ([http://www.who.int/mental\\_health/management/schizophrenia/en/](http://www.who.int/mental_health/management/schizophrenia/en/))
- ICD-10: characteristics of schizophrenia:  
The schizophrenic disorders are characterised in general by fundamental characteristic distortions of thinking and perception, and by inappropriate or blunted affect. Clear consciousness and intellectual capacity are usually maintained, although certain cognitive deficits may evolve in the course of time. The disturbance involves the most basic functions that give the normal person a feeling of individuality, uniqueness, and self-direction. The most intimate thoughts, feelings, and acts are often felt to be known to or shared by others, and explanatory delusions may develop, to the effect that natural or supernatural forces are at work to influence the afflicted individual's thoughts and actions in ways that are often bizarre. The individual may see himself or herself as the pivot of all that happens. Hallucinations, especially auditory, are common and may comment on the individual's behaviour or thoughts. Perception is frequently disturbed in other ways: colours or sounds may seem unduly vivid or altered in quality, and irrelevant features of ordinary things may appear more important than the whole object or situation. Perplexity is also common early on and frequently leads to a belief that everyday situations possess a special, usually sinister, meaning intended uniquely for the individual. In the characteristic schizophrenic disturbance of thinking, peripheral and irrelevant features of a total concept, which are inhibited in normal directed mental activity, are brought to the fore and utilised in place of those that are relevant and appropriate to the situation. Thus thinking becomes vague, elliptical, and obscure, and its expression in speech sometimes incomprehensible. Breaks and interpolations in the train of thought are frequent, and thoughts may seem to be withdrawn by some outside agency. Mood is characteristically shallow, capricious, or incongruous. Ambivalence and disturbance of volition may appear as inertia, negativism, or stupor. Catatonia may be present. The onset may be acute, with seriously disturbed behaviour, or insidious, with a gradual development of odd ideas and conduct.

# Severe mental disorders in offspring with two psychiatrically ill parents Gottesman, I. I., Laursen, T. M., Bertelsen, A. & Mortensen, P. B. (2010) *Archives of General Psychiatry*, 67, (3), 252–257

## 1. Theory/ies on which the study is based . . . continued

The course of the disorder shows equally great variation and is by no means inevitably chronic or deteriorating (the course is specified by five-character categories). In a proportion of cases, which may vary in different cultures and populations, the outcome is complete, or nearly complete, recovery. The sexes are approximately equally affected but the onset tends to be later in women. (<https://mhreference.org/lib/schizophrenic/schizophrenia-icd/schizophrenia/>)

- Bipolar disorder is a chronic episodic illness associated with behavioural disturbances. It used to be called manic depression. It is characterised by episodes of mania (or hypomania) and depression. Either one can occur first and one may be more dominant than the other but all cases of mania eventually develop depression. (<http://www.patient.co.uk/doctor/bipolar-disorder-pro>).
- ICD-10: criteria for bipolar affective disorder:  
This disorder is characterized by repeated (i.e. at least two) episodes in which the patient's mood and activity levels are significantly disturbed, this disturbance consisting on some occasions of an elevation of mood and increased energy and activity (mania or hypomania), and on others of a lowering of mood and decreased energy and activity (depression). Characteristically, recovery is usually complete between episodes, and the incidence in the two sexes is more nearly equal than in other mood disorders. As patients who suffer only from repeated episodes of mania are comparatively rare, and resemble (in their family history, premorbid personality, age of onset, and long-term prognosis) those who also have at least occasional episodes of depression, such patients are classified as bipolar. Manic episodes usually begin abruptly and last for between 2 weeks and 4-5 months (median duration about 4 months). Depressions tend to last longer (median length about 6 months), though rarely for more than a year, except in the elderly. Episodes of both kinds often follow stressful life events or other mental trauma, but the presence of such stress is not essential for the diagnosis. The first episode may occur at any age from childhood to old age. The frequency of episodes and the pattern of remissions and relapses are both very variable, though remissions tend to get shorter as time goes on and depressions to become commoner and longer lasting after middle age. Although the original concept of "manic-depressive psychosis" also included patients who suffered only from depression, the term "manic-depressive disorder or psychosis" is now used mainly as a synonym for bipolar disorder. (<http://www.bipolarhome.org/icd-10-criteria-for-bipolar/>)
- Unipolar depressive disorder is also referred to as either major depressive disorder or simply major depression. It is a serious clinical mood disorder in which feelings of sadness, frustration, loss, or anger interfere with a person's everyday life for weeks or months at a time. People with MDD are more likely to use alcohol or illegal substances than others, are at increased risk for other mental and physical health problems, and are at a much greater risk for suicide than the general population. (<http://www.healthline.com/health/clinical-depression>).
- Major depressive disorder (MDD) (also known as clinical depression, major depression, unipolar depression, or unipolar disorder; or as recurrent depression in the case of repeated episodes) is a mental disorder characterized by a pervasive and persistent low mood that is accompanied by low self-esteem and by a loss of interest or pleasure in normally enjoyable activities. ([http://en.wikipedia.org/wiki/Major\\_depressive\\_disorder](http://en.wikipedia.org/wiki/Major_depressive_disorder)).

# Severe mental disorders in offspring with two psychiatrically ill parents Gottesman, I. I., Laursen, T. M., Bertelsen, A. & Mortensen, P. B. (2010) *Archives of General Psychiatry*, 67, (3), 252–257

## 2. Background to the study

- Infrequent psychiatric dual-mating studies during the last century have relied on case histories of small clinical samples. They were all central European studies with diagnostic evaluations based on the German and Swiss concepts of Kraepelin and Bleuler, which are quite similar to the descriptions from the *International Classification of Diseases, Eighth Revision (ICD-8)* and *International Classification of Diseases, Ninth Revision (ICD-9)*. Morbid risks (i.e. age-corrected) of schizophrenia in offspring of 2 schizophrenic parents varied between 28% and 58% in 8 studies (on average, 48% in pooled data). Risk of manic depressive disorder in offspring of 2 such parents varied between 22% and 80% in 4 studies (on average 28% in pooled data), that is, between 2 and 4 times the risk in contemporary studies of children with only 1 affected parent. In offspring of one parent with schizophrenia and one parent with manic-depressive disorder, the risks of schizophrenia and manic-depressive disorder were similar to the risks in children with only one parent with schizophrenia or only one parent with manic-depressive disorder, 13% to 14% and 18% to 20% respectively.
- Gottesman et al. proposed that studies of the outcome in the offspring of parents with homotypic disorders e.g. schizophrenia x schizophrenia and bipolar affective disorder x bipolar affective disorder, may elucidate modes of transmission and possible genetic heterogeneity. Matings between those with heterotypic disorders e.g. schizophrenia x bipolar disorder, may reveal the presence and risk of possible spectrum inter-forms or other atypical forms of parental criterion diagnoses in the offspring and may be of interest to researchers intrigued by the overlap in offspring phenotypes between schizophrenia and bipolar affective disorder.
- This study aimed to build on previous research and, in an attempt to have a large sample size, was conducted using all register-based diagnoses for each patient reported in the nationwide Danish Central Psychiatric Register.

## 3. Research method

- This was a national register-based cohort study conducted in Denmark.
- A cohort of more than 2.6 million persons with a link to their biological parents, ignoring legal marital status, and with information on all psychiatric admissions among offspring and parents was established from two Danish registers with privacy guaranteed by meticulous safeguards in place: (a) the Danish Civil Registration System was established in 1968. All persons living in Denmark are assigned a unique identification number, and data on their date of birth, sex, vital status (continuously updated), and identity of parents and siblings are recorded. The identification number is used in all national registers, thus guaranteeing accurate linkage of information among registers; (b) the Danish Psychiatric Central Register contains data on psychiatric inpatient and outpatient admissions (currently about 650,000 persons with 2.8 million admissions), computerised since 1969 with complete registration from April 1, 1970, of all admissions to Danish psychiatric inpatient facilities; it has included outpatients since 1995. As there are no private psychiatric inpatient or outpatient units, all admissions in Denmark are contained in the register. From 1966 until December 31, 1993, *ICD-8* was used for diagnostic classification; *ICD-10* has been used since January 1, 1994.

# Severe mental disorders in offspring with two psychiatrically ill parents Gottesman, I. I., Laursen, T. M., Bertelsen, A. & Mortensen, P. B. (2010) *Archives of General Psychiatry*, 67, (3), 252–257

## 4. Sample

- A population-based cohort of 2.6 million persons (actual number = 2,685,301) born in Denmark, alive in 1968 or born later than 1968, and with a link to their mother and father was established from the Civil Registration System. The investigation was restricted to persons who were aged 10 years or over before 1 January 2007.

## 5. Outline of the procedure/study

- Those who had ever received diagnoses of schizophrenia, bipolar affective disorder, or unipolar depressive disorder were identified from the Psychiatric Central Register among a group of parent couples with both parents ever having been admitted to a psychiatric facility from 1 April 1970, to 1 January 2007. For each of these groups of parent couples, their offspring, the eldest reaching age 52 years at follow-up, were checked in the register for admissions with similar or related diagnoses, and cumulative incidences were calculated.
- For comparison, cumulative incidences were calculated in the offspring of couples with only one parent ever having been admitted to a psychiatric facility for the selected diagnoses and the other parent never having been admitted.
- To create a base rate from the general population for comparison, cumulative incidences were calculated in the offspring of parent couples with neither parent ever having been admitted (cleaned population) and parent couples with no restrictions on parent diagnoses (uncleaned population).
- Cumulative incidences of schizophrenia and bipolar disorder in offspring of both parents with heterotypic disorders were calculated in parent couples in which one parent was admitted for schizophrenia and the other parent was admitted for bipolar disorder to inform discussions about genetic overlap between schizophrenia and bipolar disorder. To get an estimate or impression of normality in the offspring of the various groups of parent couples, the cumulative incidences of any psychiatric diagnosis in the offspring were calculated.
- Because both the parents and their offspring may have been admitted more than once with different diagnoses, they may appear in more than 1 of the groups of parent couples or offspring; thus the groups are not mutually exclusive. Furthermore, some of the offspring may have their own children in this longitudinal design; therefore, the same person may have dual status as both offspring and in one of the groups of parent couples.
- Parents and offspring were classified according to their diagnoses at discharge from admissions to inpatient or outpatient treatment facilities. Each admissions diagnosis was defined by the corresponding codes from *ICD-8* and *ICD-10* the first time the parents and offspring were recorded with that diagnosis in the Danish Psychiatric Central Register.
- Disorders were categorised as: schizophrenia, as schizophrenia-related disorders, bipolar affective disorder, unipolar depressive disorder, 'a psychiatric disorder' as defined by numerous codes from the *ICD-8* and *ICD-10*.
- Ethics: the study was approved by the Danish Data Protection Agency. Because data available for register-based research do not include information that can lead to the identification of individuals, approval from the National Scientific Ethical Committee was not required.

# Severe mental disorders in offspring with two psychiatrically ill parents Gottesman, I. I., Laursen, T. M., Bertelsen, A. & Mortensen, P. B. (2010) *Archives of General Psychiatry*, 67, (3), 252–257

## 6. Key findings

- The risk of schizophrenia in 270 offspring of 196 parent couples who were both admitted to a psychiatric facility with a diagnosis of schizophrenia was 27.3% (increasing to 39.2% when schizophrenia-related disorders were included) compared with 7.0% in 13,878 offspring from 8,006 couples with only one parent ever admitted for schizophrenia and 0.86% in 2,239,511 offspring of 1,080,030 couples with neither parent ever admitted.
- The risk of bipolar disorder was 24.9% in 146 offspring of 83 parent couples who were ever admitted with bipolar disorder (increasing to 36.0% when unipolar depressive disorder was included) compared with 4.4% in 23,152 offspring from 11,995 couples with only one parent ever admitted and 0.48% in 2,239,553 offspring of 1,080,030 couples with neither parent ever admitted.
- Risks of schizophrenia and bipolar disorder in offspring of couples with one parent with schizophrenia and the other with bipolar disorder were 15.6% and 11.7%, respectively.
- The maximal risks of any psychiatric disorders in the offspring of parents both with schizophrenia or both with bipolar disorder were 67.5% and 44.2%, respectively.
- For the general population with no restrictions on parents' psychiatric admissions, the uncleaned control group of parents, the cumulative incidence was 14.1%. Therefore, in the study population of offspring, only 1 in 7 had been admitted by age 52 years.

## 7. Possible conclusions

- The offspring of dual matings diagnosed with psychosis constitute a super-high-risk sample of psychosis.
- The risk of offspring being admitted to hospital with a diagnosis of schizophrenia is higher if both parents have been admitted with the same diagnosis than for offspring who have either had just one parent admitted with the diagnosis or neither parent ever having been admitted with the diagnosis.
- The risk of offspring being admitted to hospital with a diagnosis of either bipolar disorder or unipolar depressive disorder is higher if both parents have been admitted with the same diagnosis than for offspring who have either had just one parent admitted with the diagnosis or neither parent ever having been admitted with the diagnosis.
- Derived risks of psychosis may be informative for counselling.
- There is evidence to support the genetic explanation of mental illness.
- Derived risks of psychosis may be of use to genetic counsellors to inform personal decisions with regard to marriage, family formation, adoption, and health insurance planning.
- Patterns of transmission may support evolving assumptions about genetic overlap for traditional categories of psychosis.



# The myth of mental illness: 50 years later

Szasz, T. (2011) *The Psychiatrist*, 35, 179–182

## 1. Theory/ies on which the study is based

- The notion of mental illness may be closely related to the social values pertinent in any social context. The meaning of mental illness rooted in everyday social psychological processes may be different from scientific and clinical understanding. In order to examine the common meaning of mental illness, the relationship between individual knowledge and implicit social knowledge needs to be explored. Social representation of mental illness seems to be structured in terms of social understanding of the causes and consequences of mental illness. Further, mental illness is thought to derive its meaning from the expectations and norms of society. Mental illness is generally labelled as a form of social deviance and viewed as including an element of volition. The social definition of mental illness appears to be rooted in the social value that non-normative behaviours that are not in line with the expectations of society are related to mental illness. (Dixit, 2013) (<http://pds.sagepub.com/content/17/1/1.abstract>).
- The mainstream view in the West is that the changes in our description and treatment of mental illness are a result of our increasing knowledge and greater conceptual sophistication. On this view, we have conquered our former ignorance and now know that mental illness exists, even though there is a great deal of further research to be done on the causes and treatment of mental illness. (<http://plato.stanford.edu/entries/mental-illness/>).
- A more extreme view, most closely associated with the psychiatrist Thomas Szasz, is that there is no such thing as mental illness because the very notion is based on a fundamental set of mistakes. He has contended that the continued belief in mental illness by psychiatrists is the result of dogmatism and a pseudoscientific approach using ad hoc defences of their main claims. He has also argued that the concept of mental illness is based on a confusion: '[The belief in mental illness] rests on a serious, albeit simple, error: it rests on mistaking or confusing what is real with what is imitation; literal meaning with metaphorical meaning; medicine with morals.' More specifically, Szasz has argued that by definition, "disease means bodily disease," and, given that the mind is not literally part of the body, disease is a concept that should not be applied to the mind. Although Szasz's position has not gained widespread credence, his writings have generated debate over questions such as whether disease must, by definition, refer to bodily disease. (<http://plato.stanford.edu/entries/mental-illness/>).

# The myth of mental illness: 50 years later

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## 2. Background to the study

- Early humans thought there were demons inside a person's head and, if they made holes in the person's skull, the demons would come out. This procedure was called trepanning.
- In the 17th century people believed that mentally ill people were possessed by the devil and many were put to death.
- The insane asylums of the 18th century treated the inmates as no different from animals since they had lost their reason. The mentally ill were chained and beaten. One infamous asylum was called Bedlam (and now we say 'It was like Bedlam').
- In the 19th century a more humane approach appeared. It was suggested that a physical disease caused the symptoms of mental illness. It was not the individual's fault that they were ill, but the fault of the disease. Since that time a vast array of mental illnesses have been identified, such as schizophrenia, manic depression, anorexia etc. Each has a set of symptoms, which enables doctors (psychiatrists) to identify the disorder and then recommend a suitable treatment.
- The view has grown that psychological categorisation of mental illness is useless at best and harmful and misleading at worst. Psychiatric diagnoses are seen to be in the minds of the observers and are not valid summaries of characteristics displayed by the observed.
- In his essay 'The myth of mental illness', published in 1960, and in his book of the same title which appeared in 1961, Szasz stated that his aim was: to challenge the medical character of the concept of mental illness and to reject the moral legitimacy of the involuntary psychiatric interventions it justifies. He proposed that the phenomena formerly called 'psychoses' and 'neuroses', now simply called 'mental illnesses', should be viewed as behaviours that disturb or disorient others or the self; reject the image of the patients as the helpless victims of pathobiological events outside their control; and withdraw from participating in coercive psychiatric practices as incompatible with the foundational moral ideals of free societies.
- Szasz noted that modern psychiatry rests on a basic conceptual error - the systematic misinterpretation of unwanted behaviours as the diagnoses of mental illnesses pointing to underlying neurological diseases susceptible to pharmacological treatments. Instead he proposed that persons called 'mental patients' should be viewed as active players in real life dramas, not passive victims of pathophysiological processes outside their control.
- In this essay, Szasz reviews the recent history of the culturally validated medicalisation of (mis)behaviours and its social consequences.
- The article offers an alternative to the medical model for an explanation of mental illness.

# The myth of mental illness: 50 years later

Szasz, T. (2011) *The Psychiatrist*, 35, 179–182

## 3. Research method

- This is an article which critiques (reviews) changes in the beliefs and concepts surrounding mental health and changes in mental healthcare in the USA over the fifty years since 1960.
- The article has four main sections:
  - Fifty years of change in US mental healthcare
  - Mental illness – a medical or legal concept?
  - ‘Mental illness’ is a metaphor
  - Revisiting *The Myth of Mental Illness*.

## 4. Outline of the article

### Section one - Fifty years of change in US mental healthcare

- In the 1950s, according to Szasz, the notion that the responsibility for the healthcare of the American people should lie with the federal government had not yet entered national consciousness.
- Most people called ‘mental patients’ were considered incurable and were confined in state mental hospitals. The physicians who cared for them were employees of the state governments. Non-psychiatric physicians in the private sector treated voluntary patients and were paid by their clients or the clients’ families.
- Since that time, the formerly sharp distinctions between medical hospitals and mental hospitals, voluntary and involuntary patients, private and public psychiatry have blurred into non-existence. Now, virtually all mental healthcare is the responsibility of the government and it is regulated and paid for by public money.
- Everyone defined as a mental health professional is now legally responsible for preventing his patient from being ‘dangerous to himself or others’ i.e. psychiatry is thoroughly medicalised and politicised.
- There is therefore no legally valid non-medical approach to mental illness, just as there is no legally valid non-medical approach to measles or melanoma.

# The myth of mental illness: 50 years later

Szasz, T. (2011) *The Psychiatrist*, 35, 179–182

## 4. Outline of the article . . . continued

### Section two – Mental illness – a medical or legal concept?

- Debate about what counts as mental illness has been replaced by political-judicial decrees and economic criteria: old diseases such as homosexuality disappear, whereas new diseases such as attention-deficit hyperactivity disorder appear.
- Fifty years ago, the question 'What is mental illness?' was of interest to physicians, philosophers, sociologists as well as the general public. This question has now been settled by the holders of political power: they have decreed that mental illness is a disease like any other. In 1999, the US president Bill Clinton declared: 'Mental illness can be accurately diagnosed, successfully treated, just as physical illness'. Surgeon general, David Satcher, agreed: 'Just as things go wrong with the heart and kidneys and liver, so things go wrong with the brain'. Thus has political power and professional self-interest united in turning a false belief into a 'lying fact'.
- According to Szasz 'the claim that mental illnesses are diagnosable disorders of the brain is not based on scientific research; it is an error, or a deception, or a naive revival of the somatic premise of the long-discredited humoral theory of disease'. His claim that mental illnesses are fictitious illnesses, although also not based on scientific research, rests on the pathologist's materialistic-scientific definition of illness as the structural or functional alteration of cells, tissues and organs. If this definition of disease is accepted, Szasz claims that mental illness is a metaphor (a figure of speech in which a word or phrase is applied to an object or action that it does not literally denote in order to imply a resemblance – Collins English Dictionary).
- In his essay/book *The Myth of Mental Illness*, Szasz called public attention to the linguistic pretensions of psychiatry and its pre-emptive rhetoric. He insisted that mental hospitals are like prisons not hospitals, that involuntary mental hospitalisation is a type of imprisonment not medical care, and that coercive psychiatrists function as judges and jailers not physicians and healers. He also suggested that the traditional psychiatric perspective of interpreting mental illnesses and psychiatric responses to them as matters of medicine; treatment and science should be discarded, instead being interpreted as matters of morals, law and rhetoric.

### Section three – 'Mental illness' is a metaphor

- The proposition that mental illness is not a medical problem runs counter to public opinion and psychiatric dogma.
- Szasz illustrates his contention that mental illness is a metaphor through the following example: 'The physician who concludes that a person diagnosed with a mental illness suffers from a brain disease discovers that the person was misdiagnosed: he did not have a mental illness, he had an undiagnosed bodily illness. The physician's erroneous diagnosis is not proof that the term mental illness refers to a class of brain diseases.' (Page 180 of original article).
- The process of biological discovery has characterised some of the history of medicine with one form of 'madness' after another being identified as the manifestation of one or another somatic disease e.g. beriberi. The result is that the illness ceases to be a form of psychopathology and becomes classified and treated as a form of neuropathology. Szasz therefore argues that, if all the conditions now called mental illnesses proved to be brain diseases, there would be no need for the notion of mental illness and the term would become devoid of meaning. However, because the term refers to the judgements of some persons about the (bad) behaviours of other persons, what actually happens is precisely the opposite - an ever-expanding list of mental disorders.

# The myth of mental illness: 50 years later

Szasz, T. (2011) *The Psychiatrist*, 35, 179–182

## 4. Outline of the article . . . continued

- *Changing perspectives on human life (and illness):*
  - According to Szasz, the old religious-humanistic perspective on the tragic nature of life has been replaced with a modern, dehumanised, pseudo medical one. The secularisation of everyday life, and thus the medicalisation of the soul and personal suffering began in the late 16th century England. Szasz illustrates this point through a reference to Shakespeare's Macbeth: Overcome by guilt for her murderous deeds, Lady Macbeth 'goes mad': she feels agitated, is anxious, unable to eat, rest or sleep. Her behaviour disturbs Macbeth, who sends for a doctor and demands that he cure his wife. The doctor says that he cannot cure her but that 'the patient must minister to himself' (Act V, Scene 3). Today however, the role of the physician as curer of the soul is uncontested. Today, people like Lady Macbeth would be considered a mentally ill patient, who, like other humans is inherently healthy/good but whose mental illness makes her sick/ill-behaved.
- *Mental illness is in the eye of the beholder:*
  - Szasz claims that all the behaviours we call mental diseases are in fact the products of the medicalisation of disturbing or disturbed behaviours i.e. the observer's construction and definition of the behaviour of the people he observes as medically disabled individuals needing medical treatment. He claims that this cultural transformation has been driven mainly by the modern therapeutic ideology that has replaced the old theological world view and the political and professional interests it sets in motion. Medical practice has always rested on patient consent. An individual with a bodily illness is therefore not deprived of his liberty (unless he is legally incompetent or demonstrates dangerous behaviour towards others because of a contagious disease). However individuals categorised as mentally ill rather than sick are deprived of their liberty and responsibility which is a violation of their human rights. Szasz holds that mental illness is a myth. Diseases of the body have causes, such as infectious agents or nutritional deficiencies, and often can be prevented or cured by dealing with these causes. However, on the other hand, he believes that individuals said to have mental diseases have reasons for their actions that must be understood. They cannot be treated or cured by drugs or other medical interventions, but may be helped by persons who respect them, understand their predicament and help them to help themselves overcome the obstacles they face. The practice of pathology and for disease as a scientific concept rests on the premise that the patient is free to seek, accept or reject diagnosis and treatment. Psychiatric practice on the other hand, rests on the premise that the patient may be a danger to either himself or others and that the moral and professional duty of the psychiatrist is to protect the patient from himself and society from the patient. However the diagnosis of a patient's illness is in the hands of a licensed physician and therefore mental illness is in the eye of the beholder.

### Section 4 – Revisiting *The Myth of Mental Illness*

- Szasz claims that many critics misread his book. He says it was not a book on psychiatry but a book about psychiatry but that many critics have overlooked the fact that it is supposed to be a radical effort to recast mental illness from a medical problem into a linguistic-rhetorical phenomenon. He is therefore not surprised that most sympathetic appraisals of his text have come from non-psychiatrists who have not felt threatened by his re-visioning of psychiatry e.g. the essay, 'The rhetorical paradigm in psychiatric history: Thomas Szasz and the myth of mental illness', by professor of communication Richard E. Vatz and law professor Lee S. Weinberg.

# The myth of mental illness: 50 years later

Szasz, T. (2011) *The Psychiatrist*, 35, 179–182

## 4. Outline of the article . . . continued

- *Having an illness does not make an individual into a patient:*
  - One of the most illicit assumptions inherent in the standard psychiatric approach to insanity is treating persons called mentally ill as sick patients needing psychiatric treatment, regardless of whether they seek or reject such help. This accounts for an obvious but often overlooked difficulty peculiar to psychiatry, namely that the term refers to two radically different kinds of practices: curing/healing souls by conversation and coercing/controlling persons by force, authorised and mandated by the state. Critics of psychiatry, journalists and the public alike regularly fail to distinguish between counselling voluntary clients and coercing-and-excusing captives of the psychiatric system.
  - Formerly, when church and state were allied, people accepted theological justifications for state-sanctioned coercion. Today, when medicine and the state are allied, people accept therapeutic justifications for state-sanctioned coercion. This is how, some 200 years ago, psychiatry became an arm of the coercive apparatus of the state. And this is why today all of medicine threatens to become transformed from personal care into political control.
  - These issues are not new. Bleuler (1911) pleaded for the recognition of the rights of 'schizophrenics' to define and control their own lives and that psychiatrists not deprive them of their liberty to take their own lives. Unfortunately, in Szasz's view, Bleuler's plea to resist 'obeying the cruel views of society' have been ignored by psychiatrists. Instead his plea led to the 'medicalisation of the longing for non-existence, led to the creation of the pseudoscience of 'suicidology' and contributed to landing psychiatry in the moral morass in which it now finds itself'. (Page 182 of the original article.)

## 5. Possible conclusions

- *According to Szasz:*
  - Psychiatry is a pseudoscience.
  - Mental illness is a myth / mental illnesses are fictitious illnesses / mental illness is a metaphor.
  - Mental illness is now considered a legal concept and no longer a medical concept.
  - The old religious-humanistic perspective on the tragic nature of life has been replaced with a modern, dehumanised, pseudo medical one.
  - Mental illness is in the eye of the beholder.
  - It is wrong to treat individuals called mentally ill as sick patients needing psychiatric treatment, regardless of whether they seek or reject such help. These individuals should have the right and liberty to define and control their own lives.
- Over the past fifty years, psychiatry (in the USA) has become thoroughly medicalised and politicised.
- Mental illness is now considered a legal concept and no longer a medical concept.
- There are alternatives to the medical model for an explanation of mental illness.



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