

Mental Illness for Beginners It's All in the Definition

I'm sometimes approached by students who know nothing about mental illness and who want good introductory sources. I usually recommend two. One is *The Diagnostic and Statistical Manual of Mental Disorders* (third edition, revised, 1987), published by the American Psychiatric Association, and known as the *DSM*. The other is an old *New Yorker* cartoon.

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 labeling 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.

Those concerned about free trade will be relieved to know that Canada-U.S. trade in the psychiatric sector has traditionally been unrestricted and will be unaffected by the Reagan-Mulroney deal. Mental illness is manufactured, patented and packaged in the U.S. by the American Psychiatric Association (APA), and is imported tariff-free into Canada. Here, it is administered by the APA's branch plant, the Canadian Psychiatric Association. There is neither a Canadian *DSM* nor a Canadian edition of the APA manual.

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.

The *DSM*, through its various editions and revisions, has gone on rediscovering drapetomania – bad behaviour, labelled a medical disorder, requiring psychiatric

ogy, evident in the *DSM*'s ballooning from one edition to the next.

We'll skip over the *DSM*'s life-wrecking disorders, like schizophrenia and its twenty-seven diagnostic sub-types, which psychiatry is just beginning to get a handle on. More instructive is the category of mundane disorders, whose expansive appetite seems to know no boundaries, except political ones. If you can't find big parts of yourself and your kids in the *DSM*, you're probably suffering from a rare normality.

"Oppositional Defiant Disorder" is an ailment of the young. Its symptoms include: "is often angry and resentful"; "often actively defies or refuses adult requests."

"Attention-deficit Hyperactivity Disorder" also afflicts the young. Symptoms: "Often blurts out answers to questions before they have been completed"; "often does not seem to listen to what is being said to him or her." (Note non-sexist usage.)

Among the adult disorders:

"Self-defeating Personality Disorder." Symptoms: "engages in excessive self-sacrifice that is unsolicited by the intended recipient"; "helps fellow students write papers but is unable to write his or her own."

"Histrionic Personality Disorder." Symptoms: "is inappropriately sexually seductive in appearance or behaviour"; "is overly concerned with physical attractiveness." (Note unstated sexist assumptions.)

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-

an etiquette guide, a kind of Miss Manners with powers to commit. Like all etiquette guides, it is inherently conservative, upholding the established order by finding disorder in the rebellious kid, not the child-hating society, in the too-altruistic, not the hyper-competitive culture, and in the slave to advertising, not advertising itself.

IT SHOULD COME AS NO SURPRISE

to learn there is no rigorous or even adequate definition of mental illness, either in the *DSM* or anywhere else. There is, however, quite a precise definition of mental patient. A mental patient is someone who has slept overnight in a mental institution. Simply consulting a private psychiatrist is not sufficient.

Implausible as it may seem, a century of pseudo-scientific research into mental illness has failed to produce any scientific knowledge whatsoever, with the exception of the Irreversibility Principle, which is to say, mental illness is incurable.

Unfortunately, irreversibility has been obscured in recent years, for which we have no one to blame but the homeless. Because they have so few mental institutions to return to, the revolving door is rusting up and the system is breaking down. The World Health Organization calls the crisis the Reagan Cure.

In saner times, the facts were quite clear, as the following examples will show. Of all patients discharged from B.C.'s Riverview Mental Hospital in 1960, ninety per cent were readmitted at least once by 1970. In the public arena, Thomas Eagleton tangled with the Irreversibility Principle in 1972 when he attempted to run for the U.S. vice-presidency, years after having been hospitalized for depression. He didn't get far.

And an every-day reminder that there's no such thing as an ex-mental patient can be found even now in the familiar sort of headline that says, "Ex-Mental Patient Slays 3."

Bad press about mental patients has saturated the public mind. According to attitude surveys, nobody likes them. They make people nervous. Mental patients are viewed as unpredictable, threatening and prone to violence. The truth is the opposite. Most of them tend toward introspection, withdrawal and passivity. Their rates of violent crime are actually lower than those of the general population. Still, you've never actually

seen a headline that said, "Non-Mental Patient Slays 3."

THOMAS SZASZ' EXPLANATION

for the lack of scientific discoveries about mental illness is that it doesn't exist. For thirty years he has been arguing, completely in vain, that mental illness is a metaphor which has been mistaken for a fact. That a sick economy or a sick car has no need of medical attention is obvious not only to everyone but also to psychiatrists — they don't make the conceptual error of taking their BMWs to the hospital for a check-up.

Illness and disease are ideas that apply to the body, Szasz insists, and he asks what possible role medicine can have in the study and "treatment" of beliefs, morals and emotions, which are, after all, the bailiwick of psychiatry. Minds can't be ill, he yells after his colleagues as they rush off, only brains can. But in an oblique sort of way he's getting through.

When psychiatrists know nothing about a subject, they say they're just beginning to get a handle on it. When they spot a handle-like object on a distant horizon, they declare the sighting a revolution. Psychiatry is now in the grip of the Brain Revolution. New books on neuropsychiatry are pouring out of publishers' warehouses, and few doubt that discoveries in brain research are the most exciting development the field has seen in decades.

If Szasz is proven entirely wrong and the brain probes right, we'll still see no Nobel prizes in the next six months. Psychiatric self-promotion aside, the Brain Revolution is probably on about the same time-track as the greenhouse effect. More immediate is the danger that mental patients will be further abused by a viewpoint which regards them as so much protoplasm. Matthew Dumont, another psychiatrist who doesn't get invited to staff parties, warns that the last time so much emphasis was placed on the biochemical defects of the mentally ill was during the thirties in Germany.

IF PART OF PSYCHIATRY SEEMS

caught up in intellectual abstractions about whether Jenny is appropriately or inappropriately sexually seductive, another part is entirely pragmatic. One of its major, concrete achievements in this country was the framing of a social contract between the Canadian Psychiatric Association and the Canadian state.

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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trists emerged as the undisputed kingpins of the mental health empire. They give the orders, they write the prescriptions, they commit the patients.

The procedures for involuntarily committing a patient to a psychiatric facility reveal something of the force and farce of the medical model. Within the mental health field, only psychiatrists have the legal authority to sign the pink committal forms. Outside the field, any MD can "do a pink" on a patient, as industry jargon has it. As a result, a psychologist can't lock you up for being nuts, but a surgeon, dermatologist or obstetrician can.

The second thing psychiatry got was money, in the form of medicare. Psychiatrists are the only mental health personnel who are authorized to bill medicare privately. Social workers, psychic healers and spoon benders have to make it in the marketplace. The B.C. Medical Services Plan pays psychiatrists an average of ninety dollars per hour (actually, per fifty minutes). At thirty-five hours a week and forty-eight weeks a year, the average B.C. psychiatrist has an income (before investment earnings) of \$150,000.

Outrageous, you say, but remember that the guy or gal is cooped up in a small office with artificial lighting and real mental patients for thirty-five hours a week.

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

very little direct contact with patients of any kind. In general, the more education you have about the mentally ill, the less time you're required to spend with them. (That's the point of getting an education.)

In private practice too, psychiatrists see few real mental patients. Instead, as many are fond of saying, they "choose to treat 'healthy patients,'" formerly called "normal neurotics." Orwellian, perhaps, but these patients, with garden-variety problems in living, can be quite entertaining and attractive and they don't stain the chair. These things are not unimportant to the average psychiatrist.

Healthy patients bring another perk to the psychiatric encounter. Since the patients are not ill, psychiatrists are generally able to claim that therapy has produced a cure, regardless of what it has produced. The ego gratification associated with curing healthy patients has inspired most private psychiatrists to give up on trying to cure sick ones.

WHILE WORKING PSYCHIATRISTS are wrestling in the trenches with healthy patients and their problems, the psychiatric establishment is often wrapped up in close encounters of a less cuddly kind. It regularly finds itself in political skirmishes with irate groups protesting their treatment at the hands of *The Diagnostic and Statistical Manual*. Pressure from the women's movement has been successful in ridding the *DSM* of much of its sexist literary style and some of its more egregious stereotypes of women, gains which barely scratch the surface of psychiatric sexism.

The gay liberation movement, including the gay caucus within psychiatry, scored a genuine success about a decade ago by having homosexuality, in and of itself, abolished as a disorder. No one set foot in a lab or spent a cent on medical research, but tens of millions of mentally ill homosexuals were instantly cured. It was a bleak day for psychiatry. Drapetomania all over again.

Psychiatry may have lost the gay baby, but in a splendid gesture of circum-spection it managed to save some of the bathwater. There now appears in the *DSM* a sexual disorder known as "Ego-dystonic Homosexuality." It pertains to patients whose sexual preference is homosexuality but who say they would prefer another preference. "Ego-dystonic Heterosexuality" is not listed in the *DSM*'s index.

AMBROSE BIERCE, WHO DEFINED a lawyer as "one trained in circumvention of the law," didn't define a psychiatrist as "one trained in indifference to human suffering," probably because he died in 1914, before psychiatry got on its feet. But it would have appealed to his perverse sensibilities to know that this unfair generalization would be acceptable to the minority of psychiatrists to whom it is unfair, and offensive to the majority to whom it isn't. TM

Lanny Beckman is the publisher of New Star Books, whose most recent title is Shrink Resistant: The Struggle Against Psychiatry in Canada, edited by Bonnie Burstow and Don Wietz (Vancouver, 1988).

Then:



Now:

