CHAPTER 20

Reading 20.1 **Dickenson, D. and Fulford, K.W.M. (2000). Rationality, responsibility and values. Chapter 4 in *In Two Minds: a casebook of psychiatric ethics*. Oxford: Oxford University Press. (Extract, pps 109–111. Cartoon by Jonny Cowee.)**

Reading 20.2 **The case continues from: Dickenson, D. and Fulford, K.W.M. (2000). Rationality, responsibility and values. Chapter 4 in *In Two Minds: a casebook of psychiatric ethics*. Oxford: Oxford University Press. (Extract, p 112.)**

Reading 20.3 **American Psychiatric Association (1994). Introduction, *Diagnostic and Statistical Manual of Mental Disorders* (4th edn). Washington, DC: American Psychiatric Association. (Extract p. xv.)**

Reading 20.4 **Definition of Mental Disorders, pps xxi–xxii, in American Psychiatric Association (1994). *Diagnostic and Statistical Manual of Mental Disorders*. Washington, DC: American Psychiatric Association. (Extract pps xxi–xxii.)**

Reading 20.5 **Diagnostic features of Personality Disorders, p 630, in American Psychiatric Association (1994), *Diagnostic and Statistical Manual of Mental Disorders,* Washington, DC: American Psychiatric association**

Reading 20.6 **Diagnostic Feature of Paraphilias, pps 522–523, American Psychiatric Association (1994). *Diagnostic and Statistical Manual of Mental Disorders*. Washington, DC: American Psychiatric Association. (Extract, p 523.)**

Reading 20.7 **Dickenson, D. and Fulford, K.W.M. (2000). Basic concepts: your myth or mine. Chapter 3 in *In Two Minds: a casebook of psychiatric ethics*. Oxford: Oxford University Press. (Extract p 59–60.)**

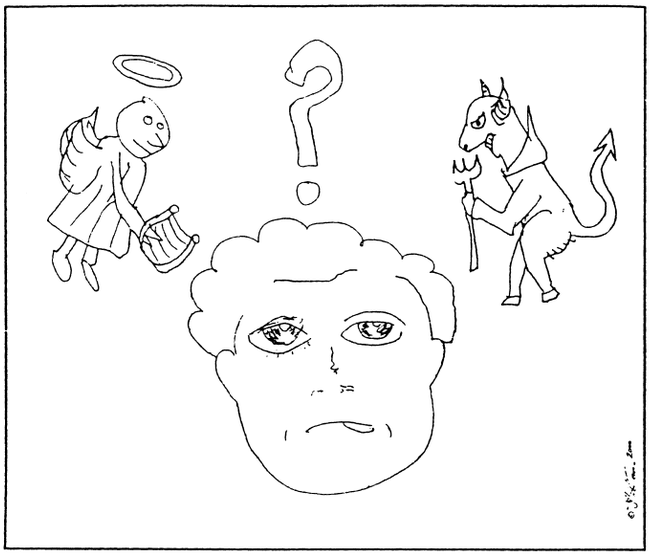
Reading 20.8 **Reich, W. (1999). Psychiatric diagnosis as an ethical problem. Chapter 10 in *In Psychiatric Ethics* (ed. S. Bloch, P. Chodoff, and S. Green) (3rd edn). Oxford: Oxford University Press. (pages 193–224).**

Reading 20.1 EXERCISE 1

Simon Greer's case history, from: Dickenson, D. and Fulford, K.W.M. (2000). Rationality, responsibility and values. Chapter 4 in *In Two Minds: a casebook of psychiatric ethics*. Oxford: Oxford University Press. (Extract, pps 109–111. Cartoon by Jonny Cowee.)

Simon, 40 years old, was a senior African-American professional, from a middle-class Baptist family. Although not particularly religious in outlook, he had had occasional, relatively unremarkable, psychic experiences at various times in his life. These had led him to seek the guidance of a professional 'seer', whom he occasionally consulted on major life events and decisions.

His story was that his hitherto successful career was now threatened by legal action from his colleagues. Although he claimed to be innocent, mounting a defence would be expensive and hazardous. He had responded to this crisis by praying at a small altar which he set up in his front room. After an emotional evening's outpouring, he discovered that the candle wax had left a 'seal' or 'sun' on several consecutive pages of his Bible, covering certain letters and words. He described his experiences thus: 'I got up and I saw the seal that was in my father's Bible and I called X and I said, you know, "Something remarkable is going on over here". I think the beauty of it was the specificity by which the sun burned through. It was . . . in my mind, a clever play on words.' Although the marked words and letters had no explicit meaning, Simon interpreted this event as a direct communication from God, which signified that he had a special purpose or mission.



After this first episode, Simon received a complex series of 'revelations', largely conveyed through the images left in melted candle wax. He carried photos of these, which most observers found unimpressive, but which were, for him, clearly representations of biblical symbols, particularly from the book of Revelations (the bull, the 24 elders, the arc of the covenant, and so on). He interpreted them as signifying that 'I am the living son of David . . . and I'm also a relative of Ishmael, and . . . of Joseph'. He was also the 'captain of the guard of Israel'. He found this role carried awesome responsibilities: 'Sometimes I'm saying—O my God, why did you choose me, and there's no answer to that'. His special status had the effect of 'increasing my own inward sense, wisdom, understanding, and endurance' which would 'allow me to do whatever is required in terms of bringing whatever message it is that God wants me to bring'.

His beliefs were highly systematized, in that he interpreted much of his ongoing experience in terms of them. His colleagues were agents of Satan, trying to thwart him, and his career successes were evidence of God's special favour. Relatively trivial obstacles which he encountered in daily life—such as having a cold at the time of the interview—were satanically motivated trials of purpose. In the course of these experiences, Simon had both heard God's voice and seen 'prophetic' visions. He expressed these beliefs with full conviction 'The truths that are up in that room are the truths that have been spoken of for 4000 years'. When confronted with scepticism, he commented: 'I don't get upset, because I know within myself, what I know'.

He also described experiences of his thoughts being 'short-circuited'. 'If you're sitting and watching television, and then somebody turns on the vacuum cleaner, and the TV goes on the fritz, it's like that'; and again, 'the things that come are not the things that I have been thinking about . . . they kind of short-circuit the brain, and bring their message'.

Simon had no insight in the sense (defined in the PSE, symptom 104) that he considered his mental processes to be completely normal. He had told various friends and ministers about them, and believed that 'no-one really thought I was crazy because . . . they've known me all my life . . . and I think God would not permit it, to be honest with you'. However, he was careful to conceal what was happening from his colleagues, as he recognized that they would perceive it as suspect. Moreover, while his beliefs were clearly subculturally influenced, other members of his cultural group regarded them as abnormal. Indeed, he was puzzled by the way in which certain of the ministers he had consulted drew attention to their messianic overtones. He had 'stopped talking to some of the ministers' and he commented that 'people want to take it away from me, and say "I'm glad that you don't see it as something especially for you" . . . they'll try and dismiss me out of the equation, which I find fascinating'.

Reading 20.2 EXERCISE 2

Simon Gree: The case continues from: Dickenson, D. and Fulford, K.W.M. (2000). Rationality, responsibility and values. Chapter 4 in *In Two Minds: a casebook of psychiatric ethics*. Oxford: Oxford University Press. (Extract, p 112.)

The case continues:

A year after the initial interview, he made contact again. He reported that in the interval his career had flourished and that he had used some of the money he had made to set up a new charitably oriented institution. His revelations had continued, indeed they had increased in frequency and scope, but they had been entirely beneficial in his life. They had given him the conviction to contest and win the law suit against him, and more generally to succeed as a high-achieving black person in a predominantly white, racist context. He had high self-esteem, firm moral convictions, and a strong sense of purpose in life. He confided that his mission involved unifying 'true Christianity' (a 'return to the ancient ways of the worship of the Lord') and 'true Islam'. He had plans to announce himself live on TV but was waiting for the right signs.

Reading 20.3 EXERCISE 4

Extract* from: American Psychiatric Association (1994). Introduction, *Diagnostic and Statistical Manual of Mental Disorders* (4th edn). Washington, DC: American Psychiatric Association. (Extract p. xv.)

DSM-IV was the product of 13 Work Groups (see Appendix J), each of which had primary responsibility for a section of the manual. This organization was designed to increase participation by experts in each of the respective fields. We took a number of precautions to ensure that the Work Group recommendations would reflect the breadth of available evidence and opinion and not just the views of the specific members. After extensive consultations with experts and clinicians in each field, we selected Work Group members who represented a wide range of perspectives and experiences. Work Group members were instructed that they were to participate as consensus scholars and not as advocates of previously held views. Furthermore, we established a formal evidence-based process for the Work Groups to follow.

* *NOTE*: the passage from which this extract is taken is given in full in chapter 11, Reading 11.2

Reading 20.4 EXERCISE 7

Extract from: Definition of Mental Disorders, pps xxi–xxii, in American Psychiatric Association (1994). *Diagnostic and Statistical Manual of Mental Disorders*. Washington, DC: American Psychiatric Association. (Extract pps xxi–xxii.)

Despite these caveats [about the difficulties of defining mental disorder], the definition of *mental disorder* that was included in DSM-III and DSM-III-R is presented here because it is as useful as any other available definition and has helped to guide decisions regarding which conditions on the boundary between normality and pathology should be included in DSM-IV. In DSM-IV, each of the mental disorders is conceptualized as a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (e.g., a painful symptom) or disability (i.e., impairment in one or more important areas of functioning) or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom. In addition, this syndrome or pattern must not be merely an expectable and culturally sanctioned response to a particular event, for example, the death of a loved one. Whatever its original cause, it must currently be considered a manifestation of a behavioral, psychological, or biological dysfunction in the individual. Neither deviant behavior (e.g., political, religious, or sexual) nor conflicts that are primarily between the individual and society are mental disorders unless the deviance or conflict is a symptom of a dysfunction in the individual, as described above.

Reading 20.5 EXERCISE 7

Two extracts from: Diagnostic features of Personality Disorders, p 630, in American Psychiatric Association (1994), *Diagnostic and Statistical Manual of Mental Disorders*, Washington, DC: American Psychiatric association

Extracts 1: page 630

The essential feature of a Personality Disorder is an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture and is manifested in at least two of the following areas: cognition, affectivity, interpersonal functioning, or impulse control (Criterion A). This enduring pattern is inflexible and pervasive across a broad range of personal and social situations (Criterion B) and leads to clinically significant distress or impairment in social, occupational, or other important areas of functioning (Criterion C).

Extracts 2: also page 630

The clinician should assess the stability of personality traits over time and across different situations. Although a single interview with the person is sometimes sufficient for making the diagnosis, it is often necessary to conduct more than one interview and to space these over time. Assessment can also be complicated by the fact that the characteristics that define a Personality Disorder may not be considered problematic by the individual (i.e., the traits are often ego-syntonic). To help overcome this difficulty, supplementary information from other informants may be helpful.

Reading 20.6 EXERCISE 7

Extract from: Diagnostic Feature of Paraphilias, pps 522–523, American Psychiatric Association (1994). *Diagnostic and Statistical Manual of Mental Disorders.* Washington, DC: American Psychiatric Association. (Extract, p 523.)

In some situations, acting out the paraphiliac imagery may lead to self-injury (as in Sexual Masochism). Social and sexual relationships may suffer if others find the unusual sexual behavior shameful or repugnant or if the individual's sexual partner refuses to cooperate in the unusual sexual preferences. In some instances, the unusual behavior (e.g., exhibitionistic acts or the collection of fetish objects) may become the major sexual activity in the individual's life. These individuals are rarely self-referred and usually come to the attention of mental health professionals only when their behavior has brought them into conflict with sexual partners or society.

Reading 20.7 EXERCISE 8

The story of Elizabeth Orton from: Dickenson, D. and Fulford, K.W.M. (2000). Basic concepts: your myth or mine. Chapter 3 in *In Two Minds: a casebook of psychiatric ethics*. Oxford: Oxford University Press. (Extract p 59–60.)

Elizabeth Orton is a 35-year-old solicitor, with a ten-month-old baby, Anthony. She has a congenital hip malformation which has required numerous surgical procedures and sometimes confinement to a wheelchair, although at present her mobility is quite good. Her delivery, however, was by Caesarean section, and afterwards she suffered some postnatal depression. Although there are now no clinical signs of depression, she continues to insist that she does not want the baby. Her 50-year-old husband, Tim, who is semi-retired, does most of the child care outside the hours when Anthony attends a day nursery, but recently he was away for six nights. During that time Elizabeth telephoned her health visitor for help, upset because she had shaken the baby.

The health visitor alerted Social Services, who (together with the police) have the statutory responsibility for investigating cases of suspected child abuse, and the child protection Register. When the baby is not at his day nursery, Tim or another designated person must be with the baby; Elizabeth is no longer allowed to care for him on her own. She has also been required by Social Services to agree to see a psychiatrist. If she does not accept psychiatric treatment, she has been told that Anthony may well be taken into care—to which Tim is deeply opposed.

Elizabeth insists that she is perfectly willing to have the baby taken away from the home, but that she fears her marriage would not survive. In a way she would be happier if the baby could be adopted immediately: what she dreads is the social embarrassment, her husband's grief, and the uncertainty of the child's long-term future if a series of short-term fostering placements are arranged. So she is co-operating very minimally with the requirement of psychiatric treatment, which she calls 'emotional blackmail.' At the most recent interagency child protection case conference, however, it was decided to keep Anthony at home, on the at-risk register, and to continue the requirement of psychiatric care for Elizabeth, in the hope that she will develop more 'normal' maternal feelings.

The consultant psychiatrist treating Elizabeth, Daniel Isaacs, feels caught in an extremely awkward position. He has developed a reasonably good therapeutic relationship with Elizabeth, because, he thinks, she feels he is the only one who is concentrating on her rather than on the baby. He does not actually believe that Elizabeth has any form of mental illness. Although his opinion was sought at the case conference, he thought that this finding was not very welcome. In addition, he had doubts about whether he should have revealed confidential clinical information about Elizabeth in that setting. (Elizabeth and Tim were also invited to attend, but chose not to.) Dr Isaacs also got himself into hot water by pointing out that in his experience, fathers who posed a threat of violence to their children were not usually asked to seek psychiatric treatment, so long as the mother was there to protect the child. 'Probably not,' he was told, 'although the child would still be on the at-risk register. But could we please concentrate on the child's best interests, and leave gender politics out of this?'

Reading 20.8 EXERCISE 11

Full chapter: Reich, W. (1999). Psychiatric diagnosis as an ethical problem. Chapter 10 in *In Psychiatric Ethics* (ed. S. Bloch, P. Chodoff, and S. Green) (3rd edn). Oxford: Oxford University Press. (pages 193–224).

Institutions, professions, and technologies pose ethical challenges because they are controlled by human beings and are capable of causing good or harm to other human beings. Accidents of nature, such as fetal malformations, do not in themselves pose ethical problems, even if they cause harm, because they are not under human control. But when they come under such control—for example, through the creation of a technology, such as amniocentesis—then what once may have been an accident becomes, as a result of the possibility of human intervention, preventable, and what was once ethically neutral therefore becomes ethically charged.

In psychiatry, powers, institutions, and technologies exist that, through their acts, systems, and techniques, have the potential for causing good as well as harm. And, as the profession's practitioners, psychiatrists have the freedom to act within it. Clearly, then, psychiatry's practices, as well as those who carry out those practices, inhabit an arena of ethical concern.

Ever since psychiatry emerged as a separate discipline it has been criticized for ethical abuses in every sphere of its activity. Its ability summarily to cancel a person's freedom through its power to commit that person, against his or her will, to a psychiatric hospital probably has been the subject of most such criticism: psychiatrists have been accused of forcibly hospitalizing persons who have not required it—indeed, persons who have not even been mentally ill. Other aspects of the profession have also been criticized on ethical grounds. Psychiatric institutions have often been accused of demeaning patients, and the technologies of electroconvulsive therapy, behaviour-modification, medication, psychosurgery, and psychotherapy have raised vexing and abiding issues regarding the control of behaviour.

Common to all these activities is one psychiatric act: diagnosis. It is the prerogative to diagnose that enables psychiatrists to commit patients against their wills, that delineates the populations subjected to their care, and that sets in motion the methods they will use for treatment. And it is therefore this prerogative that should provoke perhaps the most fundamental—and, consequently, the most serious—ethical examination.

Of course, the ethical problem of diagnosis stems from its capacity for misuse—that is, the knowing misapplication of diagnostic categories to persons to whom they do not apply, a misapplication that may place those individuals at risk for the harmful effects of psychiatric diagnosis. These effects include not only the loss of personal freedom, and not only the subjection to noxious psychiatric environments and treatments, but also the possibility of life-long labelling [1–3], as well as a variety of legal and social disadvantages ranging from declarations of non-responsibility in family and financial affairs to, under the most extreme circumstances, under Nazi rule, the deprivation of life [4–23].

In general, misdiagnoses may be said to originate in two ways. The first way is *purposeful*: the psychiatrist applies a standard psychiatric diagnosis to a person for whom he or she knows it to be inappropriate in order to achieve some end that is not, by common definition, medical. That end may vary from instance to instance. For example, the psychiatrist may be under direct and obvious pressure from a family to hospitalize a troublesome member of that family, or from political authorities to hospitalize a troublesome dissident. On the other hand, the psychiatrist may also issue a purposeful misdiagnosis at the person's own request. For example, a diagnosis resulting in hospitalization may be a protection against a worse fate, such as jail in the case of a criminal offender, the military draft in the case of a war-resister, or the birth of an unwanted child in the case of a woman seeking an abortion in a place where the procedure is available only to those who can show medical need. In both types of cases of purposeful misdiagnosis, harm may be said to result. In the first type the harm is obviously to the person. In the second, it is to the integrity of the profession. One's concern should certainly be for the first type of harm; but the second, largely overlooked as a sort of victimless crime, also requires attention.

But though purposeful misdiagnoses should be a serious concern, it is the *other* kind—misdiagnoses that result not from the willful misapplication of psychiatric categories, but from the primarily *non-purposeful* causes—that deserve the greatest scrutiny. They deserve it because most misdiagnoses belong in this category. And they deserve it because purposeful misdiagnoses are in general clear and usually understood as unethical, while those that are non-purposeful are much more subtle and insidious, much more a part of the fabric of the field itself, and much more difficult to identify and stop.

To be sure, there is a sense in which it could be argued that non-purposeful misdiagnoses do not constitute a true ethical problem: after all, if such diagnoses are not purposefully carried out then they do not involve knowledge or free will on the part of psychiatrists and are beyond their control. But that is not quite the case. The mere fact that something is not completely purposeful does not entail that it is completely non-purposeful. This category involves, in the main, non-medical needs, pressures, and compromises that affect the diagnostic process but enter the psychiatrist's awareness to only a partial degree. The fact that psychiatrists allow themselves, for their own comfort, to ignore this awareness, or their responsibility to strengthen it, raises this category of misdiagnosis to the highest level of ethical concern.

Non-purposeful misdiagnoses, it should be stressed, are different from *mistakes* in diagnosis. Mistakes in diagnosis result from a process in which, for want of adequate information about the patient or the illness, or lack of proper training, the psychiatrist issues a diagnosis to a person whose clinical state should be categorized differently. Non-purposeful misdiagnoses by contrast, result from a process in which a psychiatrist has both adequate information about the patient and the illness and proper training, but issues an incorrect diagnosis because of factors extrinsic

to the patient—and does so without being aware, or fully aware, that he or she is doing so. Sometimes, such awareness is altogether absent: the misdiagnosis is non-purposeful in the fullest sense. Sometimes, however, awareness would be present were it not for the efforts of the psychiatrist, through the use of various techniques of denial and self-delusion, to escape the moral self-condemnation that would result from such awareness. At this most extreme end of the spectrum of non-purposefulness, the veneer of non-awareness may be so thin as to allow awareness, and therefore purposefulness, to emerge in such a manner as to make it difficult to distinguish from the purposefulness present in clear-cut cases of conscious, fully purposeful, misdiagnosis. In the main non-purposeful misdiagnosis can be traced to at least three sources. It will be to these sources that the remainder of this discussion will be devoted.

The inherent limitations of the diagnostic process

Certainly the simplest source of non-purposeful misdiagnosis lies in the vulnerability of the diagnostic process to error. Over the years it has been shown that the process can have poor or questionable reliability [24–26]; may be subject to inconsistency and change; may suffer from bias [27–32]; and tends to rely on subjective criteria (such as, in the case of the diagnosis of schizophrenia, the psychiatrist's impression of the patient's 'understandability' [33–34], or 'peculiar behaviour' [36], his assessment of 'the feel of the case' [37], or his development, during the interview with the patient, of a 'praecox feeling'[38]. In addition, psychiatrists may diagnose health rather than illness because, as Scheff has observed, physicians as a group feel that a 'type-2 error' (accepting a hypothesis that is false) is less dangerous than a 'type-1 error' (rejecting a hypothesis that is true) [39].

Many of these limitations have been eased considerably by the introduction of diagnostic classification systems and manuals that employ relatively objective criteria for the diagnosis of mental illnesses, particularly the American Psychiatric Association's *Diagnostic and statistical manual of mental disorders* [40]. This manual is constructed in a fashion that tends to reduce significantly the effects of those aspects of the diagnostic process that are influenced by subjective factors or ideologically based theories regarding the aetiologies of mental illnesses. In the absence of clear, conclusive, and universally accepted criteria, such as physical evidence for the presence of, say, one or another type of schizophrenia or affective disorder, such diagnostic approaches as the one taken by this manual provide important, though by no means certain, safeguards against diagnostic error [41–49]; Nevertheless, psychiatric diagnosis, though increasingly rooted in scientific research, remains a process that is vulnerable to error: and it is the responsibility of the diagnosing psychiatrist to remember its limitations with humility, and to maintain a willingness to review diagnostic decisions and admit fallibility. At best, psychiatrists are no better than their tools; and they must acknowledge the limitations of those tools as the starting-points of their own.

The power of diagnostic theory to shape psychiatric vision

But vulnerable as the diagnostic process in psychiatry is to its own limitations, likely as those limitations may be to lead psychiatrists to a misdiagnosis, and hard as they must try to guard against them, psychiatric diagnosis has yet other vulnerabilities that are even more subtle, more pervasive, and more difficult to recognize—and that, therefore, demand even greater vigilance. Again, the danger is misdiagnosis—non-purposeful but still damaging—and the ethical problem is the degree to which psychiatrists allow themselves to ignore the forces and circumstances that lead to, and make use of, such misdiagnosis.

In large measure diagnosis is a social act. It takes place in a social context. The psychiatrist observes behaviour and judges it against a social—often local—norm. This is not necessarily inappropriate. Psychiatric illnesses, particularly those characterized by psychosis, often affect persons in ways that lead them to ignore social norms and transgress generally accepted verbal and behavioural boundaries; and such trespasses may, in fact, be the most sensitive and early indicators of possible illness. To be sure, the social basis of diagnosis is itself a problem, since the psychiatrist must know precisely where the social boundaries should be drawn, and which trespasses are the result not of illness but of some other cause—such as, for example, social activism, artistic style, mere eccentricity or, for that matter, a rearing in another culture. But psychiatrists are, in the main, at least dimly aware of these problems, having been apprised of them during training or, failing that, in the course of ongoing practice.

Another basis for diagnostic judgement—one that shapes the diagnostic vision of the psychiatrist no less powerfully than the social one, but is, nevertheless, generally unrecognized—is the diagnostic theory itself. In most countries psychiatrists are guided by one or more theories of mental illness; and often those theories are associated with diagnostic systems that are their functional and practical expressions. And, depending on the specificity of the system to which he or she subscribes, the ways in which a psychiatrist assesses a person's behaviour, draws conclusions about it, weighs the variance between the person and the social norm—indeed, *sees* the person—may be heavily influenced by the assumptions underlying the system and the approach that system takes to recognizing and identifying mental illness. The system, after all, delineates categories of illness and identifies the criteria by which behaviours and the persons who exhibit them deserve to be placed in those categories; and every time such a placement is made the categories, as well as the system itself, are reified. To the psychiatrist who accepts the system as real, this occasions no concern: the reality of the system has merely found a correspondence in the reality of the patient's illness. To one who

finds the categories mistaken, however, or the criteria too narrowly or too broadly defined, such reification may be simply self-deceptive and false, and may result in misdiagnoses that are as systematic as only a system can make them.

In many countries this danger, though important, has been limited in recent years. In the United States, for example, the most recent editions of the official diagnostic of manual have shifted to a descriptive, atheoretical approach to the diagnosis of mental illnesses, the aetiologies of most of which have not been established using commonly accepted scientific methods. In the main, the American Psychiatric Association's *Diagnostic and statistical manual* (DSM) defines mental illnesses by describing their clinical features, which are generally easily identifiable behavioural signs or symptoms. Moreover, these manuals have classified those mental illnesses not according to aetiologies they are presumed (but have not necessarily been proved) to share, but rather according to the clinical features they share. In addition, they have listed specific diagnostic criteria for making diagnoses, the use of which increases diagnostic reliability. As a result of all this, clinicians have been more successful than in the past in agreeing on the diagnoses of mental illnesses characterized by features that are easily described and recognized, such as the psychoses; in the cases of other disorders, particularly the personality disorders, the criteria for which are more unclear, there has been less consensual reliability.

In other countries the World Health Organization's *International classification of diseases* (ICD) has been widely used. The ICD provides less detail in its descriptions of mental illnesses than does the *Diagnostic and statistical manual*; but it, too, provides a basis for relatively good reliability in diagnosis, particularly in the diagnosis of the major mental disorders. In the former Soviet Union, however, a diagnostic system was put in place in the 1960s through the 1980s that, though in many ways highly descriptive, was, unlike the Diagnostic and statistical manual not based on research that meets commonly accepted scientific standards. In its definitions of the schizophrenic disorders this system employed such broad and loose criteria that it permitted the diagnosis of schizophrenia in cases in which, in the West, there would be no finding of any mental illness. As a result, Soviet psychiatrists who used this diagnostic system systematically tended to diagnose as ill—and, often, genuinely to *see* as ill—persons who would not be diagnosed as ill anywhere else.

This Soviet diagnostic system was developed during the 1960s by Andrei V. Snezhnevsky, the founder of what came to be called the Moscow School of Psychiatry and, until his death in 1987, the head of the Institute of Psychiatry of the USSR Academy of Medical Sciences (renamed in 1983 the All-Union Centre for Psychiatry and Mental Health), the central psychiatric research institution in that country. During the 1940s and 1950s Snezhnevsky worked at, and then became chairman of the Department of Psychiatry of the Central Postgraduate Medical Institute, probably the most prestigious institute in the Soviet Union for advanced training and degrees. Upon his ascension to the directorship of the Institute of Psychiatry in 1962 Snezhnevsky dedicated the institute and its resources to the problem of schizophrenia, which was the focus of his central theory and of his diagnostic approach. Over the next decade, he and his staff continued to refine the system, doing clinical research designed to elaborate its details. By the early 1970s many of his former students and trainess were in charge of the nation's academic psychiatric centers; the journal he edited, the *Korsakov Journal of Neuropathology and Psychiatry*, was the only psychiatric periodical in the USSR and regularly carried news of his school's research and of the fine points of its diagnostic system. The pattern of psychiatric teaching and research in centers far from Moscow felt the effect of his guidance and views, exerted through his role as an influential member of review committees for government ministries responsible for the approval of research and training grants. By the middle and late 1970s the hegemony of the Moscow School in the realm of psychiatric theory and practice, particularly diagnostic theory and practice, was almost complete: it was clearly the dominant force in Soviet psychiatry, and its diagnostic system was the standard Soviet approach to the diagnosis of mental illness. This dominance continued for some time even after Snezhnevsky's death, despite criticisms of Soviet psychiatry in general and Soviet diagnostic methods in particular [50–53].

Following the collapse of the Soviet Union the Moscow School ceased being an institutional force, though its teachings continued to influence the persons who had been trained by it. Nevertheless, its experience is very telling. The Moscow School's diagnostic system focused particularly on schizophrenia; but because its definition of schizophrenia was so extraordinarily broad, that definition took in vast sectors of non-schizophrenia psychopathology—sectors that, grouped together, encompass much of the territory of mental illness. The theory behind the system was based on the assumption that schizophrenia has three different forms; that these forms vary from each other not so much in their symptoms, as traditionally has been assumed in the West since Kraepelin, but in their course; and that a particular schizophrenic patient's course-form may be identified on the basis of a retrospective analysis of the development of his or her illness [54–57].

A schematic rendering of the characteristics distinguishing the three course-forms of schizophrenia is presented in Fig. 10.1.

1. The 'continuous form' is characterized by the development of symptoms early in life, usually by late adolescence or early adulthood, with a general worsening as life progresses. Patients falling into this category do not, as a rule, improve.
2. The 'periodic form' is characterized by periods of acute illness, interspersed with periods of remission during which the patient regains health.
3. The 'shift-like form' is a mixture of the other two. As in the periodic form there are acute attacks; however, each attack leaves the patient more ill than he or she was prior to that attack, so that, overall, as in the continuous form, there is a general worsening of the illness during the course of the patient's life.

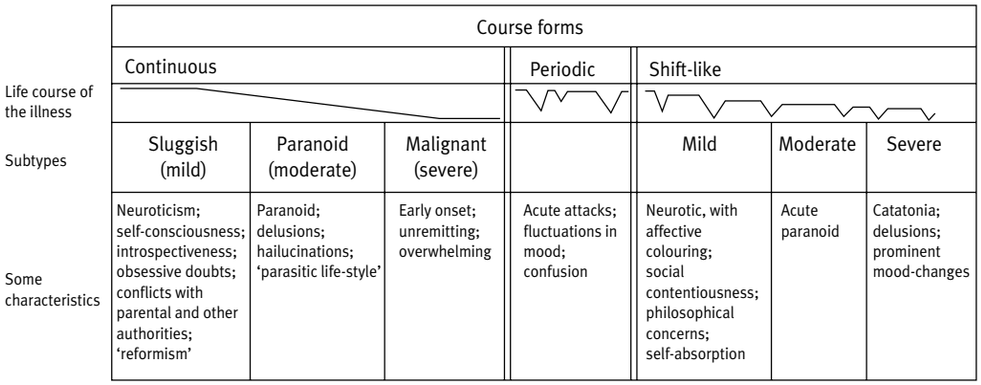


Fig. 10.1 Features of the Snezhnevsky course-forms

What is so unique—and, in the end, so problematic—about this system is the fact that *two of the course-forms have subtypes ranging from mild to severe, and that in those two, the continuous and the shift-like, the mild subtypes are characterized by symptoms that are not psychotic*. In almost all countries psychiatrists would probably agree that persons who satisfy the Moscow School's criteria for the moderate and severe subtypes of each of these course-forms really are, by their criteria as well, schizophrenic. But they would probably disagree about the Moscow School's criteria for the mild subtypes, and would judge the persons who satisfy them to be neurotic, rather than schizophrenic, suffering from a personality disorder, or even mentally well. Fig. 10.1 notes the characteristics attributed by the Moscow School to persons grouped according to these subtypes.

The other feature of the system that adds to its potential danger—indeed, multiplies it—is the Moscow School's assumption that *each of the course-forms represents, in essence, a separate illness, one that has its own biological basis, which is, in turn, genetically determined*. This implies that a person categorized as belonging in, say, the sluggish (mild) subtype of the continuous form has the same illness as anyone else in that form, including someone belonging in the malignant (severe) subtype; and, though he or she has a more mildly expressed version of that illness, he or she has it nevertheless—and for life. Such a person may therefore be subject to many of the disadvantages, social and personal, as the person who is much more severely ill.

What is so troubling about this is that the criteria given for the mild subtypes of schizophrenia apply to many persons who clearly would be seen by most psychiatrists in the West as not schizophrenic. In fact, it could be predicted that, applied to a broad population, this system would draw into the schizophrenic fold precisely such persons—persons, that is, with neuroses, personality disorders, affective illnesses, or no mental illnesses at all. There is evidence that this has indeed occurred. Some of the evidence is impressionistic. Rollins, for example, reported in her book on child psychiatry in the Soviet Union that patients with primarily neurotic or psychopathic-like symptoms were typically given diagnoses by Soviet psychiatrists in the schizophrenic range[58]. More directly, Holland reported, after a sojourn in Moscow's Institute of Psychiatry, that Soviet patients could be diagnosed as schizophrenic even if they exhibited no signs of the illness, and that once the diagnosis was given, even if it were further subtyped as being of the mild variety, it continued to be used on the assumption that the patient had a lifelong, genetically based condition [59–62].

But the most telling evidence came from the International Pilot Study of Schizophrenia (IPSS). During the late 1960s and early 1970s nine centres around the world, including centres located in Washington, DC, and Moscow, evaluated patients for schizophrenia and collected data about them. The centre in Moscow was Snezhnevsky's Institute of Psychiatry. As part of the study, a computer was programmed by John K. Wing to re-diagnose the patients originally diagnosed as schizophrenic using data regarding the patients' symptoms that were gathered by the various centres; the computer used strict criteria for its own re-diagnoses, notably those formulated by Kurt Schneider [63]. While most centres did 'well'—that is, while the computer 'agreed' with most of the diagnoses of schizophrenia rendered at those centres—two centres did poorly.

One of these, Washington DC, did poorly primarily because its diagnosticians followed the rules of their own diagnostic system, and, unlike the computer, tended not to differentiate between schizophrenia, schizophrenia-like psychoses, and paranoid psychoses. The computer gave them low marks because it found their schizophrenic patients to be, by its criteria, psychotic in other ways, though agreement as to psychosis was high. The other centre that did poorly was Moscow's Institute of Psychiatry; however, the reasons were different. A larger percentage of its diagnosed schizophrenics were reassigned by the computer not to the psychotic, but rather to the depressive and neurotic categories. Table 10.1 shows the computer classification (i.e. re-diagnosis) of patients who were originally diagnosed at the nine centres as belonging to those subtypes most likely to contain patients who would be considered by psychiatrists in many countries to be 'borderline schizophrenic', or merely 'borderline'. For eight of the centres these subtypes were identified as 'simple' and 'latent,' for Moscow, it was 'sluggish' (the mild subtype of the Moscow School's continuous form). Although the numbers are small the difference seems striking. The patients classified as belonging in these subtypes in eight of the centres, including Washington DC

Table 10.1 IPSS computer classifications of schizophrenia subtype diagnoses

IPSS Centre	Schizophrenia subtype diagnoses	No. of patients	Computer classifications (%)				
			Schizophrenic similar psychoses	Paranoid psychoses	Manic psychoses	Depressive psychoses	Depressive neuroses
Washington	Simple	4	50	33	17	0	0
	Latent	2					
Moscow	Sluggish	12	0	0	33	8	58
7 remaining centres	Simple	27					
	Latent	8	71	9	6	0	14

but not Moscow, were classified by the computer as overwhelmingly schizophrenic or as having paranoid or schizophrenia-like psychoses, while the patients classified in the mild subtype by the Moscow diagnosticians, following the rules of the Moscow School, were classified by the computer as being primarily affectively ill or depressed, just as one might have predicated from an inspection of the system's broad diagnostic criteria [64].

A final confirmation of the tendency of the Moscow School's diagnostic system to overdiagnose schizophrenia came from a Soviet psychiatrist, one working at Moscow's Serbsky Institute of Forensic Psychiatry. In an unprecedented article in a Western psychiatric journal, E. P. Kazanetz used his own computer exercise to show that the Moscow School's system tended to overdiagnose as endogenous schizophrenics persons who were only exogenously ill—that is, it tended to diagnose, as chronically ill, persons whose illnesses were primarily of an acute, externally caused type. Furthermore, Kazanetz added the observation that such overdiagnosis could be harmful to persons with acute illnesses assigned irrevocably to psychiatric registers of the chronically ill. Together with the evidence from the IPSS, Kazanetz's study reveals the degree to which an overbroad diagnostic scheme can result in overbroad diagnostic practice [65].

What is so extraordinary, and so ethically significant, about the Soviet experience is that patients who were misdiagnosed in the IPSS and in the population studied by Kazanetz were misdiagnosed—that is, diagnosed as schizophrenic despite the fact that almost all other psychiatrists would diagnose them as belonging in less severe categories of mental illness—*only because of the dictates of the diagnostic system that was then officially in place*. Those Soviet psychiatrists really *saw* the patients as schizophrenic; or, to put it another way, *the system created a category, first on paper and then, through training, in the minds of Soviet psychiatrists, which was eventually assumed to represent a real class of patients and which was inevitably filled by real persons*. Those diagnosticians came to see schizophrenic pathology as including very mild forms and diagnosed accordingly. Persons who should not have received those diagnoses did, to their detriment; and psychiatrists who should not have given them did, in apparent full faith. Had those psychiatrists been sensitive to the capacity of diagnostic systems to shape the way psychiatrists understand, categorize, and perceive psychopathology, they might have been able, one hopes, to avert this result.

It would be valuable to examine briefly, in this context, the role played by the Moscow School of Psychiatry's diagnostic system in the diagnosis of Soviet dissidents during the quarter-century before the collapse of the Soviet Union. The purposeful misdiagnosis of Soviet dissidents will be noted at the end of this essay. A number of dissidents, however, were probably not misdiagnosed purposefully. Rather, they were probably misdiagnosed because their behaviour was socially odd, a kind of oddness for which there is a diagnostic niche in the Moscow School's broad definitions of schizophrenia. For, as it happens, many of the ways in which Soviet dissidents behaved, often in response to the governmental pressures brought to bear on them, were precisely the same, almost uncannily so, as the behaviours and characteristics said by the Moscow School to be common among mild schizophrenics, sluggish or otherwise. Table 10.2 contains a list of characteristics that were cited by Soviet psychiatrists in the case histories of certain dissidents in order to buttress their findings that those dissidents were ill. To be sure, those characteristics are typical of the ones that were often cited as signs of illness by the Moscow School's theoreticians. But they are also very typical of dissidents, particularly those who had to live the kinds of lives lived by dissidents in the Soviet Union. For example: fear, suspiciousness, and depression (hardly unexpected feelings among persons being hounded by the state); poor adaptation to the social environment (something without which you wouldn't *be* a

Table 10.2 Vulnerable styles

Overlap of common dissident styles and schizophrenic symptoms as described by the Moscow School of Psychiatry

- Originality
- Ideological formulations
- Fear and suspiciousness
- Religiosity
- Depression
- Ambivalence, guilt, internal conflicts, and behavioural disorganization
- Intensity
- Attention to detail
- Poor adaptation to the social environment
- Shift of interests
- Reformism

dissident); and 'reformism' (which is another way of describing the tendency to dissent, at least before the advent of *perestroika*).

The result of all this was devastating for dissidents during the quarter-century before the end of the Soviet Union. Dissidents were, of course, routinely arrested. Some of them were then sent by the KGB, quite cynically, to psychiatrists, even though the KGB had no reason to think they were ill. These psychiatrists, learning of the KGB's wish that the dissidents be found mentally ill, did indeed find them ill, often giving them as a diagnosis one of the categories of mild schizophrenia. The dissidents' trials could then be held without them, they could be sent for indeterminate amounts of time to hospitals for the criminally insane, and their views could be depicted as the sick products of sick minds. Such unethical behaviour by psychiatrists will be discussed later in this chapter.

But in other cases another process sometimes also occurred—a process involving different motivations but ending with the same results. In those instances the KGB, encountering dissidents, saw before them persons who were, in a few striking ways, very different from nearly everyone else in Soviet society: in the name of goals (e.g. democratization or freedom of speech) that were, by all rational standards of the time, hopelessly elusive, they were willing to court inevitable and overwhelming punishment. Moreover, they were extraordinarily committed to those goals, and sometimes even chastised their interrogating officials for transgressing the Soviet constitution. Those investigators, struck by the apparent inability of these dissidents to appreciate reality, sometimes interpreted their behaviours as odd and a sign that something might not be quite right with them—that they were, perhaps, mentally ill. They then asked psychiatrists to examine these dissidents. But the psychiatrists were themselves the products of the same societies as the officials, were also struck by the same self-endangering and, by ordinary Soviet standards, apparently irrational behaviour, and were left with the same doubts about the dissidents' mental health. They knew, however, that it was precisely such behaviours that were said to be characteristic of the mild schizophrenias described by the Moscow School. And, resolving their doubts, they issued that diagnosis, thereby beginning the process that resulted in court-ordered hospitalizations on the grounds that, having committed socially dangerous crimes as a result of mental illness, they must be socially dangerous and, therefore, separated from society.

That this latter path to hospitalization actually took place appears to have been supported by the findings of delegation of American psychiatrists who visited the Soviet Union in 1989 [68]. In that visit about half the Soviet patients who were re-diagnosed by the American psychiatrists were found not to be mentally ill by Western standards. Of these, a number had been hospitalized in 1987 or later and others, who had been hospitalized earlier, remained in hospital in 1987 and 1988—during the period, that is, after Gorbachev's 'new thinking' on human rights had hit its stride. One could reasonably assume that during those two years the KGB and the psychiatrists who had so willingly served them would have been expected *not* to purposefully hospitalize dissidents they knew to be mentally well; after all, each such hospitalization could have seriously undermined the effort of the Soviet Union to improve its human-rights image abroad, an effort that was necessary if the Soviets were to achieve a number of their goals in the international arena. That psychiatrists nevertheless diagnosed such people as ill suggests, to this writer at least, the likelihood (at least some cases) that they really thought the dissidents were ill. To be sure, some of these cases could also have been, and probably were, a result of the persistence of cynical habits among officials and psychiatrists who just couldn't change their ways; but the other explanation seems at least as compelling (and, to me, more so) [67–70].

Although the consequences of an unusually broad and vulnerable psychiatric diagnostic system have been particularly painful and destructive in the Soviet context, that context should not be considered the only one in which such damage could be wreaked. The Soviet diagnostic scheme represents an extreme spectrum system—a system that posits a spectrum of schizophrenic illness ranging in severity from the most mild to the most severe, and caused by a genetic deficit of variable clinical expression. Such diagnostic schemes have, in fact, been considered in some form in the West [71–81]. To be sure, they have not been introduced into formal diagnostic systems; however, given the Soviet experience, it would be valuable to weigh the potential of such systems for similar overdiagnoses.

The beauty of diagnosis as a solution to human problems

A third source of non-purposeful psychiatric misdiagnoses, and probably the most significant, is the attractiveness of the diagnostic process as a means of solving or avoiding complex human problems. With remarkable ease diagnoses can turn the fright of chaos into the comfort of the known; the burden of doubt into the pleasure of certainty; the shame of hurting others into the pride of helping them; and the dilemma of moral judgement into the clarity of medical truth. Because of their nature, functions, and meanings, diagnoses can do such things in efficient and powerful ways; and the fact that they can makes their use by psychiatrists for such ends remarkably irresistible, enormously unrecognizable, and in the final analysis, utterly human [82].

Diagnosis as explanation, mitigation, and exculpation

Perhaps the most fetching beauty of diagnosis is its capacity to instantly explain: behaviour that is odd, objectionable, troublesome, or illegal, can be through the mediation of diagnosis, suddenly be understood, explained, and explained away. To be sure, such behaviour may indeed be the product of diagnosable mental illness. But the capacity of a diagnosis to perform this function makes its use a temptation even in cases in which such illness does not exist or, at best, is only marginally present.

The arena in which this diagnostic temptation has been most evident has been the law. For years psychiatrists have been asked to testify as witnesses in cases of persons accused of various crimes. Often the prosecution and defence have called upon such witnesses who, in turn, have presented conflicting testimony about whether or not the actions carried out by the accused were a product of mental illness. While such conflicts have occasionally embarrassed the profession by suggesting that either side in a case can get psychiatric testimony in support of any diagnosis it wishes, at least they have been straightforward. Generally, the clinical questions have had to do with the presence or absence of some kind of psychosis, a group of mental conditions that can render a defendant legally not responsible for his or her actions; and the testimony has usually involved judgements about whether or not the defendant's behaviours and history met certain widely-accepted criteria for these, the most agreed-upon areas of psychopathology.

Naturally, defendants and defence counsels have often sought findings of 'not guilty by reason of insanity', even when they have suspected or known insanity not to have played a role, because of their belief that, at least in cases of such serious crimes as murder or rape, confinement in a hospital may be shorter than the sentence that would be likely to be imposed should the defendant be found guilty and not insane. Still, some persons *do* commit crimes because they are insane: the law recognizes that insanity compromises free will, and classifies someone without free will as legally not responsible for his or her actions; it is the right of defendants to use that defense; and psychiatrists have a role, as a result of their expertise in recognizing such mental illness, in testifying on the substance of the defence.

The trouble is that attempts have been made to expand that role into realms in which psychiatrists do not have expertise. The pressure for that expansion has been the wish to explain diagnostically—and explain away legally—criminal behaviours that do not involve classical psychotic states. Instead of insanity the clinical questions have involved issues about which psychiatry has almost no validated knowledge: questions primarily of coercion, persuasion, and influence. In a series of cases defence lawyers have turned to psychiatrists to testify about the effects of certain environmental pressures on individual development and judgement, and on the role these factors played in the genesis of the criminal behaviour. The defence argument has usually been that these factors created a diagnosable mental condition, one that explained the behaviour and, in a legal sense, either mitigated or totally exculpated it.

A well-known case of this sort is the 1976 bank-robbery trial of Patricia Hearst, in which the defendant was said to have been incapable of criminal intent because she had undergone a process of 'coercive persuasion', a process that had affected her capacity for free will. Not only the defense, but also many observers, favoured such a diagnostic exculpation: it made it possible to understand how such an ordinary, peaceful, apolitical, and utterly American young woman could have turned so suddenly into such an extraordinary, violent, ideological, and anti-American revolutionary. The court allowed the novel defence—novel because it stepped beyond the traditional realm of insanity into the broader arena of persuasion—and a battery of psychiatrists supported it with their testimony. The jury, however, rejected it, despite its attractive advantages: it did not accept diagnostic explanation as a basis for legal exculpation [83,84].

The attractiveness of the diagnostic process as a means of explanation and exculpation has revealed itself in the legal arena a number of times since the Hearst trial. In each instance the defence contended that environmental factors had influenced or determined the criminal act; and, in each instance, psychiatrists took the stand to issue their supporting diagnostic opinions. In a celebrated Florida case, a young boy who was accused of having killed an old woman was defended with the explanation that his mind had been affected by television violence. As in the Hearst trial, the jury found such use of diagnosis inadequate to the task of explaining away the defendant's behaviour.

Despite these setbacks it seems likely that the beauty of diagnosis will continue to be appreciated in the legal arena, and that psychiatrists will continue to expand the ambit of their diagnostic expertise into realms about which almost nothing certain is known. It seems possible that in time psychiatric testimony will offer itself in support of psychological defences of all kinds—defences, for example, that attribute criminal actions to the defendant's early childhood rearing or to the pressures of his or her adolescent peers. While such influences undoubtedly exist, almost nothing is known about how they affect the capacity for individual judgement and the existence of free will. That some psychiatrists are willing to testify on these matters in the belief that they have such knowledge demonstrates not only the settled habit of such psychiatrists to opine on issues beyond their scientific domain, but also, it seems, the satisfaction gained from finding in the storehouse of the profession some explanation that will transform a person's criminal act into a symptomatic one, and that will turn a painful moral question into a painless medical one.

Nor should the turn to diagnosis in such cases on the part of psychiatrists occasion any wonder. It is a natural turn when an explanation for unwanted behaviour is needed, and is accomplished every day, outside the arena of the law, by non-psychiatric laymen as well. For example, journalists and other observers turn to it for simplifying explanations when political figures engage in behaviour that is inexplicable in ordinary political terms [85–89]. Still others call upon diagnostic explanations to justify forgiveness or elicit sympathy in situations ranging from breaches of airline etiquette[90] to more serious transgressions of industrial ethics [91] and literary propriety [92]. That psychiatrists similarly turn to diagnoses in the search for satisfying explanatory simplification, ones that substitute medicine for morals, is therefore not surprising; the satisfactions and advantages are the same, except that in the hands of the psychiatrists diagnoses achieve official status and recognition, and result in lasting effects which are not always, even in these cases, salutary.

Diagnosis as reassurance

A second beauty of diagnosis is its power to reassure. When acts are committed whose implications are disturbing—acts that suggest vulnerabilities in ourselves, our institutions, or our communal beliefs—diagnoses often come to mind, both in the layman and psychiatrist, which serve to shift the frame of the behaviour from the threatening personal or social arena to a safer medical one.

In one widely publicized case this shift was effected toward its reassuring end through the cooperation of all concerned, psychiatrist and laymen alike. In 1974, Dr William T. Summerlin, a young researcher hired by the Memorial Sloan-Kettering Cancer Center on the basis of his promising work in transplantation immunology, reported that he had been successful in grafting skin from genetically unrelated animals. When other researchers were unable to confirm these astonishing results Summerlin, in response, repeated his experiments, reportedly inking in the skins of his mice to make it appear as if the grafts had taken. When this was revealed by Summerlin's research assistant, a special in-house committee was constituted to investigate the matter. The major threat posed by the Summerlin affair was the possibility that the American public might conclude that not only that researcher, but research itself, was suspect. To a community that depended on the magnificent largess of its various constituents and supporters—a largess that from US government sources alone approached more than two billion dollars a year at the time (and is about six times that figure now)—such a prospect was indeed distressing. Moreover, there were other concerns. Summerlin's story, after all, did violence to the new American dream: he was a young man from the country's heartland who had been embraced by the Eastern scientific establishment only to prove himself, if the allegations were true, shamefully unreliable. What of that dream? And, besides, what was to become of young Summerlin himself?

The solution to all these distressing concerns was quick in coming. First, the investigating committee issued its findings: Summerlin's 'unusual behavior involved at least a measure of self-deception, or some other aberration, which hindered him from adequately gauging the impact and eventual results of his conduct' [93]. Then, at a press conference, the cancer centre's president, Dr Lewis Thomas, a researcher and physician himself, went on to elaborate. 'The fraud in this work,' Dr Thomas informed the assembled reporters, was 'a result of mental illness' [94].

In one stroke, all concerns were eased. Summerlin's actions were the result not of a vulnerability in research, nor of the habits of researchers, but, rather, of a fault in the man. Moreover, that fault was not moral, but, rather, medical. And, besides that, it was short-lived. At his own news conference, four days later, Summerlin volunteered that he had been suffering from an acute depression, a condition that accounted for his 'irrational act', and for which he had already begun psychiatric treatment. The psychiatrist, Summerlin explained, had prescribed rest and physical exercise, and he was already feeling much better. And so, indeed, did those who had been so distressed by the implications of Summerlin's act: the diagnosis preserved not only the good name of science, and not only the integrity of the scientific community, but also Summerlin, who could now be seen in more reassuring terms, not as a person who would be forever morally tainted, but rather as one whose treatment would leave him clean, whole, and good, and ready to resume his professional life.

Whether Summerlin's behaviour was or was not, in fact, the result of an acute depression cannot, of course, be confirmed here; but the case is important because it illustrates the ease with which a turn to diagnosis can, at the same time, allay multiple concerns. When a psychiatrist is faced by such a case, when a means—the diagnostic process—is available that can accomplish so much, and when others are themselves inclined to think that mental illness can or should be used to explain the behaviour, it is hard to imagine that the psychiatrist will not look seriously at that option, and even find himself or herself considering it with greater favour than ordinarily he or she might in other cases involving similar behaviours—even when those cases pose no threat or raise no concerns.

Diagnosis as the humane transformation of social deviance into medical illness

Another beauty of diagnosis is its power to reclassify whole categories of socially unacceptable behaviour as the products of psychiatrically diagnosable conditions. This kind of reclassification derives, in essence, from a liberal utopian impulse: people are naturally good, and if someone acts to the detriment of society he must be ill. Hence, the social response should aim not at punishment, and not merely at control, but rather at treatment. If this approach is taken, presumably everyone benefits: the deviant, the 'root causes' of whose transgressions are thereby recognized and cured; society and its authorities, which are no longer in the position of exacting harsh punishments; and psychiatrists, whose redefinitions make all this possible, and who can feel themselves in the noble position of healing where others would have only hurt.

Probably the most striking examples of such reclassification may be found in connection with sexual behaviours that have traditionally been classified as socially undesirable. As a result of developments in medical technology, as well as shifts in popular views, some of these behaviours have been reclassified in psychiatric—and, therefore, diagnostic—terms. One such development, the synthesis of drugs that reduce sexual drive, has resulted in calls for their use in cases involving sexual offenders. Some years ago, for example, one drug company advertised in the *British Journal of Psychiatry* that its product 'had proven to be of value in treating men who have been guilty of sexual offences such as exhibitionism; paedophilia; indecent assault; rape incest; voyeurism; bestiality and paederasty'. In addition, the company pointed out that other types of 'aberrant' sexual behaviours, even those not considered illegal, may also be 'controlled', including 'homosexual activities; fetishism; transvestism; compulsive masturbation; and sexual aggression in senile or mentally defective

hospital patients'. In the United States, prisoners serving jail sentences for rape have gone to court demanding that they be treated with similar agents [95]. Other technological developments, those of a surgical type, have made still other 'treatment' options available, with individuals and their doctors rushing in to re-classify the aberrancy or malady in medical terms that have been tailored to fit the new treatments—and the increasing demands.

The danger here is that despite their humanitarian goal, it is not at all clear that such re-classifications serve that end. Attributing to an exhibitionist, or rapist, or a voyeur an underlying diagnosable psychiatric condition—hyper-sexualism—and then treating that condition by pharmacological or surgical means is not necessarily human—and, in fact, has not yet been proved to work. Indeed, the surgical approach to transsexualism, a darling of 1960s medical technology, has been shown to be seriously questionable [96]. Certainly it is not at all clear that such redefinitions have improved the lots of the persons redefined.

Analogous attempts at reclassification have also occurred in other areas of psychiatry, with equally questionable results for both the professionals and their newly classified patients. Young offenders, for example, have been told by courts and other authorities that they would not be punished for their drug-taking or other social trespasses if they submitted to psychiatric treatment; and psychiatrists and psychiatric hospitals sometimes have acquiesced in this process by making their practices, facilities, and diagnoses available to this population, usually in good faith and full belief. Instead of being recorded as criminals such persons have been hospitalized as sociopaths or, sometimes, as persons with borderline personality disorders, or even one or another form of schizophrenia—with the result that they have been labeled and treated as such, with inadvertently *worse* effects for the individuals than would have resulted from their original designations as deviants or criminals.

Diagnosis as exclusion and dehumanization

So far we have examined the beauty of diagnosis as a means of accomplishing ends that in some sense reflect the universal wish to be or do good. From time to time we all have an urge to exculpate, to reassure, and to turn deviance into illness; diagnosis does these things, does them magically and utterly; and, in turning to it, whether as laymen or as psychiatrists, we have what we think are the diagnosee's interests at heart. However, the diagnostic process has a beauty that leads us well beyond the realm of generous human interest. We also use it because it helps us do things we otherwise could not being ourselves to do.

The roots of this tendency are primitive, powerful, and universal. When we want to do unto others as we would not have them do unto ourselves, we find some way of turning them into others. We usually do that by labeling them, by excluding them from our own group, and by dehumanizing them—by defining their status as less than ours and, therefore, less human. Stalin knew that, and did it on a national scale when he wanted to turn popular opinion against those who disagreed with him. Khrushchev, in his 1956 Twentieth Party Congress speech, described the process well. Stalin, he said:

> originated the concept of 'enemy of the people'. This term automatically rendered it unnecessary that the ideological errors of man or men engaged in a controversy be proven; this term made possible the usage of the most cruel repression, violating all norms of revolutionary legality, against anyone who in any way disagreed with Stalin. . . [97]

Stalin understood that a person labeled 'an enemy of the people' would be seen by a wary and besieged population as a dangerous outsider who must be excluded from Soviet society. So seen, the outsider would be suddenly transformed into someone who is different, not truly a member of society, not truly a man—and, therefore, into someone who could and should be imprisoned, shot, or otherwise silenced without the sympathy that ordinarily would be accorded a non-labelled fellow comrade. In her remarkable memoir of her life with Osip Mandelstam, *Hope against hope*, Nadezhda Mandelstam, the poet's widow, located the origin of the Soviet tendency to distinguish between 'one of us' and 'not one of us' (the second group commonly being known as 'alien elements') in Lenin himself. Lenin, she points out, established that distinction during the Civil War with his 'Who whom', the phrase he used to summarize the difference between the Bolsheviks and their enemies [98]. In the same memoir she also showed how widespread was the tendency under Stalin, even among the intelligentsia, to exclude and dehumanize those officially cast out. Thus, when an acquaintance was arrested on unknown and usually arbitrary charges, people would tell each other—probably to reassure themselves that they would not be next—that 'he isn't one of us'. It was, for many, necessary 'to avoid those stricken by the plague' [99].

Even more graphic examples of the dehumanizing power of labeling, and the universal tendency to use it, can be drawn from the context of war. In the First World War both sides had ways of turning each other into objects whose deaths would be less than tragic, somehow almost deserved. In the Second World War the Nazis pushed this strategem to the limits, using labeling to transform various groups, especially Jews, into 'vermin' whose extermination would be a blessing.

Diagnosis is perfectly suited to label, exclude, and dehumanize in both its informal and formal usages. Informally, the terms 'crazy', 'mad', and even 'schizophrenic' often serve as exclusionary labels that are used in everyday language to identify others who are annoying, discomfiting, and different. Formally applied—that is, by psychiatrists—diagnoses can make a person into someone who seems wholly other, and who *requires* exclusion. Depending on the severity of the diagnosis, he or she may be seen as disordered, polluted, and dangerous. In short, a diagnosis can turn him or her into another kind of human being, perhaps less than human, certainly not a fellow human being; and he or she not only has a need to be put away—he or she *needs* to be put away. Such diagnostic transformations can serve the needs of psychiatric

systems under certain conditions in exactly the same way that it can serve the needs of family and social systems when their peace and tranquility are disturbed by the symptoms of the mentally ill.

Psychiatric systems can benefit from the process of diagnostic exclusion and dehumanization, because those systems subject individuals to experiences and conditions that would be difficult to impose without the advantage that such diagnostic transformation affords. Psychiatric hospitals, especially of the public variety, may be unpleasant places; and some psychiatric techniques, such as the use of drugs, electric shock, restraints, and confinement to seclusion rooms, may be experienced by patients as highly noxious. Psychiatrists know that in hospitalizing patients they may be, in the service of treatment, also causing them a certain degree of harm. The awareness of possible harm is compounded if the patient is an involuntary one, if the most invasive or liberty-depriving techniques are used, and if the patient responds to those conditions and techniques with the insistence that he is not sick and with a plea that they should be altered or stopped and that he should be released. At such times the psychiatrists must harden their hearts. And what facilitates this process is, among other things, the diagnosis. With it, the psychiatrists can see the person as a patient, one whose pleas are not simple, soulful, human importunings, but rather the routine and expected reactions of ill patients to the illnesses that have possessed them and to the treatments to which they have been subjected. With such a diagnosis, psychiatrists can proceed, and not have to see themselves as violators of human freedom and dignity. In fact, they can see themselves as helping, through the hospitalization and the use of such interventions, to transform a psychiatric case back into a human being, back into someone like themselves: they can, in good conscience, allow themselves to do unto the patient that which they would not have others do unto them.

The advantage to the psychiatrist of diagnostic dehumanization is only a special instance of that disadvantage in everyday life. After all, psychiatric patients carry on the largest portions of their lives outside the psychiatric system, and place non-psychiatrists in similar, even more vexing dilemmas. The behaviours of such patients may be extremely distressing to friends, neighbours, and relatives, who in turn, seek help for themselves by persuading the individual to consult mental health authorities, by coercing him to do so in some way, or by enlisting others, such as the police, to carry out such coercion. Sometimes, having been successful, these friends, neighbours, or relatives may recognize that their wish to be rid of the individual, and their actions to accomplish that end, were in part in the service of their own comfort; and, realizing the unpleasantness that may result to the patient because of their actions, they may feel some shame. That shame, however, can be dissipated if they remind themselves that the person is, in fact, mentally ill, that his objectionable behaviours are caused not by him but by a disease, and that their purpose in bringing him to the attention of civil and mental health authorities was related not to their own needs but to the needs of a person temporarily beset by a disease. This disease, they may reassure themselves, has obscured his usual humanity, and makes it necessary to carry out acts that, in the cases of healthy people, would constitute transgressions of their civil liberties, but that, in his case, represent only kindness, concern, and the desire to restore him to the normal community of man.

Of course, people do become psychotic, and do, in their psychoses, sometimes require interventions that we would not want inflicted upon ourselves. What is important here, though, is the capacity of diagnosis to enable persons who respect and even love such individuals to suspend their ordinary tendency to honour these individuals' stated wishes—to reverse, that is, the usual meaning of compassion, so that what the person wants is precisely the opposite of what he or she is given.

If diagnosis enables us to do that in such cases, then it has a great capacity to do it in other cases as well, ones that involve no respect or love. For example, in cases of marginal illness, when persons annoy others by their socially unacceptable behaviour, it may become too easy to enlist the aid of diagnosis in response. In that circumstances civil authorities can turn to the psychiatric system in the hope that it will aid them in removing the disturbance and in making them feel, through the issuance of a diagnosis, that they had been right in making that resort; and it may become too easy for those in the psychiatric system to acquiesce and issue a diagnosis—even when such a diagnosis may be somewhat doubtful, and even when the consequences may be unpleasant—on the basis of the self-deceptive rationale that a diagnosed person is not quite a person, and probably needs to undergo this kind of treatment, at least until it has its effect, exorcizes the disease, and brings him back to a fully human state.

Diagnosis as self-confirming hypothesis

Perhaps the most remarkable property of diagnosis, and sometimes the most enraging for the diagnosed patient, is its capacity for inevitable self-confirmation. That property is used in everyday life by persons who call others 'crazy' or 'weird': once they do so, everything that the receivers of such lay diagnoses do can be attributed to, and dismissed as a result of, those or similar psychopatholizing epithets. In fact, every thing they do subsequently can become a proof that the original assessment was correct. This 'catch-22' quality of the pathological naming therefore functions with even greater efficiency and inevitability within psychiatry itself. An actual clinical case observed by this author illustrates this well.

Case 1

The chief psychiatrist at a medical-school teaching hospital was asked to see a 65-year-old woman by the woman's son, a medical-school faculty member, and by her husband, a physician in a nearby community. The woman, they explained, had become 'negative' at home, disagreeable, more insistent than she previously had been about her views, and, in other ways as well, had undergone changes of personality. The chief psychiatrist, who tended to interpret behaviour and its aberrations as direct

products of brain-functioning or malfunctioning, concluded that, in the case of this woman, such a malfunctioning had taken place. He diagnosed an organic brain syndrome, one probably caused by the ageing process, and admitted her to the hospital to confirm the diagnosis. The resident psychiatrist assigned to the case, however, could find no objective evidence of such malfunctioning. Meanwhile, the patient—finding herself in the strange circumstances of a therapeutic community, in which staff and patients were expected to aid each other in recognizing illness and in promoting health—became extremely distressed. She repeatedly insisted, to all who would hear, and in every community or group meeting, that she was not ill and should not be a patient. The response she received was consistent: she would certainly not have been admitted to the hospital had she not been ill, and the only way for her to achieve health was to acknowledge her illness. At first she quietly tried to accept the ward routines in the hope that she would be discharged rapidly. When this failed she complained loudly, angrily, and at length. The senior medical and nursing staff, observing her behaviour, cited it to the resident psychiatrist as a 'catastrophic reaction', typical of persons with her diagnosis who are challenged by taskes they can no longer master. Given fluphenazine, she quieted; and the drug-induced response was then cited as an improvement that further demonstrated the validity of the original diagnosis.

Of course the diagnosis may indeed have been correct: the resident psychiatrist may have been wrong and the chief right. But, given *the authority structure* of the ward, and the nature and effects of diagnoses, particularly those issued in such settings, it became almost inevitable that the chief's clinical pronouncement would confirm itself no matter what occurred. In the absence of objective, physically based criteria, many psychiatric diagnoses are capable of such self-confirmation whether they derive from a psycho-analytic orientation or, as in this case, an organic one. Indeed, even in this case in which a psychiatric diagnosis was issued that is more susceptible to physical confirmation than most, the lack of such confirmation failed to derail the inevitable train of events. In such a climate it becomes simply too easy to diagnose: one is rarely proved wrong, and the penchant for rapid assessment, valued so highly in general medical settings (especially academic ones) as an emblem of knowledge and expertise, has few means of objective checks in the psychiatric arena, and can result in too cavalier an issuance of diagnoses—diagnoses that, because they may be wrong, and because they have so pronounced a tendency to persist, can be highly distressing and, ultimately, damaging. Of course, this dilemma is made still worse under circumstances in which the diagnoses are issued not in the spirit of academic showmanship, or as an expression of ideological bias, but, rather, as a result of hasty or uncaring judgements. But whatever the spirit, the results to the patient are the same.

Diagnosis as discreditation and punishment

One particularly destructive function of diagnosis evident in everyday life is its capacity to discredit by attributing a person's views, politics, actions, or conclusions to a mind gone sick: diagnosis as a weapon.

We see this everywhere. In the Middle East, for example, the Shah of Iran, before losing power, identified Libya's Colonel Qadaffi as a 'crazy fellow' [100]. In turn, Ahmed Zaki Yamani, then the Saudi oil minister, described the Shah as 'highly unstable mentally' [101]. Egypt's President Anwar Sadat diagnosed Iran's Ayatollah Ruhollah Khomeini 'a lunatic' [102], a compliment the ayatollah then passed on to President Carter [103]. In Israel, the Labour opposition had similar views about Prime Minister Begin [104], while, on the West Bank, Ali Jabari, the Palestinian mayor of Hebron, campaigned to have the leaders of the PLO locked up in insane asylums [105].

And elsewhere, at other times. Thus Lenin, in 1919, said of the poet Maxim Gorky: 'all of your impressions are totally sick . . . your nerves have obviously broken down . . . Just as your conversation, your letter is the sum total of sick impressions carrying you to sick conclusions. This is all a pure sick psyche . . . It is clear that you have worked yourself up into sickness' [106]. The Soviet press, in 1977, criticized the dissident physicist Andrei Sakharov for 'pathological individualism' [107]. A West German political leader described the Carter administration's reported plan to produce a neutron bomb: 'a symbol of mental perversion' [108]. And, after learning of his shift from black radical militant to capitalist religious conservative, Eldridge Cleaver's friends called him 'schizophrenic' [109].

Within psychiatry diagnosis has also surfaced as a weapon. In 1964 American psychiatrists were polled, and diagnosed the presidential candidate, Barry Goldwater, with whose views many of them disagreed, as mentally ill. A decade earlier, members of the profession, supporting the Alger Hiss defence, diagnosed Hiss's accuser, Whittaker Chambers, as a psychopath without ever having examined him. And the CIA, understanding the power of diagnosis to discredit, made plans in 1954 to use it in its covert operations [110]. Its hopes were to administer LSD to those it wished to make mad—or, more to the point, to those it wished to be diagnosed by others as mad. Under the influence of the drug these enemies of the United States would seem psychotic, with the anticipated result that their own people, having come to that diagnostic conclusion, would reject or depose them.

But the most flagrant setting for the raw use of psychiatry to discredit—and, indeed, to intimidate and punish—has been the former Soviet Union. And it is here that the category of *non-purposeful* misdiagnoses that was defined earlier in this chapter, and to which most of the chapter has been devoted, begins to merge with, and seems at times indistinguishable from, the category of *purposeful* misdiagnoses.

During the last quarter-century of the former Soviet Union several hundred dissidents were arrested for political trespasses and, as noted earlier, sent to psychiatrists, found mentally ill, and committed for involuntary stays at psychiatric hospitals for the criminally insane [111–120]. Of these a number have been truly ill [121]. A number almost surely have not [122]. To the extent that

they have not, and to the extent that the diagnoses in those cases were rendered at the direct or indirect request of governmental authorities, these actions represent the worst expression of *purposeful* misdiagnoses—that is, purposeful psychiatric abuse. In many cases, however, the misdiagnoses were probably issued in full or partial sincerity [123–126]; as noted earlier in this chapter, at least some of these misdiagnoses having been the result of the influence of the Moscow School's overbroad and overinclusive criteria for the diagnosis of schizophrenia that reigned in Soviet psychiatry during the period between the 1960s and the end of the Soviet era.

Whatever the motivations behind the particular misdiagnoses may have been—whether they were issued purposefully or non-purposefully, in full awareness of their inaccuracy or in non-awareness (or only partial awareness)—the very fact that psychiatrists were asked to examine the dissidents in the first place illustrates the beauty of diagnosis in all its array—not only as a means to discredit, and not only as a means to punish, but also as a means to dehumanize, to transform social deviance into medical illness, as well as a means to reassure and to explain.

Diagnosis as the reflection of social trends

One use of diagnosis that has been particularly problematic has involved the diagnosis of 'recovered' or 'repressed' memory. This diagnosis was made with particular frequency in the United States during the early 1990s by mental-health practitioners (especially psychologists and social workers, but also a number of psychiatrists) who attributed certain symptoms they believed persons had, or certain of their behaviours, to experiences that they were assumed to have had during their childhoods but could not remember because memories of those experiences had been 'repressed'. These experiences were generally assumed to have involved sexual abuse, often said to have been carried out by a parent. In some cases the abuses were believed to have involved bizarre, sometimes satanic, rituals. On occasion, as a result of these diagnoses, parents or others, such as persons in charge of schools, would be subjected to criminal charges and punishments [127–132].

The great frequency of such diagnoses diminished rapidly after a number of celebrated cases resulted in lawsuits against therapists making such diagnoses. Some of them were found to be baseless when it became apparent that therapists, believing in the diagnosis, suggested it in various ways to patients who then 'produced' memories 'documenting' the diagnosis. In reaction, the phenomenon produced an organization, the False Memory Syndrome Foundation, founded in significant measure by parents who had been accused of such abuse and supported by a number of prominent psychiatrists. A number of professional organizations, including the American Psychiatric Association and the American Psychological Association, issued statements warning against the possible dangers related to such diagnoses [134]. In addition, medical malpractice insurance companies provided guidelines to psychiatrists on how to minimize the likelihood of lawsuits related to such diagnoses [135].

To some extent the growth of the tendency to expect—and to 'recover'—'repressed memories' was a product of trends in the general culture, especially in the United States, related to a focus on victimization and concerns particularly regarding women. Such victimization, as well as childhood abuse, obviously occurs. But when the search for such abuse becomes part of the diagnostic enterprise, and especially when psychiatric 'symptoms' said to be the products of such abuse are identified that are ambiguous and could be the result of numerous factors, what can follow is considerable harm not only to the families of patients but also to the patients themselves—and, not least, to the mental health professions and the diagnostic enterprise. It is not surprising, given the vulnerabilities of the latter, that diagnosis was turned to in the effort to condemn reprehensible practices that take place; but it was unfortunate that diagnostic procedures were distorted in the process.

Conclusion

If we turn to diagnosis because of its non-medical beauty we are at risk, whether we are laymen or psychiatrists, of being injured by that beauty. For years people have been coming to psychiatrists to circumvent the law: they have sought diagnoses to help them get abortions or evade the military draft. Psychiatrists often saw little danger in such humanitarian deeds, and responded to the requests willingly. But the danger was there, and we need only look to the former Soviet Union to appreciate its extreme potential. Things went awry in that country because a powerful tool was just too attractive and too capable of misuse to be protected from it; the fear of governmental power was too great, the respect for the law too weak, the diagnostic scheme too broad, and the opportunities for self-deception on the part of both ordinary bureaucrats and well-trained psychiatrists too available. But the same attraction to diagnosis, the same appreciation of its multiple beauties, exists in the West; and though our laws have protected us from succumbing to a similar fate, the law itself has a certain weakness for diagnosis, tends to be partial to its charms, and is exquisitely susceptible to its inroads. Psychiatrists have to understand that diagnosis plays a powerful, varied, and unrecognized role in the lives of all persons; that that role is equally powerful and no less varied and unrecognized in the lives of psychiatrists; and that all abuses of diagnoses are a psychiatric problem in considerable measure because they are a *human* problem, and probably stem less from the corruption of the profession than from the needs and vulnerabilities of us all.

Naturally, psychiatrists must be expected not to misdiagnose knowingly. But in order to avert non-purposeful misdiagnoses, psychiatrists must come to appreciate the limitations of the diagnostic process itself, the capacity of diagnostic theories and schools to influence and shape psychiatric perceptions of behaviour, and

the inherent beauties of diagnosis that make it so enticing to use that only the most stringent efforts on the part of psychiatrists, and the most serious attention on the part of their teachers, will keep that them from yielding unknowingly to those beauties—indeed, will keep psychiatrists from failing to recognize that they even exist.

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