# Leftovers/Lanny Beckman

## Mental Illness for Beginners It's All in the Definition

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In the cartoon, the psychiatrist says to

the patient on the couch, "A nameless dread? That's easy. We've got names for everything." The DSM is where the names for everything can be found. It is psychiatry's official labelling bible, found in every mental health facility on the continent. Its function is to aid the clinician in suiting the mental patient's action to the DSM's word. The result, ten times out of ten, is a diagnosis.

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The DSM has its roots in the antebellum south. In mid-nineteenth century America, slaves were fleeing plantations in increasing numbers. Slave owners called in the American Psychiatric Association (conveniently founded in 1844), which quickly discovered a disease called drapetomania, a morbid compulsion to be free. The worst offenders had to be locked up and treated in mental institutions until their illness had been brought under control. They were then discharged and returned to their owners.

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Clearly, the subject matter here is not disease or medical disorder. The *DSM* is essentially a compendium of values, though even that concept is often too grandiose. To a large extent, the *DSM* is



intervention. Drapetomania itself has been lost to psychiatry and the *DSM* (cured, apparently, around the time of the Emancipation Proclamation), but it has been amply replaced. While diseases come and go, psychiatry has been relentless in its quest to achieve a net gain in the units of human life it can call its own. Thomas Szasz, a maverick American psychiatrist, first diagnosed this disorder as "psychiatric imperialism." Untreated, it has developed a florid symptomatol-

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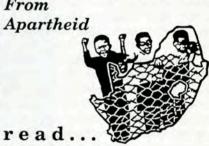
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The two parties came to the bargaining table united in the view that caring for the mentally ill is a distasteful and futile job that no sane person would voluntarily undertake. By proposing to undertake it at all, psychiatry began the negotiations from a position of great strength. The government, like Thomas Szasz, preferred to believe that mental illness didn't exist. Psychiatry said that's just what it would make the government believe. In return, it wanted the store. They ran for the pens.

The store was crammed with concessions. The first thing psychiatry got was power, in the form of the medical model. Mental illness being an illness and psychiatrists being medical doctors, it seemed only logical to elaborate these particulars in mental health legislation. The logic is weakened by the fact that, without a cure for mental illness, the best palliative is compassion and love, qualities which are endangered emotions in the medical fraternity. Nonetheless, when the act had been written, psychia-

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K1 P 5R1 (613) 233-5939 trists emerged as the undisputed kingpins of the mental health empire. They give the orders, they write the prescriptions, they commit the patients.

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Well, not quite. In fact, psychiatrists spend very little time with real mental patients, like schizophrenics – the kind who sleep overnight in mental institutions. In these institutions, psychiatrists act as consultants to front-line, lower-echelon mental health workers, having

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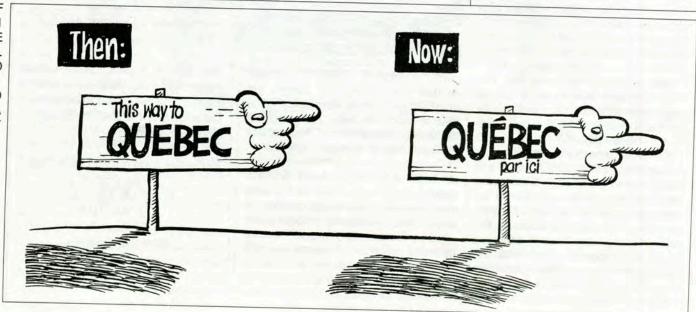
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HIS MAGAZINE

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Depending upon one's point of view, the situation is a good deal better or a good deal more chilling than Mr. Beckman describes. Readers were left with the impression that only American diagnostic systems in psychiatry are imported into Canada. In fact, the American psychiatric community can be seen as resisting imperialistic trends from the World Health Organization, whose International Classification of Disease, Ninth Edition (ICD-9, for short) is the official classification system in Canada and the U.S. A comparison of ICD-9 and the Diagnostic and Statistical Manual of Mental Disorders (DSM) shows the major weaknesses of both in detail (vague diagnostic criteria in the former, a cookbook approach to criteria in the latter), but it also shows that they are trying to describe much the same conditions, which psychiatrists the world over see. Mr. Beckman correctly notes that the personality disorder section is still very weak in DSM. Having participated in field trials to test out ICD-10, I can assure him that this area is also rather poor in the latter and that, practically, this limits its usefulness.

This brings me to the main point. Diagnosis, after all, is medical shorthand; it is an attempt to describe a recognized condition in a few words. This has use in treatment and especially prognosis. This may help us understand why the children's disorders are so confusing; how does a certain constellation of symptoms (including parental and school complaints) end up when the child is an adolescent? Do all kids who have conduct disorders or oppositional defiant disorders become hard-core criminals or dangerous terrorist revolutionaries? Not only do the police and repressive governments want to know, but a fair number of parents are also surprisingly interested in their children's lives.

The other part of Mr. Beckamn's article requires comment as well. Although he decries labelling, Mr. Beckman appears to have fallen into the alltoo-common intellectual and emotional trap of suggesting that "mental patients" are incurable, that nothing is known about their illnesses, and that all we can give them is our love and compassion because their miserable lives have been ruined by bad luck compounded by medical incompetence.

My impression is quite a different one, even though I work in a large psychiatric hospital with very sick patients.

I have to work with the idea that something must be done to lessen the suffering of individuals and that this something must include not only compassion and the best application of what is known to be effective but also the hope that more will be known to make treatment and prevention better. Most "mental patients" are actually in the community. These are people who have suffered from the very common illness of major depression, the vast majority of whom recover completely with treatment and are happy to do so. Schizophrenia is another illness with a different response to treatment and a different prognosis, but even so, most people with this illness respond somewhat at least to pharmacological and psychosocial interventions. Indeed, most of them hardly look like "mental patients." While I agree that neurotics do not merit as much treatment time as schizophrenics, I would also point out that they don't get nearly so much as the latter, who require a much more sophisticated multidisciplinary approach. The analogy is just as true in the rest of medicine. The people doctors see in their offices are usually far less sick than the ones in hospital, where, after all, doctors are consultants to nursing staff who spend the whole day with patients. Surgeons operate but don't do nursing care or physiotherapy. The same is true for psychiatrists in hospital practice. Thus, the conspiracy against the "mental patient" widens to include nurses, psychologists, social workers and other professionals who are to be found in the average Canadian psychiat-

ric hospital. Nevertheless, in our system, it is physicians who carry the final responsibility.

My last comment is in agreement with Mr. Beckman's remarks about sexual bias in diagnosis. This also should not be surprising since psychiatrists are part of a larger community which has its own value judgements about personal characteristics, such as sexual preference. If anything, medicine as a profession does not lead enought where it should do, and therefore has often to make embarrassing attempts to catch up with the times. Do not let us forget that years ago it was the opinion not only of the public but also of most of the medical profession that "mental patients" were incurable. Most physicians understand mental illnesses (note the plural) somewhat more optimistically nowadays because of research into efficacy of treatments, outcome and causal factors. Unfortunately, this attitude about these illnesses and the people that have them has not yet received as much acceptance in the community at large. Psychiatrists are a lot less flippant than Mr. Beckman suggests about depriving people of their civil liberties (which judges do on medical recommendation).

As citizens we should be concerned about our health care system, and I should be the last to suggest that the fact one is not a member of the medical profession denies one the right to criticize. However, special interest groups like doctors are often useful to consult, as are many patient and family groups. This would allow more factual reporting.

David Bloom Douglas Hospital Centre Verdun, Quebec

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Lanny Beckman, "Mental Illness for Beginners: It's All in the Definition," which appeared in the February/89 issue.

Depending upon one's point of view, the situation is a good deal better or a good deal more chilling than Mr. Beckman describes. Readers were left with the impression that only American diagnostic systems in psychiatry are imported into Canada. In fact, the American psychiatric community can be seen as resisting imperialistic trends from the World Health Organization, whose International Classification of Disease, Ninth Edition (ICD-9, for short) is the official classification system in Canada and the U.S. A comparison of ICD-9 and the Diagnostic and Statistical Manual of Mental Disorders (DSM) shows the major weaknesses of both in detail (vague diagnostic criteria in the former, a cookbook approach to criteria in the latter), but it also shows that they are trying to describe much the same conditions, which psychiatrists the world over see. Mr. Beckman correctly notes that the personality disorder section is still very weak in DSM. Having participated in field trials to test out ICD-10, I can assure him that this area is also rather poor in the latter and that, practically, this limits its usefulness.

This brings me to the main point. Diagnosis, after all, is medical shorthand; it is an attempt to describe a recognized condition in a few words. This has use in treatment and especially prognosis. This may help us understand why the children's disorders are so confusing; how does a certain constellation of symptoms (including parental and school complaints) end up when the child is an adolescent? Do all kids who have conduct disorders or oppositional defiant disorders become hard-core criminals or dangerous terrorist revolutionaries? Not only do the police and repressive governments want to know, but a fair number of parents are also surprisingly interested in their children's lives. The other part of Mr. Beckman's article requires comment as well. Although he decries labelling, Mr. Beckman appears to have fallen into the all too-common intellectual and emotional trap of suggesting that "mental patients" are incurable, that nothing is known about their illnesses, and that all we can give them is our love and compassion because their miserable lives have been ruined by bad luck compounded by medical incompetence.

My impression is quite a different one, even though I work in a large psychiatric hospital with very sick patients.

I have to work with the idea that something must be done to lessen the suffering of individuals and that this something must include not only compassion and the best application of what is known to be effective but also the hope that more will be known to make treatment and prevention better. Most "mental patients" are actually in the community. These are people who have suffered from the very common illness of major depression, the vast majority of

whom recover completely with treatment and are happy to do so. Schizophrenia is another illness with a different response to treatment and a different prognosis, but even so, most people with this illness respond somewhat at least to pharmacological and psychosocial interventions. Indeed, most of them hardly look like "mental patients." While I agree that neurotics do not merit as much treatment time as schizophrenics, I would also point out that they don't get nearly so much as the latter, who require a much more sophisticated multidisciplinary approach. The analogy is just as true in the rest of medicine. The people doctors see in their offices are usually far less sick than the ones in hospital, where, after all, doctors are consultants to nursing staff who spend the whole day with patients. Surgeons operate but don't do nursing care or physiotherapy. The same is true for psychiatrists in hospital practice. Thus, the conspiracy against the "mental patient" widens to include nurses, psychologists, social workers and other professionals who are to be found in the average Canadian psychiatric hospital. Nevertheless, in our system, it is physicians who carry the final responsibility.

My last comment is in agreement with Mr. Beckman's remarks about sexual bias in diagnosis. This also should not be surprising since psychiatrists are part of a larger community, which has its own value judgements about personal characteristics, such as sexual preference. If anything, medicine as a profession does not lead enough where it should do, and therefore has often to make embarrassing attempts to catch up with the times. Do not let us forget that years ago it was the opinion not only of the public but also of most of the medical profession that "mental patients" were incurable. Most physicians understand mental illnesses (note the plural) somewhat more optimistically nowadays because of research into efficacy of treatments, outcome and causal factors. Unfortunately, this attitude about these illnesses and the people that have them has not yet received as much acceptance in the community at large. Psychiatrists are a lot less flippant than Mr. Beckman suggests about depriving people of their civil liberties (which judges do on medical recommendation).

As citizens we should be concerned about our health care system, and I should be the last to suggest that the fact one is not a member of the medical profession denies one the right to criticize. However, special interest groups like doctors are often useful to consult, as are many patient and family groups. This would allow more factual reporting.

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