Editor's Briefing

SANITY AND INSANITY

Highlights

In the midst of a pandemic mental health dominates many of our conversations and consultations. Daniela Strelchuk's qualitative paper offers much to fine tune our antennae to help people at risk of developing psychosis; and research on interventions for depression and anxiety provide welcome hope we can develop non-pharmaceutical options that work in primary care. Two editorials gently lay gauntlets at our feet: prison medicine is not mainstream but is long neglected; and

long COVID will feature heavily on clinic lists for months and years. The mobilisation of primary care to tackle the immediate problem of vaccination is astonishing and will be a story for the grandchildren in years to come. Our Deputy Editor, Professor David Misselbrook, offers an ethicist's slant on vaccination and risk. The editorial from the Joint Committee on Vaccination and Immunisation (JCVI) fleshes out the policies and their appreciation of the importance of primary care in this national effort.

On being sane in insane places

In the early 1970s Professor David Rosenhan scruffed himself up and walked into the red-bricked Haverford State Hospital in Pennsylvania with a fictional tale of auditory hallucinations: 'hollow, empty, thud'. He was admitted for 9 days, his apparent acute paranoid schizophrenia in remission. He went on to write a paper on eight 'pseudopatients' admitted to 12 institutions in the US. The pseudo-patients were all faking it and were 'sane' but all were admitted and given various diagnoses around psychosis. The paper On being sane in insane places was published in Science in 1973, has thousands of citations, and has had a profound effect on the direction of psychiatry. 1 Curiously, there is only a single mention of his paper in the BJGP archives in a 1979 article by BR Barnett, a consultant psychoanalyst.2

There are two enduring themes in Rosenhan's work: first, the damning inference was that psychiatry has no reliable method to tell who is truly ill. One might sympathise with that conclusion. The lack of objective markers was keenly felt then; you can draw a line between Rosenhan's study and the development of the Diagnostic and Statistical Manual of Mental Disorders with its relentless pursuit of formal codifications. And, second, once people are labelled, it impacts on everything we do and how we perceive them. Labels, once applied, are notoriously sticky.

I'm not sure I trust any of the statistics around the proportion of GP time spent on mental health. They often require a process of torturous disaggregation and a pursuit of a mind/body dualism that simply doesn't chime with clinical practice. A 2013 paper by Chris Salisbury and colleagues presents a far more recognisable picture of general practice — an average of 2.5 problems per 11.9 minute consultation but each problem having potential for multiple 'issues' be they psychological/emotional, medicationrelated, or social.3 People are wonderfully messy, deeply entangled, and rarely easily categorised.

There is a critical 2020 post-script to Rosenhan's study. Susannah Cahalan experienced labelling when she developed psychosis, was initially tagged as schizophrenic, but was then yanked back from the brink when found to have an autoimmune encephalitis. She was cured and not 'cordoned' off from the rest of medicine'.4 This also leads us to an intriguing question about brain pathology: why are neurology and psychiatry separate, though overlapping, specialities? Cahalan's book The Great Pretender leads us to the incredible conclusion that Rosenhan's paper was, in all likelihood, a fabrication. Yet, the processes of labelling and the wrestling with diagnostic codes are as pertinent as ever.

Euan Lawson, Acting Editor, BJGP

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