Lectures Notes

The DSM V and the Concept of Mental Illness

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"You can know the name of a bird in all the languages of the world, but when you're finished, you'll know absolutely nothing whatever about the bird… So let's look at the bird and see what it's doing – that's what counts. I learned very early the difference between knowing the name of something and knowing something."

Richard Feynman, Physicist and 1965 Nobel Prize laureate (1918-1988)

"You have all I dare say heard of the animal spirits and how they are transfused from father to son etcetera etcetera – well you may take my word that nine parts in ten of a man's sense or his nonsense, his successes and miscarriages in this world depend on their motions and activities, and the different tracks and trains you put them into, so that when they are once set a-going, whether right or wrong, away they go cluttering like hey-go-mad."

Lawrence Sterne (1713-1758), "The Life and Opinions of Tristram Shandy, Gentleman" (1759)

The Insanity Defense

"It is an ill thing to knock against a deaf-mute, an imbecile, or a minor. He that wounds them is culpable, but if they wound him they are not culpable." (Mishna, Babylonian Talmud)

Insanity defense (NGRI- Not Guilty by Reason of Insanity)

Cannot tell right from wrong ("lacks substantial capacity either to appreciate the criminality (wrongfulness) of his conduct" - diminished capacity), **did not intend to act the way he did** (absent "mens rea") and/or **could not control his behavior** ("irresistible impulse").

Impairment of a "person's perception or understanding of reality". "Guilty but mentally ill" verdict is contradiction in terms.

Yet, criminal maybe mentally ill and maintain perfect reality test and thus be **criminally responsible** (Jeffrey Dahmer). Compare this to **religion or love**.

Consider the following case:

A mother bashes the skulls of her three sons. Two of them die. She claims to have acted on instructions she had received from God. She is found not guilty by reason of insanity. The jury determined that she "did not know right from wrong during the killings."

But why exactly was she judged insane?

Her belief in the existence of God - a being with inordinate and inhuman attributes - may be irrational.

Shared psychosis and statistical conformity

She claimed that God has spoken to her.

Lauded in religious circles.

She claimed that God had instructed her to kill her boys. Surely, God would not ordain such evil?

Same as Abraham and Jesus.

Her actions were wrong and incommensurate with both human and divine (or natural) laws.

Yes, but they were perfectly in accord with a literal interpretation of certain divinely-inspired texts, millennial scriptures, apocalyptic thought systems, and fundamentalist religious ideologies (such as the ones espousing the imminence of "rupture"). Unless one declares these doctrines and writings insane, her actions are not.

Mother is perfectly sane. Her frame of reference is different to ours. Hence, her definitions of right and wrong are idiosyncratic. Her grasp of reality - the immediate and later consequences of her actions - was never impaired.

Normalcy

Statistical response

Average and the common are normal.

Contra: anomic societies Hitler's Germany or Stalin's Russia.

Functional response

Patient functioning and happy, not distressed (ego-syntonic)?

Contra: evidently mentally ill people are rather happy and reasonably functional.

Rejection

"Normalcy" leads to medicalization and pathologization

Study the disorders (phenomenology), not metaphysical imaginary and ideal state.

Mental Illness:

1. **Deviance**
2. **Impaired judgment** and **Flawed Reality Test**
3. **Deficient Impulse Control**
4. **Discomfort**
5. **Dysfunctional, self-defeating, and self-destructive** behaviors.

Medical School

Mental disorders = physiological-biochemical **brain** disorders of the brain

Cured by restoring the balance of **substances and secretions** in the brain (psychopharmacology)

BUT

Is this **curing** or merely **repressing** the disease (**latency**)

Nature (genetics) or **nurture** (environment, abusive or wrong nurturance)

Correlation is not causation

Mental health disorder is **value judgment, or statistical observation**.

Psychoactive medication, foods, talk therapy, and interpersonal interactions **alter behaviour and mood.**

Single genes or gene complexes are "associated" with mental health diagnoses, personality traits, or behaviour patterns. But no causes-and-effects or known interaction of nature and nurture, genotype and phenotype, the plasticity of the brain and the psychological impact of trauma, abuse, upbringing, role models, peers, and other environmental elements.

Medicines (David Kaiser ***"Against Biologic Psychiatry"*** (Psychiatric Times, Volume XIII, Issue 12, December 1996) **treat symptoms, not the underlying processes that yield them**.

Spiritual View

Mental ailments = metaphysical discomposure of **soul** (holistic)

"With Freud and his disciples started the medicalization of what was hitherto known as "sin", or wrongdoing. As the vocabulary of public discourse shifted from religious terms to scientific ones, offensive behaviors that constituted transgressions against the divine or

social orders have been relabelled. Self-centredness and dysempathic egocentricity have now come to be known as "pathological narcissism"; criminals have been transformed into psychopaths, their behavior, though still described as anti-social, the almost deterministic outcome of a deprived childhood or a genetic predisposition to a brain biochemistry gone awry - casting in doubt the very existence of free will and free choice between good and evil. The contemporary "science" of psychopathology now amounts to a godless variant of Calvinism, a kind of predestination by nature or by nurture."

Functional School

Mental health disorders = **perturbations** in the proper, **statistically "normal",** behaviours (d**ysfunctions**.)
Ego-dystony and deviance "mended" when **functionality restored**.

"Normal" people adapt to their environment - both human and natural.

"Abnormal" ones try to adapt their environment - both human and natural - to their idiosyncratic needs/profile.

If they succeed, their environment, both human (society) and natural is pathologized.

Thomas Szasz in article***"The Lying Truths of Psychiatry:***

Mental health scholars infer the etiology of mental disorders (form a theory) from the success or failure of treatment modalities ("reverse engineering")

This is acceptable if the experiments meet the criteria of the **scientific method**.

The **theory must be**:

All-inclusive (anamnetic), **consistent**, **falsifiable**, **logically compatible**, **monovalent**, and **parsimonious**. Psychological "theories" are not.

The **outcome**:

Culture-bound bias

Ever-shifting mental health "diagnoses" (neurosis, homosexuality, narcissism)

"Two eminent retired psychiatrists are warning that the revision process is fatally flawed. They say the new manual, to be known as DSM-V, will extend definitions of mental illnesses so broadly that tens of millions of people will be given unnecessary and risky drugs. Leaders of the American Psychiatric Association (APA), which publishes the manual, have shot back, accusing the pair of being motivated by their own financial interests - a charge they deny." (New Scientist, "Psychiatry's Civil War", December 2009).

Mental Disorders and the Social Order

Mentally ill **quarantined involuntarily and coerced into treatment** by medication, psychosurgery, or electroconvulsive therapy.

Enormous economic interests of psychiatry and psychopharmacology.

"The wording used in the DSM has a significance that goes far beyond questions of semantics. The diagnoses it enshrines affect what treatments people receive, and whether health insurers will fund them. They can also exacerbate social stigmas and may even be used to deem an individual such a grave danger to society that they are locked up ... Some of the most acrimonious arguments stem from worries about the pharmaceutical industry's influence over psychiatry. This has led to the spotlight being turned on the financial ties of those in charge of revising the manual, and has made any diagnostic changes that could expand the use of drugs especially controversial." (New Scientist, "Psychiatry's Civil War", December 2009).

Abstract concepts are useful metaphors, theoretical entities with explanatory or descriptive power.

"Mental health disorders" deal with "**Other**". Taxonomies, are also tools of social coercion and conformity (**Michel Foucault and Louis Althusser**) **social engineering and control**.

Case Study: Moral Insanity

Benjamin Rush (USA) and in France Pinel's "manie sans delire" (insanity without delusions): lack of impulse control, rage, and violence, no delusions (today: psychopaths, Antisocial Personality Disorder).

In 1835, the British J. C. **Pritchard**, Bristol Infirmary "***Treatise on Insanity and Other Disorders of the Mind***": "**moral insanity**".

"a morbid perversion of the natural feelings, affections, inclinations, temper, habits, moral dispositions, and natural impulses without any remarkable disorder or defect of the intellect or knowing or reasoning faculties and in particular without any insane delusion or hallucination" (p. 6).

"(A) propensity to theft is sometimes a feature of moral insanity and sometimes it is its leading if not sole characteristic." (p. 27). "(E)ccentricity of conduct, singular and absurd habits, a propensity to perform the common actions of life in a different way from that usually practised, is a feature of many cases of moral insanity but can hardly be said to contribute sufficient evidence of its existence." (p. 23).

"When however such phenomena are observed in connection with a wayward and intractable temper with a decay of social affections, an aversion to the nearest relatives and friends formerly beloved - in short, with a change in the moral character of the individual, the case becomes tolerably well marked." (p. 23)

"(A) considerable proportion among the most striking instances of moral insanity are those in which a tendency to gloom or sorrow is the predominant feature ... (A) state of gloom or melancholy depression occasionally gives way ... to the opposite condition of preternatural excitement." (pp. 18-19) - personality, affective, and mood disorders confused!

Henry Maudsley (1885):

"(Having) no capacity for true moral feeling - all his impulses and desires, to which he yields without check, are egoistic, his conduct appears to be governed by immoral motives, which are cherished and obeyed without any evident desire to resist them." ("Responsibility in Mental Illness", p. 171).

BUT ...

"(Moral insanity is) a form of mental alienation which has so much the look of vice or crime that many people regard it as an unfounded medical invention (p. 170).

"**Die Psychopatischen Minderwertigkeiter**" (1891) J. L. A. Koch "**psychopathic inferiority or (later editions) personality**":

People who are not retarded or mentally ill but still display a rigid pattern of misconduct and dysfunction throughout their increasingly disordered lives.

8th edition of E. Kraepelin's seminal "**Lehrbuch der Psychiatrie**" suggested **six additional types of disturbed personalities**: excitable, unstable, eccentric, liar, swindler, and quarrelsome.

Focus was on **antisocial, annoying, and non-conformist** behavior.

"**The Psychopathic Personality**" (9th edition, 1950) and "**Clinical Psychopathology**" (1959), K. Schneider labelled "psychopaths" people who harm and inconvenience **themselves** (depressed, socially anxious, excessively shy and insecure).

Scottish psychiatrist, Sir David Henderson (1939, "Psychopathic States") psychopaths:

"(T)hroughout their lives or from a comparatively early age, have exhibited disorders of conduct of an antisocial or asocial nature, usually of a recurrent episodic type which in many instances have proved difficult to influence by methods of social, penal and medical care or for whom we have no adequate provision of a preventative or curative nature."

Three types of psychopaths:

Aggressive (violent, suicidal, and prone to substance abuse);

Passive and inadequate (over-sensitive, unstable and hypochondriacal, introverts (schizoid) and pathological liars);

Creative (managed to become famous or infamous.)

1959 **Mental Health Act for England and Wales**, "psychopathic disorder" was defined thus, in section 4(4):

"(A) persistent disorder or disability of mind (whether or not including subnormality of intelligence) which results in abnormally aggressive or seriously irresponsible conduct on the part of the patient, and requires or is susceptible to medical treatment."

Canadian Robert, Hare distinguishes the **psychopath** from the patient with mere antisocial personality disorder vs. orthodoxy.

1950, Schneider wrote about **co-morbidity**:

"Any clinician would be greatly embarrassed if asked to classify into appropriate types the psychopaths (that is abnormal personalities) encountered in any one year."

Personality Disorders

"**Personality Disorders in Modern Life**", **Theodore Millon and Roger Davis** define **personality** as:

"(A) complex pattern of deeply embedded psychological characteristics that are expressed automatically in almost every area of psychological functioning." (p. 2)

DSM IV-TR (2000) defines **personality traits** as:

"(E)nduring patterns of perceiving, relating to, and thinking about the environment and oneself that are exhibited in a wide range of social and personal contexts." (p. 686)

Temperament: biological-genetic template that interacts with our environment.

Character: outcome of socialization, during formative years

Brain and Personality

Case of **Phineas Gage**.

In 1868, Harlow, his doctor:

"He became "fitful, irreverent, indulging at times in the grossest profanity (which was not previously his customs), manifesting but little deference to his fellows, impatient of restraint or advice when it conflicts with his desires, at times pertinaciously obstinate yet capricious and vacillating, devising many plans for future operation which are no sooner arranged than they are abandoned in turn for others appearing more feasible ... His mind was radically changed, so that his friends and acquaintances said he was no longer Gage."

Soldiers with penetrating head injuries suffered in World War I:

Orbitomedial wounds made people "**pseudopsychopathic**": grandiose, euphoric, disinhibited, and puerile.

Damage to **dorsolateral convexities**: lethargic and apathetic ("**pseudodepressed**").

Geschwind: many had both syndromes.

DSM: brain-injured may acquire traits and behaviors typical of certain personality disorders but head trauma never results in a full-fledged personality disorder.

"General diagnostic criteria for a personality disorder:

F. The enduring pattern is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., head trauma)." (DSM-IV-TR, p.689)

Personality disorders: identity dysfunctions (all-pervasive)

Common Features

They are persistent, relentless, stubborn, and insistent (except those suffering from the Schizoid or the Avoidant Personality Disorders).

They feel entitled to - and vociferously demand - preferential treatment and privileged access to resources and personnel. They often complain about multiple symptoms. They get involved in "power plays" with authority figures (such as physicians, therapists, nurses, social workers, bosses, and bureaucrats) and rarely obey instructions or observe rules of conduct and procedure.

They hold themselves to be superior to others or, at the very least, unique. Many personality disorders involve an inflated self-perception and grandiosity. Such subjects are incapable of empathy (the ability to appreciate and respect the needs and wishes of other people). In therapy or medical treatment, they alienate the physician or therapist by treating her as inferior to them.

They are self-centered, self-preoccupied, repetitive, and, thus, boring.

Subjects with personality disorders seek to manipulate and exploit others. They trust no one and have a diminished capacity to love or intimately share because they do not trust or love themselves. They are socially maladaptive and emotionally unstable.

Etiology

Childhood and early adolescence as problems in personal development.

Exacerbated by repeated **abuse, trauma, abandonment, and rejection**.

Constitute **adaptive defense mechanims**

Clinical Features

Rigid and enduring patterns of traits, emotions, and cognitions.

Stable and all-pervasive (affect all areas of life), not episodic.

Cause **distress**

Comorbid with mood and anxiety disorders.

Alloplastic defenses and external locus of control.

Paranoid persecutory delusions and **anxieties**.

They regard everyone and everything as mere **instruments of gratification**.

Differential Diagnosis: No hallucinations, delusions or thought disorders (except brief psychotic "microepisodes", mostly during treatment). Fully oriented, with clear senses (sensorium), good memory and a satisfactory general fund of knowledge.

Criticism of DSM

Axis II personality disorders: deeply ingrained, maladaptive, lifelong behavior patterns, "***qualitatively distinct clinical syndromes"*** (p. 689) = **categorical** approach.

"**Diagnostic thresholds**" between normal and abnormal absent or weakly supported.

Polythetic form of the DSM's Diagnostic Criteria – only a subset of the criteria is adequate grounds for a diagnosis – generates unacceptable diagnostic **heterogeneity** (people diagnosed with the same personality disorder may share only one criterion or none.)

No exact relationship between Axis II and Axis I disorders and chronic childhood and developmental problems and personality disorders.

Differential diagnoses vague and personality disorders are **insufficiently demarcated**. The result is **excessive co-morbidity** (multiple Axis II diagnoses).

No discussion of spectrum: normal character (personality), personality traits, or personality style (Millon) from personality disorders.

Little **documented clinical experience** regarding disorders and treatment modalities.

Many personality disorders "**not otherwise specified**".

Cultural bias.

Dimensional alternatives to the categorical approach acknowledged in DSM-IV-TR:

"An alternative to the categorical approach is the dimensional perspective that Personality Disorders represent maladaptive variants of personality traits that merge imperceptibly into normality and into one another" (p.689)

Issues:

- The longitudinal course of the disorder(s) and their temporal stability from early childhood onwards;
- The genetic and biological underpinnings of personality disorder(s);

- The development of personality psychopathology during childhood and its emergence in adolescence;

- The interactions between physical health and disease and personality disorders;

- The effectiveness of various treatments – talk therapies as well as psychopharmacology.

EXPANDED VERSION

"You can know the name of a bird in all the languages of the world, but when you're finished, you'll know absolutely nothing whatever about the bird… So let's look at the bird and see what it's doing – that's what counts. I learned very early the difference between knowing the name of something and knowing something."

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Lawrence Sterne (1713-1758), "The Life and Opinions of Tristram Shandy, Gentleman" (1759)

Someone is considered mentally "ill" if:

1. His conduct rigidly and consistently deviates from the typical, average behaviour of all other people in his culture and society that fit his profile (whether this conventional behaviour is moral or rational is immaterial), or

2. His judgment and grasp of objective, physical reality is impaired, and

3. His conduct is not a matter of choice but is innate and irresistible, and

4. His behavior causes him or others discomfort, and is

5. Dysfunctional, self-defeating, and self-destructive even by his own yardsticks.

Descriptive criteria aside, what is the ***essence*** of mental disorders? Are they merely physiological disorders of the brain, or, more precisely of its chemistry? If so, can they be cured by restoring the balance of substances and secretions in that mysterious organ? And, once equilibrium is reinstated – is the illness "gone" or is it still lurking there, "under wraps", waiting to erupt? Are psychiatric problems inherited, rooted in faulty genes (though amplified by environmental factors) – or brought on by abusive or wrong nurturance?

These questions are the domain of the "medical" school of mental health.

Others cling to the spiritual view of the human psyche. They believe that mental ailments amount to the metaphysical discomposure of an unknown medium – the soul. Theirs is a holistic approach, taking in the patient in his or her entirety, as well as his milieu.

The members of the functional school regard mental health disorders as perturbations in the proper, statistically "normal", behaviours and manifestations of "healthy" individuals, or as dysfunctions. The "sick" individual – ill at ease with himself (ego-dystonic) or making others unhappy (deviant) – is "mended" when rendered functional again by the prevailing standards of his social and cultural frame of reference.

In a way, the three schools are akin to the trio of blind men who render disparate descriptions of the very same elephant. Still, they share not only their subject matter – but, to a counter intuitively large degree, a faulty methodology.

As the renowned anti-psychiatrist, Thomas Szasz, of the State University of New York, notes in his article ***"The Lying Truths of Psychiatry"***, mental health scholars, regardless of academic predilection, infer the etiology of mental disorders from the success or failure of treatment modalities.

This form of "reverse engineering" of scientific models is not unknown in other fields of science, nor is it unacceptable if the experiments meet the criteria of the scientific method. The theory must be all-inclusive (anamnetic), consistent, falsifiable, logically compatible, monovalent, and parsimonious. Psychological "theories" – even the "medical" ones (the role of serotonin and dopamine in mood disorders, for instance) – are usually none of these things.

The outcome is a bewildering array of ever-shifting mental health "diagnoses" expressly centred around Western civilisation and its standards (example: the ethical objection to suicide). Neurosis, a historically fundamental "condition" vanished after 1980. Homosexuality, according to the American Psychiatric Association, was a pathology prior to 1973. Seven years later, narcissism was declared a "personality disorder", almost seven decades after it was first described by Freud. Prominent psychiatrists have taken to accusing the committee that is busy writing the next, fifth edition of the DSM (to be published in 2013) of pathologizing large swathes of the population:

"Two eminent retired psychiatrists are warning that the revision process is fatally flawed. They say the new manual, to be known as DSM-V, will extend definitions of mental illnesses so broadly that tens of millions of people will be given unnecessary and risky drugs. Leaders of the American Psychiatric Association (APA), which publishes the manual, have shot back, accusing the pair of being motivated by their own financial interests - a charge they deny." (New Scientist, "Psychiatry's Civil War", December 2009).

II. Personality Disorders

In their opus magnum "Personality Disorders in Modern Life", Theodore Millon and Roger Davis define personality as:

"(A) complex pattern of deeply embedded psychological characteristics that are expressed automatically in almost every area of psychological functioning." (p. 2)

The Diagnostic and Statistical Manual (DSM)) IV-TR (2000), published by the American Psychiatric Association, defines personality traits as:

"(E)nduring patterns of perceiving, relating to, and thinking about the environment and oneself that are exhibited in a wide range of social and personal contexts." (p. 686)

Laymen often confuse and confute "personality" with "character" and "temperament".

Our temperament is the biological-genetic template that interacts with our environment.

Our temperament is a set of in-built dispositions we are born with. It is mostly unalterable (though recent studies demonstrate that the brain is far more plastic and elastic than we thought).

In other words, our temperament is our nature.

Our character is largely the outcome of the process of socialization, the acts and imprints of our environment and nurture on our psyche during the formative years (0-6 years and in adolescence).

Our character is the set of all acquired characteristics we posses, often judged in a cultural-social context.

Sometimes the interplay of all these factors results in an abnormal personality.

Phineas Gage was a 25 years old construction foreman who lived in Vermont in the 1860s. While working on a railroad bed, he packed powdered explosives into a hole in the ground, using tamping iron. The powder heated and blew in his face. The tamping iron rebounded and pierced the top of his skull, ravaging the frontal lobes.

In 1868, Harlow, his doctor, reported the changes to his personality following the accident:

He became "fitful, irreverent, indulging at times in the grossest profanity (which was not previously his customs), manifesting but little deference to his fellows, impatient of restraint or advice when it conflicts with his desires, at times pertinaciously obstinate yet capricious and vacillating, devising many plans for future operation which are no sooner arranged than they are abandoned in turn for others appearing more feasible ... His mind was radically changed, so that his friends and acquaintances said he was no longer Gage."

In other words, his brain injury turned him into a psychopathic narcissist.

Similarly startling transformation have been recorded among soldiers with penetrating head injuries suffered in World War I. Orbitomedial wounds made people "pseudopsychopathic": grandiose, euphoric, disinhibited, and puerile. When the dorsolateral convexities were damaged, those affected became lethargic and apathetic ("pseudodepressed"). As Geschwind noted, many had both syndromes.

The DSM is clear: the brain-injured may acquire traits and behaviors typical of certain personality disorders but head trauma never results in a full-fledged personality disorder.

"General diagnostic criteria for a personality disorder:

F. The enduring pattern is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., head trauma)." (DSM-IV-TR, p.689)

From my book "Malignant Self-love - Narcissism Revisited":

"It is conceivable, though, that a third, unrelated problem causes chemical imbalances in the brain, metabolic diseases such as diabetes, pathological narcissism, and other mental health syndromes. There may be a common cause, a hidden common denominator (perhaps a group of genes).

Certain medical conditions can activate the narcissistic defense mechanism. Chronic ailments are likely to lead to the emergence of narcissistic traits or a narcissistic personality style. Traumas (such as brain injuries) have been known to induce states of mind akin to full-blown personality disorders. Such "narcissism", though, is reversible and tends to be ameliorated or disappear altogether when the underlying medical problem does. Other disorders, like the Bipolar Disorder (mania-depression) are characterised by mood swings that are not brought about by external events (endogenous, not exogenous). But the narcissist's mood swings are strictly the results of external events (as he perceives and interprets them, of course).

But phenomena, which are often associated with NPD (Narcissistic Personality Disorder), such as depression or OCD (obsessive-compulsive disorder), are treated with medication. Rumour has it that SSRI's (such as Fluoxetine, known as Prozac) might have adverse effects if the primary disorder is NPD. They sometimes lead to

the Serotonin syndrome, which includes agitation and exacerbates the rage attacks typical of a narcissist. The use of SSRI's is associated at times with delirium and the emergence of a manic phase and even with psychotic microepisodes.

This is not the case with the heterocyclics, MAO and mood stabilisers, such as lithium. Blockers and inhibitors are regularly applied without discernible adverse side effects (as far as NPD is concerned).

Not enough is known about the biochemistry of NPD. There seems to be some vague link to Serotonin but no one knows for sure. There isn't a reliable non-intrusive method to measure brain and central nervous system Serotonin levels anyhow, so it is mostly guesswork at this stage."

Personality disorders are dysfunctions of our whole identity, tears in the fabric of who we are. They are all-pervasive because our personality is ubiquitous and permeates each and every one of our mental cells. I just published the first article in this topic titled "What is Personality?". Read it to understand the subtle differences between "personality", "character", and "temperament".

In the background lurks the question: what constitutes normal behavior? Who is normal?

There is the statistical response: the average and the common are normal. But it is unsatisfactory and incomplete. Conforming to social edicts and mores does not guarantee normalcy. Think about anomic societies and periods of history such as Hitler's Germany or Stalin's Russia. Model citizens in these hellish environments were the criminal and the sadist.

Rather than look to the outside for a clear definition, many mental health professionals ask: is the patient functioning and happy (ego-syntonic)? If he or she is both then all is well and normal. Abnormal traits, behaviors, and personalities are, therefore defined as those traits, behaviors, and personalities that are dysfunctional and cause subjective distress.

But, of course, this falls flat on its face at the slightest scrutiny. Many evidently mentally ill people are rather happy and reasonably functional.

Some scholars reject the concept of "normalcy" altogether. The anti-psychiatry movement object to the medicalization and pathologization of whole swathes of human conduct. Others prefer to study the disorders themselves rather to "go metaphysical" by trying to distinguish them from an imaginary and ideal state of being "mentally healthy".

I subscribe to the later approach. I much prefer to delve into the phenomenology of mental health disorders: their traits, characteristics, and impact on others.

Well into the eighteenth century, the only types of mental illness - then collectively known as "delirium" or "mania" - were depression (melancholy), psychoses, and delusions. At the beginning of the nineteenth century, the French psychiatrist Pinel coined the phrase "manie sans delire" (insanity without delusions). He described patients who lacked impulse control, often raged when frustrated, and were prone to outbursts of violence. He noted that such patients were not subject to delusions. He was referring, of course, to psychopaths (subjects with the Antisocial Personality Disorder). Across the ocean, in the United States, Benjamin Rush made similar observations.

In 1835, the British J. C. Pritchard, working as senior Physician at the Bristol Infirmary (hospital), published a seminal work titled "Treatise on Insanity and Other Disorders of the Mind". He, in turn, suggested the neologism "moral insanity".

To quote him, moral insanity consisted of "a morbid perversion of the natural feelings, affections, inclinations, temper, habits, moral dispositions, and natural impulses without any remarkable disorder or defect of the intellect or knowing or reasoning faculties and in particular without any insane delusion or hallucination" (p. 6).

He then proceeded to elucidate the psychopathic (antisocial) personality in great detail:

"(A) propensity to theft is sometimes a feature of moral insanity and sometimes it is its leading if not sole characteristic." (p. 27). "(E)ccentricity of conduct, singular and absurd habits, a propensity to perform the common actions of life in a different way from that usually practised, is a feature of many cases of moral insanity but can hardly be said to contribute sufficient evidence of its existence." (p. 23).

"When however such phenomena are observed in connection with a wayward and intractable temper with a decay of social affections, an aversion to the nearest relatives and friends formerly beloved - in short, with a change in the moral character of the individual, the case becomes tolerably well marked." (p. 23)

But the distinctions between personality, affective, and mood disorders were still murky.

Pritchard muddied it further:

"(A) considerable proportion among the most striking instances of moral insanity are those in which a tendency to gloom or sorrow is the predominant feature ... (A) state of gloom or melancholy depression occasionally gives way ... to the opposite condition of preternatural excitement." (pp. 18-19)

Another half century were to pass before a system of classification emerged that offered differential diagnoses of mental illness without delusions (later known as personality disorders), affective disorders, schizophrenia, and depressive illnesses. Still, the term "moral insanity" was being widely used.

Henry Maudsley applied it in 1885 to a patient whom he described as:

"(Having) no capacity for true moral feeling - all his impulses and desires, to which he yields without check, are egoistic, his conduct appears to be governed by immoral motives, which are cherished and obeyed without any evident desire to resist them." ("Responsibility in Mental Illness", p. 171).

But Maudsley already belonged to a generation of physicians who felt increasingly uncomfortable with the vague and judgmental coinage "moral insanity" and sought to replace it with something a bit more scientific.

Maudsley bitterly criticized the ambiguous term "moral insanity":

"(It is) a form of mental alienation which has so much the look of vice or crime that many people regard it as an unfounded medical invention (p. 170).

In his book "Die Psychopatischen Minderwertigkeiter", published in 1891, the German doctor J. L. A. Koch tried to improve on the situation by suggesting the phrase "psychopathic inferiority". He limited his diagnosis to people who are not retarded or mentally ill but still display a rigid pattern of misconduct and dysfunction throughout their increasingly disordered lives. In later editions, he replaced "inferiority" with "personality" to avoid sounding judgmental. Hence the "psychopathic personality".

Twenty years of controversy later, the diagnosis found its way into the 8th edition of E. Kraepelin's seminal "Lehrbuch der Psychiatrie" ("Clinical Psychiatry: a textbook for students and physicians"). By that time, it merited a whole lengthy chapter in which Kraepelin suggested six additional types of disturbed personalities: excitable, unstable, eccentric, liar, swindler, and quarrelsome.

Still, the focus was on antisocial behavior. If one's conduct caused inconvenience or suffering or even merely annoyed someone or flaunted the norms of society, one was liable to be diagnosed as "psychopathic".

In his influential books, "The Psychopathic Personality" (9th edition, 1950) and "Clinical Psychopathology" (1959), another German psychiatrist, K. Schneider sought to expand the diagnosis to include people who harm and inconvenience themselves as well as others. Patients who are depressed, socially anxious, excessively shy and insecure were all deemed by him to be "psychopaths" (in another word, abnormal).

This broadening of the definition of psychopathy directly challenged the earlier work of Scottish psychiatrist, Sir David Henderson. In 1939, Henderson published "Psychopathic States", a book that was to become an instant classic. In it, he postulated that, though not mentally subnormal, psychopaths are people who:

"(T)hroughout their lives or from a comparatively early age, have exhibited disorders of conduct of an antisocial or asocial nature, usually of a recurrent episodic type which in many instances have proved difficult to influence by methods of social, penal and medical care or for whom we have no adequate provision of a preventative or curative nature."

But Henderson went a lot further than that and transcended the narrow view of psychopathy (the German school) then prevailing throughout Europe.

In his work (1939), Henderson described three types of psychopaths. Aggressive psychopaths were violent, suicidal, and prone to substance abuse. Passive and inadequate psychopaths were over-sensitive, unstable and hypochondriacal. They were also introverts (schizoid) and pathological liars. Creative psychopaths were all dysfunctional people who managed to become famous or infamous.

Twenty years later, in the 1959 Mental Health Act for England and Wales, "psychopathic disorder" was defined thus, in section 4(4):

"(A) persistent disorder or disability of mind (whether or not including subnormality of intelligence) which results in abnormally aggressive or seriously irresponsible conduct on the part of the patient, and requires or is susceptible to medical treatment."

This definition reverted to the minimalist and cyclical (tautological) approach: abnormal behavior is that which causes harm, suffering, or discomfort to others. Such behavior is, ipso facto, aggressive or irresponsible. Additionally it failed to tackle and even excluded manifestly abnormal behavior that does not require or is not susceptible to medical treatment.

Thus, "psychopathic personality" came to mean both "abnormal" and "antisocial". This confusion persists to this very day. Scholarly debate still rages between those, such as the Canadian Robert, Hare, who distinguish the psychopath from the patient with mere antisocial personality disorder and those (the orthodoxy) who wish to avoid ambiguity by using only the latter term.

Moreover, these nebulous constructs resulted in co-morbidity. Patients were frequently diagnosed with multiple and largely overlapping personality disorders, traits, and styles. As early as 1950, Schneider wrote:

"Any clinician would be greatly embarrassed if asked to classify into appropriate types the psychopaths (that is abnormal personalities) encountered in any one year."

Today, most practitioners rely on either the Diagnostic and Statistical Manual (DSM), now in its fourth, revised text, edition or on the International Classification of Diseases (ICD), now in its tenth edition.

The two tomes disagree on some issues but, by and large, conform to each other.

Psychology is more an art form than a science. There is no "Theory of Everything" from which one can derive all mental health phenomena and make falsifiable predictions. Still, as far as personality disorders are concerned, it is easy to discern common features. Most personality disorders share a set of symptoms (as reported by the patient) and signs (as observed by the mental health practitioner).

Patients suffering from personality disorders have these things in common:

They are persistent, relentless, stubborn, and insistent (except those suffering from the Schizoid or the Avoidant Personality Disorders).

They feel entitled to - and vociferously demand - preferential treatment and privileged access to resources and personnel. They often complain about multiple symptoms. They get involved in "power plays" with authority figures (such as physicians, therapists, nurses, social workers, bosses, and bureaucrats) and rarely obey instructions or observe rules of conduct and procedure.

They hold themselves to be superior to others or, at the very least, unique. Many personality disorders involve an inflated self-perception and grandiosity. Such subjects are incapable of empathy (the ability to appreciate and respect the needs and wishes of other people). In therapy or medical treatment, they alienate the physician or therapist by treating her as inferior to them.

Patients with personality disorders are self-centered, self-preoccupied, repetitive, and, thus, boring.

Subjects with personality disorders seek to manipulate and exploit others. They trust no one and have a diminished capacity to love or intimately share because they do not trust or love themselves. They are socially maladaptive and emotionally unstable.

No one knows whether personality disorders are the tragic outcomes of nature or the sad follow-up to a lack of nurture by the patient's environment.

Generally speaking, though, most personality disorders start out in childhood and early adolescence as mere problems in personal development. Exacerbated by repeated abuse and rejection, they then become full-fledged dysfunctions. Personality disorders are rigid and enduring patterns of traits, emotions, and cognitions. In other words, they rarely "evolve" and are stable and all-pervasive,

not episodic. By 'all-pervasive", I mean to say that they affect every area in the patient's life: his career, his interpersonal relationships, his social functioning.

Personality disorders cause unhappiness and are usually comorbid with mood and anxiety disorders. Most patients are ego-dystonic (except narcissists and psychopaths). They dislike and resent who they are, how they behave, and the pernicious and destructive effects they have on their nearest and dearest. Still, personality disorders are defense mechanisms writ large. Thus, few patients with personality disorders are truly self-aware or capable of life transforming introspective insights.

Patients with personality disorder typically suffer from a host of other psychiatric problems (example: depressive illnesses, or obsessions-compulsions). They are worn-out by the need to reign in their self-destructive and self-defeating impulses.

Patients with personality disorders have alloplastic defenses and an external locus of control. In other words: rather than accept responsibility for the consequences of their actions, they tend to blame other people or the outside world for their misfortune, failures, and circumstances. Consequently, they fall prey to paranoid persecutory delusions and anxieties. When stressed, they try to preempt (real or imaginary) threats by changing the rules of the game, introducing new variables, or by trying to manipulate their environment to conform to their needs. They regard everyone and everything as mere instruments of gratification.

Patients with Cluster B personality disorders (Narcissistic, Antisocial, Borderline, and Histrionic) are mostly ego-syntonic, even though they are faced with formidable character and behavioral deficits, emotional deficiencies and lability, and overwhelmingly wasted lives and squandered potentials. Such patients do not, on the whole, find their personality traits or behavior objectionable, unacceptable, disagreeable, or alien to their selves.

There is a clear distinction between patients with personality-disorders and patients with psychoses (schizophrenia-paranoia and the like). As opposed to the latter, the former have no hallucinations, delusions or thought disorders. At the extreme, subjects who suffer from the Borderline Personality Disorder experience brief psychotic "microepisodes", mostly during treatment. Patients with personality disorders are also fully oriented, with clear senses (sensorium), good memory and a satisfactory general fund of knowledge.

Indeed, personality disorders are an excellent example of the kaleidoscopic landscape of "objective" psychiatry.

The classification of Axis II personality disorders – deeply ingrained, maladaptive, lifelong behavior patterns – in the ***Diagnostic and Statistical Manual***, fourth edition, text revision [American Psychiatric Association. DSM-IV-TR, Washington, 2000] – or the DSM-

IV-TR for short – has come under sustained and serious criticism from its inception in 1952, in the first edition of the DSM.

The DSM IV-TR adopts a categorical approach, postulating that personality disorders are ***"qualitatively distinct clinical syndromes"*** (p. 689). This is widely doubted. Even the distinction made between "normal" and "disordered" personalities is increasingly being rejected. The "diagnostic thresholds" between normal and abnormal are either absent or weakly supported.

The polythetic form of the DSM's Diagnostic Criteria – only a subset of the criteria is adequate grounds for a diagnosis – generates unacceptable diagnostic heterogeneity. In other words, people diagnosed with the same personality disorder may share only one criterion or none.

The DSM fails to clarify the exact relationship between Axis II and Axis I disorders and the way chronic childhood and developmental problems interact with personality disorders.

The differential diagnoses are vague and the personality disorders are insufficiently demarcated. The result is excessive co-morbidity (multiple Axis II diagnoses).

The DSM contains little discussion of what distinguishes normal character (personality), personality traits, or personality style (Millon) – from personality disorders.

A dearth of documented clinical experience regarding both the disorders themselves and the utility of various treatment modalities.

Numerous personality disorders are "not otherwise specified" – a catchall, basket "category".

Cultural bias is evident in certain disorders (such as the Antisocial and the Schizotypal).

The emergence of dimensional alternatives to the categorical approach is acknowledged in the DSM-IV-TR itself:

"An alternative to the categorical approach is the dimensional perspective that Personality Disorders represent maladaptive variants of personality traits that merge imperceptibly into normality and into one another" (p.689)

The following issues – long neglected in the DSM – are likely to be tackled in future editions as well as in current research. But their omission from official discourse hitherto is both startling and telling:

- The longitudinal course of the disorder(s) and their temporal stability from early childhood onwards;
- The genetic and biological underpinnings of personality disorder(s);
- The development of personality psychopathology during childhood and its emergence in adolescence;

- The interactions between physical health and disease and personality disorders;

- The effectiveness of various treatments – talk therapies as well as psychopharmacology.

III. The Biochemistry and Genetics of Mental Health

Certain mental health afflictions are either correlated with a statistically abnormal biochemical activity in the brain – or are ameliorated with medication. Yet the two ***facts*** are not ineludibly facets of ***the same*** underlying phenomenon. In other words, that a given medicine reduces or abolishes certain symptoms does not necessarily mean they were ***caused*** by the processes or substances affected by the drug administered. Causation is only one of many possible connections and chains of events.

To designate a pattern of behaviour as a mental health disorder is a value judgment, or at best a statistical observation. Such designation is effected regardless of the facts of brain science. Moreover, correlation is not causation. Deviant brain or body biochemistry (once called "polluted animal spirits") do exist – but are they truly the roots of mental perversion? Nor is it clear which triggers what: do the aberrant neurochemistry or biochemistry cause mental illness – or the other way around?

That psychoactive medication alters behaviour and mood is indisputable. So do illicit and legal drugs, certain foods, and all interpersonal interactions. That the changes brought about by prescription are desirable – is debatable and involves tautological thinking. If a certain pattern of behaviour is described as (socially) "dysfunctional" or (psychologically) "sick" – clearly, every change would be welcomed as "healing" and every agent of transformation would be called a "cure".

The same applies to the alleged heredity of mental illness. Single genes or gene complexes are frequently "associated" with mental health diagnoses, personality traits, or behaviour patterns. But too little is known to establish irrefutable sequences of causes-and-effects. Even less is proven about the interaction of nature and nurture, genotype and phenotype, the plasticity of the brain and the psychological impact of trauma, abuse, upbringing, role models, peers, and other environmental elements.

Nor is the distinction between psychotropic substances and talk therapy that clear-cut. Words and the interaction with the therapist also affect the brain, its processes and chemistry - albeit more slowly and, perhaps, more profoundly and irreversibly. Medicines – as David Kaiser reminds us in ***"Against Biologic Psychiatry"*** (Psychiatric Times, Volume XIII, Issue 12, December 1996) – treat symptoms, not the underlying processes that yield them.

IV. The Variance of Mental Disease

If mental illnesses are bodily and empirical, they should be invariant both temporally and spatially, across cultures and societies. This, to some degree, is, indeed, the case. Psychological diseases are not context dependent – but the pathologizing of certain behaviours is. Suicide, substance abuse, narcissism, eating disorders, antisocial ways, schizotypal symptoms, depression, even psychosis are considered sick by some cultures – and utterly normative or advantageous in others.

This was to be expected. The human mind and its dysfunctions are alike around the world. But values differ from time to time and from one place to another. Hence, disagreements about the propriety and desirability of human actions and inaction are bound to arise in a symptom-based diagnostic system.

As long as the ***pseudo-medical*** definitions of mental health disorders continue to rely exclusively on signs and symptoms – i.e., mostly on observed or reported behaviours – they remain vulnerable to such discord and devoid of much-sought universality and rigor.

V. Mental Disorders and the Social Order

The mentally sick receive the same treatment as carriers of AIDS or SARS or the Ebola virus or smallpox. They are sometimes quarantined against their will and coerced into involuntary treatment by medication, psychosurgery, or electroconvulsive therapy. This is done in the name of the greater good, largely as a preventive policy.

Conspiracy theories notwithstanding, it is impossible to ignore the enormous interests vested in psychiatry and psychopharmacology. The multibillion dollar industries involving drug companies, hospitals, managed healthcare, private clinics, academic departments, and law enforcement agencies rely, for their continued and exponential growth, on the propagation of the concept of "mental illness" and its corollaries: treatment and research.

"The wording used in the DSM has a significance that goes far beyond questions of semantics. The diagnoses it enshrines affect what treatments people receive, and whether health insurers will fund them. They can also exacerbate social stigmas and may even be used to deem an individual such a grave danger to society that they are locked up ... Some of the most acrimonious arguments stem from worries about the pharmaceutical industry's influence over psychiatry. This has led to the spotlight being turned on the financial ties of those in charge of revising the manual, and has made any diagnostic changes that could expand the use of drugs especially controversial." (New Scientist, "Psychiatry's Civil War", December 2009).

VI. Mental Ailment as a Useful Metaphor

Abstract concepts form the core of all branches of human knowledge. No one has ever seen a quark, or untangled a chemical bond, or surfed an electromagnetic wave, or visited the unconscious. These are useful metaphors, theoretical entities with explanatory or descriptive power.

"Mental health disorders" are no different. They are shorthand for capturing the unsettling quiddity of "the Other". Useful as taxonomies, they are also tools of social coercion and conformity, as Michel Foucault and Louis Althusser observed. Relegating both the dangerous and the idiosyncratic to the collective fringes is a vital technique of social engineering.

The aim is progress through social cohesion and the regulation of innovation and creative destruction. Psychiatry, therefore, is reifies society's preference of evolution to revolution, or, worse still, to mayhem. As is often the case with human endeavour, it is a noble cause, unscrupulously and dogmatically pursued.

VII. The Insanity Defense

"It is an ill thing to knock against a deaf-mute, an imbecile, or a minor. He that wounds them is culpable, but if they wound him they are not culpable." (Mishna, Babylonian Talmud)

If mental illness is culture-dependent and mostly serves as an organizing social principle - what should we make of the insanity defense (NGRI- Not Guilty by Reason of Insanity)?

A person is held not responsible for his criminal actions if s/he cannot tell right from wrong ("lacks substantial capacity either to appreciate the criminality (wrongfulness) of his conduct" - diminished capacity), did not intend to act the way he did (absent "mens rea") and/or could not control his behavior ("irresistible impulse"). These handicaps are often associated with "mental disease or defect" or "mental retardation".

Mental health professionals prefer to talk about an impairment of a "person's perception or understanding of reality". They hold a "guilty but mentally ill" verdict to be contradiction in terms. All "mentally-ill" people operate within a (usually coherent) worldview, with consistent internal logic, and rules of right and wrong (ethics). Yet, these rarely conform to the way most people perceive the world. The mentally-ill, therefore, cannot be guilty because s/he has a tenuous grasp on reality.

Yet, experience teaches us that a criminal maybe mentally ill even as s/he maintains a perfect reality test and thus is held criminally responsible (Jeffrey Dahmer comes to mind). The "perception and understanding of reality", in other words, can and does co-exist even with the severest forms of mental illness.

This makes it even more difficult to comprehend what is meant by "mental disease". If some mentally ill maintain a grasp on reality, know right from wrong, can anticipate the outcomes of their actions, are not subject to irresistible impulses (the official position of the American Psychiatric Association) - in what way do they differ from us, "normal" folks?

This is why the insanity defense often sits ill with mental health pathologies deemed socially "acceptable" and "normal" - such as religion or love.

Consider the following case:

A mother bashes the skulls of her three sons. Two of them die. She claims to have acted on instructions she had received from God. She is found not guilty by reason of insanity. The jury determined that she "did not know right from wrong during the killings."

But why exactly was she judged insane?

Her belief in the existence of God - a being with inordinate and inhuman attributes - may be irrational.

But it does not constitute insanity in the strictest sense because it conforms to social and cultural creeds and codes of conduct in her milieu. Billions of people faithfully subscribe to the same ideas, adhere to the same transcendental rules, observe the same mystical rituals, and claim to go through the same experiences. This shared psychosis is so widespread that it can no longer be deemed pathological, statistically speaking.

She claimed that God has spoken to her.

As do numerous other people. Behavior that is considered psychotic (paranoid-schizophrenic) in other contexts is lauded and admired in religious circles. Hearing voices and seeing visions - auditory and visual delusions - are considered rank manifestations of righteousness and sanctity.

Perhaps it was the content of her hallucinations that proved her insane?

She claimed that God had instructed her to kill her boys. Surely, God would not ordain such evil?

Alas, the Old and New Testaments both contain examples of God's appetite for human sacrifice. Abraham was ordered by God to sacrifice Isaac, his beloved son (though this savage command was rescinded at the last moment). Jesus, the son of God himself, was crucified to atone for the sins of humanity.

A divine injunction to slay one's offspring would sit well with the Holy Scriptures and the Apocrypha as well as with millennia-old Judeo-Christian traditions of martyrdom and sacrifice.

Her actions were wrong and incommensurate with both human and divine (or natural) laws.

Yes, but they were perfectly in accord with a literal interpretation of certain divinely-inspired texts, millennial scriptures, apocalyptic thought systems, and fundamentalist religious ideologies (such as the ones espousing the imminence of "rupture"). Unless one declares these doctrines and writings insane, her actions are not.

we are forced to the conclusion that the murderous mother is perfectly sane. Her frame of reference is different to ours. Hence, her definitions of right and wrong are idiosyncratic. To her, killing her babies was the right thing to do and in conformity with valued teachings and her own epiphany. Her grasp of reality - the immediate and later consequences of her actions - was never impaired.

It would seem that sanity and insanity are relative terms, dependent on frames of cultural and social reference, and statistically defined. There isn't - and, in principle, can never emerge - an "objective", medical, scientific test to determine mental health or disease unequivocally.

VIII. Adaptation and Insanity - (correspondence with Paul Shirley, MSW)

"Normal" people adapt to their environment - both human and natural.

"Abnormal" ones try to adapt their environment - both human and natural - to their idiosyncratic needs/profile.

If they succeed, their environment, both human (society) and natural is pathologized.

Note on the Medicalization of Sin and Wrongdoing

With Freud and his disciples started the medicalization of what was hitherto known as "sin", or wrongdoing. As the vocabulary of public discourse shifted from religious terms to scientific ones, offensive behaviors that constituted transgressions against the divine or social orders have been relabelled. Self-centredness and dysempathic egocentricity have now come to be known as "pathological narcissism"; criminals have been transformed into psychopaths, their behavior, though still described as anti-social, the almost deterministic outcome of a deprived childhood or a genetic predisposition to a brain biochemistry gone awry - casting in doubt the very existence of free will and free choice between good and evil. The contemporary "science" of psychopathology now amounts to a godless variant of Calvinism, a kind of predestination by nature or by nurture.

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