JLS-9 LOOKING FOR SANITY (3)

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Dear Mr. Nolte,

Man is fond of classifying. The knack of recognizing and describing similarities and differences between objects and events in the physical universe paralleled the development of the human mind. It was a mark of our evolutionary fitness. New Guinea natives can recognize 135 species of birds. Physicists classify the elements of matter from hydrogen to hahnium in their elegant period table. Psychiatrists classify people. But of all her devotees, Classification has smiled least upon psychiatry.

In 1959 there were no fewer than 75 largely inconsistent psychiatric schemes in use worldwide for classifying mentally disordered people. We in the United States live subject to the suzerainty of DSM-II, the Diagnostic and Statistical Manual of the American Psychiatric Association, enacted by majority vote in 1968. (I've reproduced its list of 212 rubrics a few pages hence, though not its glossary of definitions, and

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there will be occassion to refer to it in the future.) It is a revision of DSM-I, voted into being in 1952, which derived from the nosological (= classificatory = taxonomic) scheme of Emil Kraepelin (1856-1926), the progenitor of modern psychiatric nomenclature. A brilliant synthesizer, Kraepelin drew together the isolated concepts of French and German workers of the preceding generation and applied the descriptive natural science methods of his time to construct a taxonomy patterned along biological lines in which disease entities were established by the joint occurrence of specified symptoms in relation to the cause, course, and outcome of the disorder. The Kraepelinian concept that a disease is a thing or an entity is today in disrepute and has for the most part yielded to the view that a mental 'disease' is simply a collection of observable symptoms that are frequently found in each other's company. But psychiatric nomenclature has changed little in its essentials since the sixth edition of Kraepelin's Textbook in 1899.

The idea of mental disease enters our courtrooms through many doors. The insanity defense permits a criminal defendant to avoid responsibility by showing that his failure to control himself or to appreciate the wrongfulness of his act was the product of a mental disease or defect. Courts in most states conduct competency hearings to determine whether you have the 'capacity' to sue and be sued, to vote or drive, to enter into contracts, to be a juror or a doctor, to make a will, raise children, or stand trial on criminal charges, and incapacity often requires a finding of mental disease or defect. In every part of the United States you can be committed to a mental hospital against your will if you are judged mentally ill. (Some commitment statutes also require that you be dangerous to yourself or others; some only that you be 'in need of care.') Depending on where you live, insanity may also

be grounds for divorce or a defense to divorce, an excuse in negligence actions, or a warrant for having you sterilized.

When a legal standard requires a showing of mental illness or disease or defect, the expert testimony of a psychiatrist is generally required. He is asked whether an underlying disease existed at the moment in question and, in appropriate cases, whether the disease caused the incapacity or criminal act. The psychiatrist will rely on the nomenclature of DSM-II to communicate his conclusions, and in this way the standard nomenclature covertly authorizes a belief in the existence of disease entities underlying behavioral symptoms. Most courts assume that 'mental disease' is a medical term which medical science can define and that medical science actually has defined 'mental disease' in substantially a medical manner. Each element of this assumption is wrong.

One practical problem with the diagnostic categories in DSM-II is their notorious unreliability. Reliability refers to the definiteness and specificity with which a given individual can be assigned to one category or another. It is a reflection of the objectivity of criteria for class membership and the uniformity of their application. Reliability can be tested by comparing the diagnoses of one patient rendered by several psychiatrists or hospital testing services, serial diagnoses of the same patient over time, diagnoses of similar patient populations by one psychiatrist or several of them, and so forth. Countless studies have come up with almost uniformly disappointing results. Inter-rater agreement is rarely achieved more than two-thirds of the time using only three or four broad categories of abnormality and is always much lower than that when the finer gradations of 'illness' are tested. This means, of course, that a patient labelled with one name might just as likely have been given another. Diagnosis has been demonstrated to depend on the experience of the diagnos-

tician (more can mean less here!), his nationality (the best cure for schizophrenia is a voyage to England--for re-diagnosis), sex differences between observer and observed, and the social or ethnic distance between diagnostician and patient.

Eliminate these human factors: over half the unreliability persists. It inheres in the diagnostic nosology itself. Statistical procedures for identifying the natural clusters or classes into which data may fall have been enlisted in an effort to validate the logic of DSM-I and DSM-II, and the result has been conspicuous failure. Sometimes a dim, minimal structure of three or five divisions shows through the masses of symptom and trait data, but then we have cause to wonder whether this isn't an artifact of the statistical clustering procedure itself, an effect of the preconceptions and implicit models of the data takers, of their tendency to emphasize extremes and organize observations around nodal points, and of the talent of clustering techniques to discover pseudo-clusters in homogeneous data.

When you classify people, you first decide which of their characteristics are relevant for your purposes and by what principle of similarity you will group them. Their other characteristics are thenceforth ignored, lost and unmeasured, as long as you treat these people as class members. What began as observation ends up as theory-laden activity, and what you find out may be only what you were looking for. You ignore the ways that an individual may differ from himself over time. You limit the range of assumptions you will entertain about him. When you assign him, yes or no , to a given class, you thereby attribute to him class characteristics that only the average or ideal class member possesses. Class membership thus obscures some information while creating surplus meaning about the individual member. Classification widens

the gap between observer and observed by placing one inside the circle and the other outside. A diagnosis has the power to shape the behavior of patients to conform to it.

Given what you lose in classifying people, there must be compensating gains to justify the activity. I've come across five purported rationales for psychiatric classification:

1. ease of manipulation, storage, and retrieval of data

2. to reflect the natural configural properties of phenomena

3. building theories--making general statements about the classes under consideration

4. planning the treatment of patients

5. administrative uses, including patient housing and legal testimony.

Reasons 2 through 5 are ruled out by the demonstrated unreliability of diagnosis. 1 is possible even with the worst sort of data, as long as it is handily indexed, but it is hard to see why one would care to manipulate, store, and retrieve unreliable data in the first place (a clear application of the seminal aphorism of the computer age, 'garbage in--garbage out'). If diagnosis were reliable, reason 2 still would not convince, considering the failure of cluster analysis to find that mental pathology falls naturally into clusters or classes. And 3 through 5 require considerably more than reliable and logical categories. What is needed there is a measure of the validity of the psychiatric nosology.

The classificatory schemes in DSM-I and DSM-II are in the main descriptive: except for the so-called organic

(continued on p. 8)

(Extracted from DSM-II, Diagnostic and Statistical Manual of Mental

THE DIAGNOSTIC NOMENCLATURE: [1]

List of Mental Disorders and Their Code Numbers

I. MENTAL RETARDATION

Mental retardation (310-315)

310 Borderline mental retardation

311 Mild mental retardation

312 Moderate mental retardation

313 Severe mental retardation

314 Profound mental retardation

315 Unspecified mental retardation

The fourth-digit sub-divisions cited below should be used with each of the above categories. The associated physical condition should be specified as an additional diagnosis when known.

.0 Following infection or intoxication

.1 Following trauma or physical agent

.2 With disorders of metabolism, growth or nutrition

.3 Associated with gross brain disease (postnatal)

.4 Associated with diseases and conditions due to (unknown) prenatal influence

.5 With chromosomal abnormality

.6 Associated with prematurity

.7 Following major psychiatric disorder

.8 With psycho-social (environmental) deprivation

.9 With other [and unspecified] condition

II. ORGANIC BRAIN SYNDROMES

(Disorders Caused by or Associated With Impairment of Brain Tissue Function) In the categories under IIA and IIB the associated physical condition should be specified when known.

II-A. PSYCHOSES ASSOCIATED WITH ORGANIC BRAIN SYNDROMES (290-294)

290 Senile and pre-senile dementia
- .0 Senile dementia
- .1 Pre-senile dementia

291 Alcoholic psychosis
- .0 Delirium tremens
- .1 Korsakov's psychosis (alcoholic)
- .2 Other alcoholic hallucinosis
- .3 Alcohol paranoid state ((Alcoholic paranoia))
- .4* Acute alcohol intoxication*
- .5* Alcoholic deterioration*
- .6* Pathological intoxication*
- .9 Other [and unspecified] alcoholic psychosis

292 Psychosis associated with intracranial infection
- .0 Psychosis with general paralysis
- .1 Psychosis with other syphilis of central nervous system
- .2 Psychosis with epidemic encephalitis
- .3 Psychosis with other and unspecified encephalitis
- .9 Psychosis with other [and unspecified] intracranial infection

293 Psychosis associated with other cerebral condition
- .0 Psychosis with cerebral arteriosclerosis
- .1 Psychosis with other cerebrovascular disturbance
- .2 Psychosis with epilepsy
- .3 Psychosis with intracranial neoplasm
- .4 Psychosis with degenerative disease of the central nervous system
- .5 Psychosis with brain trauma
- .9 Psychosis with other [and unspecified] cerebral condition

294 Psychosis associated with other physical condition
- .0 Psychosis with endocrine disorder
- .1 Psychosis with metabolic or nutritional disorder
- .2 Psychosis with systemic infection
- .3 Psychosis with drug or poison intoxication (other than alcohol)
- .4 Psychosis with childbirth
- .8 Psychosis with other and undiagnosed physical condition
- [.9 Psychosis with unspecified physical condition]

II-B NON-PSYCHOTIC ORGANIC BRAIN SYNDROMES (309)

309 Non-psychotic organic brain syndromes ((Mental disorders not specified as psychotic associated with physical conditions))
- .0 Non-psychotic OBS with intracranial infection
- [.1 Non-psychotic OBS with drug, poison, or systemic intoxication]
  - .13* Non-psychotic OBS with alcohol* (simple drunkenness)
  - .14* Non-psychotic OBS with other drug, poison, or systemic intoxication*
- .2 Non-psychotic OBS with brain trauma
- .3 Non-psychotic OBS with circulatory disturbance
- .4 Non-psychotic OBS with epilepsy
- .5 Non-psychotic OBS with disturbance of metabolism, growth or nutrition
- .6 Non-psychotic OBS with senile or pre-senile brain disease
- .7 Non-psychotic OBS with intracranial neoplasm
- .8 Non-psychotic OBS with degenerative disease of central nervous system
- .9 Non-psychotic OBS with other [and unspecified] physical condition
  - [.91* Acute brain syndrome, not otherwise specified*]
  - [.92* Chronic brain syndrome, not otherwise specified*]

III. PSYCHOSES NOT ATTRIBUTED TO PHYSICAL CONDITIONS LISTED PREVIOUSLY (295-298)

295 Schizophrenia
- .0 Schizophrenia, simple type
- .1 Schizophrenia, hebephrenic type
- .2 Schizophrenia, catatonic type
  - .23* Schizophrenia, catatonic type, excited*
  - .24* Schizophrenia, catatonic type, withdrawn*
- .3 Schizophrenia, paranoid type
- .4 Acute schizophrenic episode
- .5 Schizophrenia, latent type
- .6 Schizophrenia, residual type
- .7 Schizophrenia, schizo-affective type
  - .73* Schizophrenia, schizo-affective type, excited*
  - .74* Schizophrenia, schizo-affective type, depressed*
- .8* Schizophrenia, childhood type*
- .90* Schizophrenia, chronic undifferentiated type*
- .99* Schizophrenia, other [and unspecified] types*

296 Major affective disorders ((Affective psychoses))
- .0 Involutional melancholia
- .1 Manic-depressive illness, manic type ((Manic-depressive psychosis, manic type))
- .2 Manic-depressive illness, depressed type ((Manic-depressive psychosis, depressed type))
- .3 Manic-depressive illness, circular type ((Manic-depressive psychosis, circular type))
  - .33* Manic-depressive illness, circular type, manic*
  - .34* Manic-depressive illness, circular type, depressed*
- .8 Other major affective disorder ((Affective psychoses, other))
- [.9 Unspecified major affective disorder]
  - [Affective disorder not otherwise specified]
  - [Manic-depressive illness not otherwise specified]

297 Paranoid states
- .0 Paranoia
- .1 Involutional paranoid state ((Involutional paraphrenia))
- .9 Other paranoid state

298 Other psychoses
- .0 Psychotic depressive reaction ((Reactive depressive psychosis))
- [.1 Reactive excitation]

Disorders [second edition], of the American Psychiatric Association, 1968)

[.2 Reactive confusion]
[Acute or subacute confusional state]
[.3 Acute paranoid reaction]
[.9 Reactive psychosis, unspecified]

[299 Unspecified psychosis]
[Dementia, insanity or psychosis not otherwise specified]

IV. NEUROSES (300)

300 Neuroses
.0 Anxiety neurosis
.1 Hysterical neurosis
.13* Hysterical neurosis, conversion type*
.14* Hysterical neurosis, dissociative type*
.2 Phobic neurosis
.3 Obsessive compulsive neurosis
.4 Depressive neurosis
.5 Neurasthenic neurosis ((Neurasthenia))
.6 Depersonalization neurosis ((Depersonalization syndrome))
.7 Hypochondriacal neurosis
.8 Other neurosis
[.9 Unspecified neurosis]

V. PERSONALITY DISORDERS AND CERTAIN OTHER NON-PSYCHOTIC MENTAL DISORDERS (301—304)

301 Personality disorders
.0 Paranoid personality
.1 Cyclothymic personality ((Affective personality))
.2 Schizoid personality
.3 Explosive personality
.4 Obsessive compulsive personality ((Anankastic personality))
.5 Hysterical personality
.6 Asthenic personality
.7 Antisocial personality
.81* Passive-aggressive personality*
.82* Inadequate personality*
.89* Other personality disorders of specified types*
[.9 Unspecified personality disorder]

302 Sexual deviations
.0 Homosexuality
.1 Fetishism
.2 Pedophilia
.3 Transvestitism
.4 Exhibitionism
.5* Voyeurism*
.6* Sadism*
.7* Masochism*
.8 Other sexual deviation
[.9 Unspecified sexual deviation]

303 Alcoholism
.0 Episodic excessive drinking
.1 Habitual excessive drinking
.2 Alcohol addiction
.9 Other [and unspecified] alcoholism

304 Drug dependence
.0 Drug dependence, opium, opium alkaloids and their derivatives
.1 Drug dependence, synthetic analgesics with morphine-like effects
.2 Drug dependence, barbiturates
.3 Drug dependence, other hypnotics and sedatives or "tranquilizers"
.4 Drug dependence, cocaine
.5 Drug dependence, Cannabis sativa (hashish, marihuana)
.6 Drug dependence, other psycho-stimulants
.7 Drug dependence, hallucinogens
.8 Other drug dependence
[.9 Unspecified drug dependence]

VI. PSYCHOPHYSIOLOGIC DISORDERS (305)

305 Psychophysiologic disorders ((Physical disorders of presumably psychogenic origin))
.0 Psychophysiologic skin disorder
.1 Psychophysiologic musculoskeletal disorder
.2 Psychophysiologic respiratory disorder
.3 Psychophysiologic cardiovascular disorder
.4 Psychophysiologic hemic and lymphatic disorder
.5 Psychophysiologic gastro-intestinal disorder
.6 Psychophysiologic genito-urinary disorder
.7 Psychophysiologic endocrine disorder
.8 Psychophysiologic disorder of organ of special sense
.9 Psychophysiologic disorder of other type

VII. SPECIAL SYMPTOMS (306)

306 Special symptoms not elsewhere classified
.0 Speech disturbance
.1 Specific learning disturbance
.2 Tic
.3 Other psychomotor disorder
.4 Disorders of sleep
.5 Feeding disturbance
.6 Enuresis
.7 Encopresis
.8 Cephalalgia
.9 Other special symptom

VIII. TRANSIENT SITUATIONAL DISTURBANCES (307)

307* Transient situational disturbances[1]
.0* Adjustment reaction of infancy*
.1* Adjustment reaction of childhood*
.2* Adjustment reaction of adolescence*
.3* Adjustment reaction of adult life*
.4* Adjustment reaction of late life*

IX. BEHAVIOR DISORDERS OF CHILDHOOD AND ADOLESCENCE (308)

308 Behavior disorders of childhood and adolescence[2] ((Behavior disorders of childhood))
.0* Hyperkinetic reaction of childhood (or adolescence)*
.1* Withdrawing reaction of childhood (or adolescence)*
.2* Overanxious reaction of childhood (or adolescence)*
.3* Runaway reaction of childhood (or adolescence)*
.4* Unsocialized aggressive reaction of childhood (or adolescence)*
.5* Group delinquent reaction of childhood (or adolescence)*
.9* Other reaction of childhood (or adolescence)*

X. CONDITIONS WITHOUT MANIFEST PSYCHIATRIC DISORDER AND NON-SPECIFIC CONDITIONS (316*—318*)[†]

316*[††] Social maladjustments without manifest psychiatric disorder
.0* Marital maladjustment*
.1* Social maladjustment*
.2* Occupational maladjustment*
.3* Dyssocial behavior*
.9* Other social maladjustment*

317* Non-specific conditions*
318* No mental disorder*

XI. NON-DIAGNOSTIC TERMS FOR ADMINISTRATIVE USE (319*)[†]

319* Non-diagnostic terms for administrative use*
.0* Diagnosis deferred*
.1* Boarder*
.2* Experiment only*
.9* Other*

psychoses, the categories designate only constellations of observable symptoms that are believed to occur together with high frequency. If an individual gets assigned to one category or another, this logically guarantees only that he exhibit the defining characteristics, the symptom complex, of that class. By itself, diagnosis implies nothing about additional characteristics beyond the criteria for class membership. But patient administration and care and theory building do require that diagnosis imply more about the individual than the characteristics that got him assigned to the class in the first place, that there be correlations between the category and important clinical variables like etiology or prognosis or treatment of choice or response to treatment or response to life, that classifying someone a paranoid schizophrenic say something about how he got that way, how to care for him, what he'll be like a year from now. Yet the vast literature concerning psychiatric diagnostic categories is practically mute on the subject of extra-class correlations. And there is little evidence that classification based on simple clinical description of symptom complexes is able to group patients who are like each other in any significant way besides appearances. A taxonomy that does not lend itself to the formulation of general laws for explanation and prediction is not a useful one.

Classification performs a <u>digitalizing</u> operation on a chaos of perceptions and information regarding another human being by ordering the chaos into a small number of discrete, yes-or-no categories. But theory-building does not require classification. Science progresses from taxonomy to more complex forms of description in which the relevant variables are preserved as continuous dimensions in the ultimate description rather than boiled down to one variable--class membership. In this regard, psychiatry is at least 100 years behind the other sciences. A dimensional model is more difficult to use, remember, store, and manipulate than discrete

categories. But this alone does not explain the intense emotion with which a large segment of the psychiatric profession are attached to their taxonomy. Why assume that data regarding human beings will conveniently fall into a small number of discrete clumps? Why spend countless hours of research time trying to prove that the nomenclature inherited from Kraepelin refers to natural, homogeneous classes of human beings? Why pretend that a nosology constructed for medical purposes will answer legal and administrative questions?

The disease-entity view of mental disorder, whether explicitly held as in Kraepelin's time or implicitly in DSM-II, is one way that organized medicine asserts its jurisdiction. Regardless of whether a diagnostic rubric indicates anything at all about the real world, it does enable the psychiatrist to communicate effortlessly and in half a minute his conclusions about a patient to judge, jury, census bureau, employer, college admission office. The category, the name, the digital information is a key to his authority, for if he were limited to the reasons behind the name, limited to the dimensional evidence for it (as one court has done[1]), the depth of his acquaintanceship with this patient and with the diverse phenomena of mental disorder might be scrutinized and his influence lessened. Is it unfair to suppose that psychiatry holds on to its rubrics for the influence they help it keep? I can think of no other reason for the insistence (ultimately unsuccessful) of the American Psychiatric Association in the Jenkins case (1962) that clinical psychologists, doctors of philosophy, should be barred from giving expert testimony on the presence or absence of mental disease because they lack medical training.

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[1] Washington v. U.S., 390 F.2d 444 (D.C. Cir. 1967).

But influence tells only part of the story. Other reasons are close at hand: in the pull of history and habit, in the human need to camouflage areas of ignorance, to hold off the dread that maybe no one in the universe comprehends this distressing phenomenon of mental disorder. By classifying, the psychiatrist succeeds in setting himself apart from the disturbing material the patient presents. Naming implies acquaintanceship and mastery. The diagnostic rubric is a very special form of communication between the psychiatrist and himself, his colleagues, his staff, and posterity. The act of reducing the wealth of information about another person into categories is in part the construction of an appearance of rationality in the face of the proven unreliability, illogicality, and invalidity of the categories themselves. By studying the multitude of ways this particular form of communication is in fact used by psychiatrists in their informal and formal speech and in their writing and by piecing together the model of rationality to which its appeals, I hope to devise a more general theory of its workings.

Thus is summarized in advance the argument of this series of newsletters, picking up from the questions that readers with commendable memories may recall were raised in JLS-4 and-5, Looking for Sanity. Future installments will develop pieces of the argument in greater detail.

One caution: the largely empirical questions I've raised do not in themselves answer the legal and ethical ones. Mental illness as a legal concept will not go away simply because the traditional names for it do not make sense. But they do point up areas where the legal system tries to transmute difficult questions of fact and of values into simple questions of fact by subcontracting important steps in the guilt-determining process to psychiatrists. To take one example: psychiatrists

are sometimes asked, as I mentioned above, to testify whether a mental disease was the cause of a defendant's criminal act. If one believes in the underlying disease-entity notion of mental disorder, this question may be intelligible. But if the most one can truly say about DSM-II and similar nosologies (putting aside questions of reliability and discreteness) is that their categories designate clusters of observable symptoms, the question of cause loses its meaning. An individual symptom or symptomatic action is then a sign or signifier of the complex of symptoms of which it is itself a part. It is a symbol, or a metonymy, for a collection of itself. To say that a mental disease caused a criminal act is thus to say that a symptom complex caused the symptom. This, of course, is absurd. And so it becomes absurd in most cases to ask a psychiatrist for expert testimony on the cause of an act.

For the lawmaker, however, the question still remains, what intuitive, everyday notion of human nature was this idea of cause meant to embody, and can it be expressed more sensibly?

Regards,

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