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The Scientific Evidence That Today's Psychiatry Cripples Itself—By Excluding 'Intent'

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PSYCHIATRISTS DISAGREE profoundly with lawyers, about what we human beings are capable of. The one says we have '**intent'**—the other that we do not. They cannot both be right. All non-psychiatrist doctors must perforce agree with the lawyers. This paper argues that these harmful discrepancies will continue, until we undo the separate watertight **human knowledge silos,** which have grown up between legal procedures, general medicine, and psychiatric practice. All three would benefit. Psychiatry in particular, suffers from a grievously narrow view of **scientific evidence**, one which is open to fundamental criticism. There are radical differences in how the fuzzy concept of 'intent' is regarded in law, in general clinical medicine and in psychiatry. Once 'intent' is accorded its due weight, our understanding of **justice**, **health** and **sanity** is vastly improved, allowing us hugely more **optimism**. This paper is based on two earlier papers—*The Scientific Evidence That 'Intent' Is Vital for Healthcare* and *Why Quakerism Is More Scientific Than Einstein.* These are deployed here, to unpick the unhealthy tangle in which today's psychiatry now finds itself. Its six sections are—(1) why 'intent' matters in law, in medicine & in psychiatry; (2) scientific quagmires; (3) a working definition for 'madness'; (4) "children are impressionable"; (5) "trust me, I'm a doctor"; and (6) skin heals, why can't minds? The breakthrough is that verbal *fuzziness* means that words can mean different things at different times—not that they are 100% meaningless. Only a better understanding of **trust**, **autonomy** and **consent** can open the way to something that is painfully absent from today's psychiatry—**a cure** for any and all mental disease.

Keywords: Intent, human knowledge silos, scientific evidence, sanity, optimism, Trust, autonomy, Consent, Adverse Childhood Events (ACE), curing mental disease

Why 'Intent' Matters in Law, in Medicine & in Psychiatry

HUMAN KNOWLEDGE, which is the bedrock of all academic journals, suffers (among other things) from being divided into too many specialities. We urgently need workable bridges between what have become alienated knowledge silos. The chasms that have grown up between legal practice, clinical medicine, and psychiatry lead to major miscarriages of justice, as well as to serious iatrogenic diseases. This paper endeavours to chart a common pathway between all three which will make eminent sense to experts on all sides, and to others. The risk, and it is an ongoing one, is that what seems elementary to one branch, will seem naïve and unacceptable to another.

Expertise, by definition, is difficult to achieve anywhere, so those who venture to comment on all three, as

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I do here, attract abrupt professional disinterest—being labelled as grossly unprofessional, or worse—a “maverick”, beyond the pale, not worthy of consideration, a heretic in urgent need of excommunication (as I’ve found). However, progress in all three, especially where they overlap (since they must) will be retrograde, until common ground can be re-established. Basically all three apply to human beings—who necessarily form the clientele for them all—thus the three have much to learn from each other, which as this paper will argue, can bring mutual benefits all round.

Start with the concept of ‘intent’. Orthodox psychiatrists fudge it. But no legal expert would tolerate even a mere hint of its dilution—the practice of law depends fundamentally upon it. “When you picked up that spade, did you *intend* to dig or to kill?” This is obvious enough in criminal law. In the time-honoured UK “Offences Against the Person Act”, which dates back to 1861, sections 18 and 20 differ radically, both in their sentencing enforcements, and on the criteria which distinguishes between them—was ‘intent’ present, or not? If “yes”, then much more severe penalties ensue. So suggestions that ‘intent’ is too woolly, or too controversial are, in legal circles, contemptuously dismissed. Fudging what ‘intent’ is, or if it even exists at all, is not an option in law. In fact, any who have faced the rigours of cross-examination in court, will be painfully aware of its crucial and ongoing significance. “What precisely did you mean by that, what did you *intend* to say?” And so on, and on, and on.

Nor is this confined to criminal law—‘intent’ forms the basis of all civil contracts too. “When you signed that paper, did you ‘intend’ to follow through—or were you disguising some devious or surreptitious motive?” Enormous legal challenges turn precisely on what was *intended* by the various parties at strategic times—to regard the participants as automatons turns the whole legal edifice into dust (as already happens too often, where psychiatry is involved). Bear in mind too, that much legal effort is expended on attempting to ascertain what precisely was in the mind of the legislators when the applicable law was first enacted—in other words, what was *their* ‘intent’. Choice, decision, consent—all are variants of ‘intent’, and could not exist without it—and if you were preposterous enough to doubt this in open court, a competent cross-examiner would have a field day, at your expense.

Clinical medicine, too, stands or falls on the ‘intent’ of each and every patient. This is most obvious where surgical procedures are involved—the Consent Form is indispensible—without it, medical practitioners of any hue, instantly and invariably open themselves up to charges of assault and battery, which perforce engage legal practitioners with some alacrity. But even in the humdrum medical consultation, the patient’s ‘intent’ is paramount. It even merits its own medical label—Patient Agency—what the patient thinks, believes, will do, or *intends*.

As a moment’s reflection will confirm, downgrading this aspect of medical intervention calls into question who the service is for—doctor or patient? Doctors who trivialise patients in this way, by disregarding their views, their ‘intents’, or otherwise neglecting their decisions, are already well on the way to bankruptcy, as happens invariably with all other human to human transactions, whenever the “customer” is rated as secondary to the “business”.

Nor is this merely academic. One of the things you learn in family medicine (I was a general practitioner for twenty years) is that gauging the level of ‘intent’ has a major bearing on the pathology involved—why did that particular person attend at that particular time, with that particular symptom? —this matters clinically. In fact it soon becomes an indispensible clinical skill which governs both the vigour and the timing of any proposed medical intervention.

More precisely too, what is a “symptom”? When I was establishing criteria for computerising the medical record (Johnson, 1980), it was obvious that I needed to define what was a symptom, and what was not. A person with a chest pain, walking past my clinic, with not the least intention of seeking my medical assistance, walked themselves out of my nascent computer system. In effect, notwithstanding any relevant *medical* significance, their symptom did not exist from my individual practitioner point of view. This would change dramatically, once they entered my door—something that without engaging their ‘intent’, their capacity to make decisions—simply could not occur.

It will thus be clear that these two branches of professional practice—law and clinical medicine—would cease to function appropriately, if ‘intent’, or choice, or an element of Free Will, were excluded from that profession’s approach. Or rather, their practice would rapidly descend into a parody of anything remotely acceptable as professional—the very heart of what they did, would have been extirpated. Human beings who appear in court, or who attend medical clinics, bring their ‘intent’ with them, without exception or demur. It is unnecessary to invoke Human Rights—the very practice, both legal and medical, would collapse into pointlessness were ‘intent’ *excluded* on any occasion, or for any reason, whatsoever.

So to the crunch. Non-psychiatrist readers will assume that no self-respecting profession would continue without taking ‘intent’, and its close cousins, to heart. It must surely come as a surprise, therefore, to find that the major psychiatric textbook of the last forty years, blankly excludes it. Or rather, textual analysis shows that it appears more prominently in the phrase “this page intentionally left blank”, than in other medical applications. ‘Intent’ is thereby allocated to writers of psychiatric texts, but actively denied to any and all psychiatric clientele. And just as both law and general medicine would collapse into dust without it, there is disturbing evidence, “hidden in plain sight”, that something painfully similar has already occurred in today’s “scientific” psychiatry.

Scientific Quagmires

Why should ‘intent’ be so badly mishandled? If its omission is so dire, you might have thought that more care would be taken to ensure its survival. In a wider context, of course, questions of Free Will, determinism, or automatism, have preoccupied philosophers ever since there were any. And with nuanced notions such as ‘intent’, the standard approach has been to place most emphasis on the words used to communicate it. What do you mean, precisely, by ‘intent’? How does this differ from other human behaviours? Does it? If you don’t define your terms, how can we know what you mean?

Underlying this, is the whole scientific ethos—progress is made by ever tighter measurement, ever stricter definition, ever clearer analysis—in fact, a prominent feature of Science is the unwillingness to tolerate fuzzy or vaguely demarcated concepts. And while this has served us well in most things, it runs up against intractable flaws—which is why we need (and will continue to need) such apparently unscientific “occupations” as the professions—in the present context, law, medicine and psychiatry.

So let’s scrutinise other words with fuzzy edges. Six immediately come to mind—if there were “scientific” definitions for the following, that were solid, repeatable, objective, unchanging, and applicable to all contexts, then these three professions could be replaced by machines within the twinkling of an eye. Try telling me what *you* mean by—(1) justice, (2) unfairness, (3) health, (4) pain, (5) sanity or (6) madness. Sadly Wittgenstein was not alone in supposing that without ever tighter definitions, meanings would decamp (“*darüber muß man schweigen”*, 1922)—life, and the world in which we find ourselves, disagrees. The real tragedy, and it’s this

which has afflicted today’s psychiatry, is to presume that Science does have the answer, and that therefore the more Science you have the better. Not so, as today’s psychiatry shows all too well. The breakthrough that is needed is to see that *fuzziness* means that words can mean different things at different times—not that they are 100% meaningless.

A quagmire is where the more you struggle, the deeper you sink and the speedier you drown—if you squander your time pretending there will be “scientific” definitions for these six vital terms, and that you don’t need to constantly re-work them every time—your neglect ensures that (2) unfairness, (4) pain, and (6) madness flourish, as they will in this imperfect world, unimpeded by you. Your “choice”, if you believe you have one.

Today’s preeminent psychiatric text, widely known as “the psychiatrist’s bible”, goes by the acronym “DSM” (1980, 1994, 2013). It is published every few years in the USA, but its influence is increasingly global. Standard legal practice is to focus tightly on what the text actually says, what my legal friend used to call “reading with the finger”—and indeed two passages from DSM-IV (1994) give weight to the above. But before proceeding with this textual analysis, we need to examine the wider basis on which this eccentric psychiatric approach relies,viz—Science.

Now, Science is no longer the bastion of solid reliable knowledge it was, or at least was hoped to be. As earlier papers have indicated (Johnson, 2017, 2020), we live in a Post-Einstein world, in which all our chains of reasoning, of human knowledge, are subject to four flaws—they have multi-starts, multi-threads, wobbly links and are always accompanied by ineradicable noise. The only way to ensure Absolute Scientific Knowledge would be to establish beyond dispute, that there has only ever been one Big Bang, not several; that single events have one and only one cause, not an infinite number; that tomorrow will always be exactly the same as today, so remedying wobbly causal links; and that noise-free communication of all this, is possible, even in this imperfect world.

This represents a major upheaval in our view of the world, and indeed of Science itself, and there will be some readers who demur. The latter may elect to remain in an Einstein-type universe, where Science can indeed confidently and absolutely predict what is going to happen next, with 100% probability. I would only say that such a world is no longer the one in which I live, and it is one in which psychiatry has gone grievously haywire. Reality, as cited in the above papers, has a way of biting those who elect not to update their perceptions.

As emphasised before (Johnson, 2020), today’s psychiatry breaches three major medical rules-of-thumb, each backed by millennia of medical wisdom. In brief these are Patient Agency, aetiology, and Patient Reaction which the DSM explicitly, and in writing, excludes. These in themselves could account for much of the collapse in today’s psychiatry. There are vital, and indeed health reasons why these medical rules-of-thumb have survived for so long—neglecting them risks gross illhealth, and in particular serious iatrogenic diseases. But this paper is concerned primarily with ‘intent’—and it is here that the failure to acknowledge Post-Einstein Science weighs most heavily.

A Working Definition for ‘Madness’

So to the textual scrutiny. In DSM-IV (1994), we read, under the subheading **Definition of Mental Disorder**—

> Although this volume is titled the *Diagnostic and Statistical Manual of Mental Disorders*, the term mental disorder unfortunately implies a distinction between “mental” disorders and “physical” disorders that is a reductionistic anachronism of mind/body dualism. A compelling literature documents that there is much “physical” in “mental” disorders and much “mental” in “physical” disorders. The problem raised by the term “mental” disorders has been much clearer than its solution, and, unfortunately, the term persists in the title of DSM-IV because we have not found an appropriate substitute. Moreover, although this manual provides a classification of mental disorders, it must be admitted that no definition adequately specifies precise boundaries for the concept of “mental disorder.” The concept of mental disorder, like many other concepts in medicine and science, lacks a consistent operational definition that covers all situations. (p. xxi, [Phrases underlined are commented on below])

In my earlier paper (2020), stamina was commended as an invaluable human asset. This DSM paragraph contains enough inconsistency, self-contradiction, special pleading, sophistry, and downright fake-philosophy to win the Ignoble Prize, or worse. That it persuades innumerable psychiatrists to suppress their better natures, saps the human spirit, at least it does mine. So, with your indulgence, we’ll defer the heavy lifting, and inspire ourselves with what is needed to repair the damage it inflicts, willy-nilly.

The present paper began with a discussion of the role of ‘intent’. The purpose of this was to demonstrate that though it could not be tightly, scientifically, defined in words, ‘intent’ nevertheless remains vital. That is to say, living organisms such as ourselves, should avoid becoming preoccupied with verbal contortions, since, if we do devote our efforts (our ‘intent’) to such pedantry, then we are bound to suffer cognitive confusion, if not paralysis, as a result.

Assuming, as I do, that ‘intent’ (however fuzzy) forms an integral and healthy component of what it means to be a living human being, then we have all the ingredients we need for **a working definition for ‘madness’.** Just as ‘leg disease’ is when your legs don’t do what you want, so ‘mental disease’ is when your ‘intent’ won’t either.

A “working definition” is what you need, if your work requires you to improve matters. So a working definition of ‘intent’, is—first, to assume that it exists; and second, that it can be engaged, persuaded, and agreed with. These are so commonplace in our everyday world, as almost to pass without notice. But no human transaction occurs without them—and where ‘intent’ goes awry, they are needed more than ever. Which is why obfuscation on the scale demonstrated by DSM-IV above, hurts.

You go to your doctor when something doesn’t work the way you want it to. There are three points which cover most problems that occur with ‘intent’ (further discussed in *Verbal Physiotherapy*, Johnson, 2018): you find you are (1) doing things you’d rather not; (2) thinking things which get in the way; or (3) succumbing to reductions in your “get up and go” (aka ‘intent’) that is more than you can well tolerate. Note the element of choice in all this—one man’s indolence is another woman’s equanimity—choices happen all the time, since that’s what ‘intent’ is for.

So why does ‘intent’ go wrong? Well, if you follow DSM-psychiatry, then the question doesn’t arise, because you haven’t got any. But if you work on the basis that ‘intent’ is a central component of human life, then you look for factors which impair it. I began such a search in July 1960. In September 1986, a trusting soul confided in me that she thought she was going to be killed “next”, because 34 years earlier, when she was six, her father had threatened to decapitate her with an axe he was waving about at that time. Her father had died some 4 years before, so her thought didn’t make sense. I told her so. It made no difference. Her thinking was on the blink.

We jointly puzzled as to why. To my unending delight, she battled on, in effect she trusted me enough to look more calmly at the death-threat her father’s abuse had implanted at that young age, in her soul. It had been

like a festering splinter, embedded ever since, which paralysed her ‘intent’ so much, it took away any means she had of removing it, unaided. Without help, she was helpless. However, calm trustworthy support and reflection empowered *her* ‘intent’ and thereby restored realistic thinking—to our joint relief, and my jubilation that we had (at last) uncovered something which worked. You can’t have peace-of-mind (aka sanity) unless you know what your ‘intent’ is doing, or rather what gets in its way. And neither Freda, as I’ll call my fellow explorer, nor myself had much of a clue before we set out. But after much heavy labour, we did, which is why we both knew for a “fact” that we’d arrived.

Since then, I’ve honed this approach in a maximum security prison, working with 50 murderers—if it works there, which it did, then it’ll work anywhere. The scientific basis is demonstrable by brain scans, which show that playing trauma tapes paralyses frontal lobes and speech centres (van der Kolk, 1996). Cerebral paralysis responds to physical physiotherapy—and in my view, emotional paralysis benefits even more from *Verbal Physiotherapy* (Johnson, 2018). But a HEALTH WARNING is needed here—it may sound simple, but it is far, far from easy. It also carries significant hazards—death fears are essential components, and death threats never far behind—so beware—never assume you know more about what is going on in another’s person’s mind—you don’t—only go into such areas like these, with explicit and fully informed consent. Without *consent*, don’t go. *You have been warned.* Bear in mind, three murderers threatened to kill me, because I presumed too much with vastly too little permission or confirmation from within. People will open, but only when they are ready, willing, and can trust.

So to text analysis of the above DSM paragraph. On reflection, since the errors are so gross, we can save time and temper by limiting comments here, to two.

First, take the phrase *“**unfortunately**, the term persists in the title of DSM-IV”*. The term in question is “mind”, or “mental”. Here we have a world best-seller purporting to help cope with diseases of the mind, declaring at the outset that its authors would much prefer to be talking about something entirely different. It’s as if a manual on diet complained about having to mention food. Even a child, in logic alone, could foresee disaster. Were psychiatry in less of a silo of its own, this fundamental blind-spot would never have been tolerated for an instant in any and all civilised discourse.

The second point tries to cement the first. The writer complains that so many terms lack *“a consistent operational definition”*. Which is precisely the point this paper has been making all along. However, this obvious verbal fact is not used to move us all on to our Post-Einstein Science, as I do, with its pressing need (indeed obligation) for being forever vigilant, circumspect, while taking unremitting personal responsibility. No, here this verbal fuzziness, though openly acknowledged, is deployed to launch a prejudiced view of what human beings are really like—mindless, unfeeling robots. (Where’s that razor-sharp cross-examiner when you most need one?)

The point becomes clearer in the second of these two textual excerpts— (DSM-IV, 1994), under the sub-heading **Use of the Manual**—

> ... The term “organic mental disorder” is no longer used in DSM-IV because it incorrectly implies that the other mental disorders in the manual do not have a biological basis. (p. 10)

Here the acknowledged verbal “fuzziness” is concretised into neurology. Mental disorders, as defined by the DSM, are not disorders of the mind, which is seen as risking a *“reductionistic anachronism of mind/body dualism”*, but as purely physical, that is to say, bound up, inextricably, with exclusively chemical disorders. I

leave it to the reader to decide what role the purveying of other chemicals, known as prescribable drugs, might be thought to play in this tendentious reasoning.

“Children Are Impressionable”

On a sunnier note, children are wonderful. They gambol through life with an endearing innocence and delight. Lambs are seen to frolic in the spring sunshine, and human toddlers can be spotted doing something entirely similar, if not with even greater gusto. At least, that’s most of the time. Or should be. Because the way society is now organised, the chances of childhood delight are shrinking. And the reason for that is not hard to find—provided you approach the topic with an open mind. Not the easiest thing to do, when we are all, each of us, the product of our very own personalised childhoods.

The poet Philip Larkin didn’t like his. He gives grim advice about childhood—advising you to “Get out as early as you can”, adding in despair, “And don’t have any kids yourself”. This is from his poem, “This be the verse” (Larkin, 1971), the first line of which rather pickles the whole topic—

> They f*ck you up, your mum and dad.
> They may not mean to, but they do.
> They fill you with the faults they had
> And add some extra, just for you.

Parents can come in for a hard time, as here. I’ve been there myself—so naturally I have to have my exculpation readily to hand. So, straightaway, before we go any further, here is my plea for one and all parents. I have yet to meet the parent who says to her or his child, “I intend to give you a psychosis”. As for myself, I would tell any cross-examiner that I honestly didn’t know. It became clear to me that I was doing something wrong, my parenting was missing a crucial ingredient—I knew that, but what it was I didn’t, I couldn’t, know. I just simply couldn’t see what it was, however hard I looked. This is what Larkin’s second line means. Happily by the time Freda asked me to help her with her emotional tangles—I had been her family doctor for some 10 years, as for her father too—by that time, I’d managed to accumulate enough social confidence to help her, and me. It had taken a long, long time—it was not until I was nearly 50—but then I’m a complicated sort of person, with a vivid imagination.

Parenting is complicated too. It’s perhaps the most challenging human occupation of them all, and the one in which the way you’ve been taught how to do it, is often the one thing which ensures you won’t succeed. You learn the language you speak when you are very small—if you don’t do it then, it’s very hard to do so later. And, in just the same way, you learn your social language too. Remember you had to learn which words are verbs, or “doing words”, and which are nouns, or “thing words”. None of this is easy. It’s surprising you ever get it right—but you do, or at least well enough. And precisely the same has to be taught about what people mean by their actions, their gestures. What does that frown mean, or that smile? Is it for me, or not? And if your parents had never learnt the difference, how could they possibly teach you? Freda’s father had never learnt to control his temper—so she and I had work to do to unpick its consequences—but we could, and we did.

Avoiding teaching your children psychosis is one thing, but violence is another. I’ve heard parents tell their children they’ll kill them when they get home, and have talked to many whose parents also threatened murder, as Freda’s did above—and of course infanticide does occur. And, to that point, I’ve met too many who believed, as Freda did, that that was precisely what was going to happen “next”, for the rest of their life—where could relief come from?

When you look for it, as I have done, this fear of dying is ubiquitous—indeed it is the one key factor that disrupts normal healthy ‘intent’. Think about it. You may happily trundle through life, with few cares—except when it comes to death. And suppose, as Freda did, that death by your father’s axe is next, how could you or she, think of much else? That’s the thing about dying—it tends to take precedence in thought—so much is happening all around that we must, perforce prioritise—self-dying hits the number one slot. Of course, you can do things in a sort of work around—but if your ‘intent’ is stuck, then everything else is of less import.

Those 50 murderers confirmed the point. Death threats of all kinds had been made to them in their infancies, so they “reasoned” that killing was the solution. Where else would you get the idea that killing other people (or yourself) helped? Whichever way you answer that, all the murderers I got to know during those 5 years, were operating on child-mode strategies, on kindergarten-world-views. Killing was part of their child-vocabulary, so it seemed unexceptional to them. My task was to point out that they hadn’t been thinking very straight about it, and that if they could grow up emotionally, then things would be calmer, and more peaceable.

I don’t recommend telling convicted murderers that they need to grow up—something more circumspect is called for. But I did know why they had all become stuck in kindergarten-mode (Freda had taught me), and I also believed that treating them, invariably, as if they were adults, would help. It did. Alarm bells were reduced to zero for three years, down from 20 a year for the previous 7. I can’t resist including a lump of verbatim dialogue from a man I call Alec—he had planned to kill every 2 years, and at one point put me on his hit list, since I’d pressed too hard, and too incautiously on his mother. The remaining dialogue is included in *Verbal Physiotherapy*, from which the numbering is taken (Johnson, 2018).

> 254. Me: Mmmm. I say to people, and I hope this doesn’t upset you, I say to people that you would have been a serial killer.
>
> 255. Alec: Yeah, yeah, and I believe that’s true, there’s no doubt about that.
>
> 256. Me: There isn’t is there?
>
> 257. Alec: I know what would have happened, but like I said I was lucky, all right I didn’t feel that way at the time, but now I know that I was lucky, I was lucky to be put in here. If I had been put in a different Unit, which at the time that’s what I wanted, the same thing would have still happened, not this—the violence. You know, and really I’ve the governors, especially the governors of Moorland and G, to thank for bringing me here.
>
> And you know, my mum on the visit, she said you’ve really matured, you’ve really like, suddenly from being like a kid and being all like teenagery and all that, you’ve just wiped that out, she says and now you can see the seriousness in your face when you’re talking about things. She says you put yourself across, where as I know before you couldn’t do that.
>
> And she admitted, she said, I suppose, I’ll be honest, she says I’m to blame. But she says, now, I know different, and I know now how to talk to you, she says, and give you the respect, as an adult, that you deserve. She says I know that I’ve overpowered you, and yeah and I have clung on to you. She says, but now while we’re not seeing each other, I can get hold of my life now and know that you are ...
>
> 258. Me: She said that?
>
> 259. Alec: Yeah.
>
> 260. Me: *She* can get on with *her* life? Ha ha ha!

Moving on, the background to this, together with ramifications are discussed more fully in *Verbal Physiotherapy*. I also discuss there, why I have enough confidence to summarise all psychiatry in three words—“children are impressionable”. Here I would emphasise that while, as Dr van der Kolk confirmed, trauma does block the frontal lobes, which freezes thinking dead, it takes special expertise to unblock them (something he doesn’t seem to think likely). Much of psychiatry, indeed of medicine in general, is pole-axed

because the sufferer cannot think, or speak about the deepest trauma they’ve ever suffered. Not all those 50 murderers did—but enough accepted my invitation to sit a while, to ponder, to re-shuffle their mental furniture, along the lines that Alec so eloquently describes. Persuading others, especially politicians, was less successful.

“Trust Me, I’m a Doctor”

This paper stands or falls on the scientific validity of ‘intent’. If we assume, as the DSM does, that ‘intent’ is far too illdefined, too nebulous, too subjective to merit the accolade “scientific”, then the doctor’s task is merely to assign a category into which any given bunch of symptoms should fall. If the human mind is just a more complex part of the Grand Order of Things, in effect a mere cog in an elaborate Clock Work Universe, then the only thing mental healthcare can do, or indeed is called upon to do, is categorise.

The central drawback of believing that ‘intent’ is invalid, that it doesn’t exist, is that treatment, healing, let alone cure, take a back seat. There is no room, as the next section of this paper emphasises, for improvement, for intervention, for amelioration in a world in which there is zero Free Will, no capacity for agency, no room for initiative, either on the part of the patient, nor, crucially from a medical viewpoint, from the doctor either. The raw practical fact is that if the patient doesn’t have ‘intent’, then neither does the doctor—s/he is as hamstrung as the patient. Both parties are human—either robotic, or sentient.You can be as “scientific” as you like, but this quandary doesn’t go away.

The point made at the outset of this paper, is that both legal and general medical practice are also in the same boat as psychiatry. There is little point in expending enormous energies in legal proceedings, or in elaborate clinical investigations, if the outcome is already predicted, or, as the ancient phrase has it, already written in the stars. Why bother? If what you want to do, your ‘intent’, has no impact in the real world, is merely the figment of your fervid imagination, then save your breath—whatever you do will make not the slightest difference.

And of course, much about the real world confirms this deterministic pessimism. Politics in particular seems to get ever worse. And any doctor, DSM or otherwise, will well recognise this viewpoint as a symptom—and all, whatever their orientation, would agree to attach the medical label “depressive”. That’s a symptom, it is *not* a “diagnosis”, or a disease. The real question is, as with ‘intent’ as a whole—what happens next? Is there something you *can* do? If you try really hard, can you make things better? Do you have to be outrageously optimistic, like me, to entertain the prospect of “cure”?

Which brings us quietly on to validity in general. Who are you going to believe? The person who says ‘intent’ is valid, or the one who says it’s not? Note, we’ve slipped from “science” to belief. And from there, it’s a small step to *choice*. Which of these radically different positions are you going *choose*? They are incompatible. You are either robotic, or not. Science, however pristine, cannot resolve this for you.

And from here, it’s no distance to “trust”. I assert you have ‘intent’—I state that you want peace-of-mind, you delight in doing, you love cooperating, communicating, consenting. Do you trust me? Trust is relying on another’s Truth. What’s true for me, may or may not be true for you—but the simple fact is Truth is always relative, always contingent—and my Truth takes strength from yours, and vice versa. I am prepared to believe people I trust, while disbelieving those I don’t—and I expect you to do the same. But, and here’s the catch, I have to exercise my ‘intent’, my initiative, my ability-to-respond, so that what I say mirrors as accurately as I can, what I see to be the case. If I don’t, or if you don’t, then Trust falters, Truth shrinks, and so do we.

And here comes Freda again. She didn’t believe she could do anything about the pending axe-attack. The reality is that at the time it occurred, that was precisely true—it was the case that her father, being twice her size and three times as strong, could easily have chopped her up as he verbally threatened to do, and being only 6 years old, she could do nothing to stop him. Frontal lobe paralysis, consequent on this trauma, meant she couldn’t change it—the memory wasn’t just a memory, it was live, it was happening all the time (even though she couldn’t “see” this)—she had to do any number of irrelevant things, merely to get through the day. Axe attacks from bigger and stronger opponents, by definition, invariably end in defeat. Sadly it’s the very trauma itself that stops you re-evaluating.

So her father was male—and his belligerence and peril leaked on to other males. In fact it spread to any who were more powerful—behind their backs, as I discussed with her at the time, they hid a hatchet. She couldn’t see the nonsense in this, because her thinking was on the blink. The deeper the trauma, the greater the need to “not-see”. Adverse Childhood Events (ACE) cover an enormous range—only the sufferer can tell you how severe each one was, and they can only do this when their ‘intent’ is empowered enough for them to do so—never before. (Have a care when investigating this, as above—death fears are rampant, and can lead to serious trouble. Proceed *only* with fully informed Consent, or not at all.)

This is the central dilemma for all trauma victims—strong people are dangerous people—avoid. But being impotent yourself, you need help, else you’ll go round and round the same circle indefinitely. What’s needed is someone who is strong, but also *safe*. Not an easy combination if you think about it. You have to get close enough to someone else to see if they too have an axe or not. But what a risk! Too much for some, especially those vulnerable enough to develop psychotic symptoms. And the vital component—Trust. You are not going to go anywhere near someone who might kill you—you’d be daft to trust them enough to do so—chances are, you couldn’t even think it. Literally.

Powerful but trustworthy—not an easy combination to secure. No wonder psychiatry is stuck—not only do sufferers prove themselves incapable (by virtue of frontal paralysis) of talking or thinking about what their real problem is—but they won’t even begin, unless they trust you not to abuse or traumatise them as past experience has taught them, all too deeply, that is what will always and inevitably happen when you are near people stronger than you. Death, though thoroughly disguised, indeed effectively “buried” by fear, is “next”.

And if you’ve the stomach for it, psychiatry today is in a worse scientific quagmire than is comfortable to imagine, let alone face up to. A whole library says so itself, but most especially Dr Joanna MonCrieff (2007) whose book title says it all—**“The Myth of the Chemical Cure”.** This remarkable textbook concludes, on its final page, that all psychiatric drugs work the same way alcohol does—

> It helps to lift the veil of medical jargon, exposing our miracle cures as psychoactive chemicals, **which distort normal brain function by producing a state of intoxication**.

There’s worse. These “miracle cures” damage brain tissue, while corrupting ‘intent’.

> It is as if the psychiatric community cannot bear to acknowledge its own published findings. Not only does the evidence on brain shrinkage have damning implications for antipsychotic drug treatment, it also weakens one of the strongest pillars of the case that schizophrenia is a brain disease. (op cit p. 110)
>
> ...however there is now clear evidence from MRI studies that both older and newer neuroleptic drugs cause atrophy of the brain within a year. (op cit p. 114; “neuroleptic” is Dr MonCrieff’s preferred label for drugs which are prescribed as “anti-psychotic”.)

If you are currently taking psychiatric drugs—do please pay especial attention to the HEALTH WARNING in the appendix below.

Dr MonCrieff’s evidence, so far unrefuted, is scientific in the best meaning of that word. Why has no notice been taken of it? It was published 13 years ago. If Scientific Evidence means anything, and scientific facts accumulate against what you do—you should alter your behaviours, especially prescribing behaviour. I draw especial attention to the increase in premature dementia, undoubtedly building up to be our next epidemic, that is hastened by prescribing psychoactive drugs to adolescents (Nordström, 2013).

The evidence is there—just how scientific are psychiatrists being? And I’ve not even mentioned Electro Shock Treatment (ECT)—akin to the mediaeval ducking stool, and about as illjudged. Some quagmire.

If you read only one of the published and excoriating indictments of today’s psychiatry, start with Robert Whitaker’s “Mad in America” (2002), before moving on to his devastating account of professional corruption (Whitaker, 2015). Then take in as much and as many as you can from the others (Vanheule, Breggin, Gøtzsche, Harrow).

Given this evidence of gross ongoing iatrogenic disease, you might have expected the world leader in psychiatric texts to comment. You’d be disappointed. The DSM has lots to say on categorising, but grievously little on treatment. Another nail in psychiatry’s coffin. And another cry for bridging the knowledge silos—if only lawyers and legislators knew the unscientific nature of today’s psychiatry, they’d be more reluctant to override patients’ consent. All medical interventions carry risk, sometimes negligible, sometimes overwhelming—empowering ‘intent’ (i.e. consent) on the part of recipients is one source of protection for both prescriber and prescribee, and their legal supporters. Of all medical treatments, everywhere, psychiatric medication stands out as being the only one which is given routinely *without* consent. A barrage of unscientific legislation floods troubled people with mandated toxic effects, based on both medical and *legal* inexpertise. If psychiatrists prefer not to tell you—how are you, or governments, to know? Time to put our shoulders to the wheel, again.

“Trust me, I’m a doctor”—Trust is an essential component of any and all healthcare—since without Trust, no therapy can even begin. More work, scientific and otherwise, desperately needs doing before mental healthcare can become fully operational again.

Skin Heals, Why Can’t Minds?

Why should I make such a fuss about cut skin healing? It happens all the time—there you are, quietly chopping your onions, or slicing your carrots—and you nick your finger. Blood streams or oozes out, depending on incisionary circumstances—you fumble with the sticking plasters, which seem designed to require all fingers to work as if uncut—and then what? Why, then you wait a few days, and the edges of the cut skin heal. Yes, the damage your knife did, is no more. It’s gone. It’s healed. It’s cured. So now you have a simple choice—do you continue to believe that the Science you’ve always known is “correct”, is true, is true to life—or do you believe your eyes, or in this case, your skin?

Because the basic and immovable fact is that Science doesn’t know what’s happened—or rather can never tell you more than you can already see. No one knows how healing skin works. And never will. There’s a simple reason for that—the dermal cells doing the actual healing are **autonomous**—they’re working on their own, they do what they do, without outside instructions or programming, either from me, from you, or from Science—wait for it—they make things up as they go along.

Of course they do, else you’d have leg skin healing the way face skin does, or finger skin like foot skin—if Einstein-type Science was correct, we’d find out how “healing” happened, and apply it to all circumstances, regardless of local decision making. If it didn’t apply to each and every “healing” (which it doesn’t), why bother with it? If there were exceptions, awkward differences, changes which local conditions imposed—then each one of these would decrease the “universality” of “knowing”. Once you say that living cells display **autonomy**, then you have ceded control of events to them. Healing requires local responding-ability—without that, it doesn’t happen.

The brutal fact is that dead skin *is* incurable. Once the skin has died, you can wait an epoch, and nothing will happen, it’ll never knit together, ever again. How can Science account for that? Go to your favourite Scientist (or look in the mirror), and ask “why does living skin heal, but dead skin doesn’t?” If you get an answer, then you can be sure that it makes no sense—worse it’s unreal, and living organism including human beings, who are unreal for too long, become extinct. It’s not so much survival of the fittest—it’s survival.

So what are we left with? We are left with workarounds, with rules-of-thumb which work most of the time, with incessant vigilance required to ensure that the particle of knowledge we currently favour, is in fact working, is in fact cutting the mustard. Because if it’s not, we may well be making things worse, in fact we’re almost bound to. Get the “diagnosis” wrong, and any treatment you happen to apply will gum things up, simply because you haven’t understood what was wrong. If you don’t know what’s wrong, how can you begin to put it right?

Of course there are a number of very useful things we *can* know about skin, and how it heals. Healing is hindered if it’s dirty, infected, or the blood supply is less than adequate. Sometimes the skin edges are too far apart, so can’t meet up and begin their quasi-miraculous work—they need help. They may need expert, specialist, even medical help—because the simple truth is that you gain expertise by experience, and if your experience encompasses skin trauma in all sorts of circumstances, then you will know more about what to do next, than most—what helps healing and what doesn’t.

So much for skin. Now re-read the last page or so, replacing the word “skin” with the word “mind”. The parallel is striking. It can’t fit in every detail, of course, but the general overlap is too close for coincidence—both skin and minds are alive, and interchanging them in this way, emphasises the vital significance of this living fact. And since society, including global society, is just a number of “minds” coming together, then what applies to skin applies to politics, and it’s important that you see for yourself how that works.

You’ll need stamina to follow through. This paper asserts that today’s psychiatry is crippled, that without ‘intent’, mental healthcare is going to get hold of the wrong view of “minds”, the wrong view of what goes wrong, and therefore cannot then do other than apply the wrong treatments. More—I claim Scientific Evidence to justify this accusation.

So what are you going to believe? Einstein was a colossus—no question. He too hankered after a Final Answer, a Single Theory that would apply in all circumstances. Quantum Mechanics, as my earlier paper emphasises (Johnson, 2020), derailed his confidence—it didn’t fit. The real world is full of Uncertain electrons—they are not autonomous like living cells, but they are decidedly unruly.

“Scientific”: what this paper seeks to achieve is a double act— (1), downgrading Science to sensible realistic proportions (i.e. being pragmatic, what “works”); while (2), boosting skin, minds, and the biosphere in general. Living processes do things, sometimes on the spur of the moment, which Einstein-type Science can’t keep up with. Time to move on. Use what works from Einstein, but be ever ready to patch up the bits that don’t.

Science as originally conceived, should be unbiased, dogma-free, and based on what is found experimentally to be the case, especially where this conflicts with prejudged notions. Fuzziness is tolerated (such as with the electron), if that’s what works, better than not. As before, *fuzziness* means that words can mean different things at different times—not that they are 100% meaningless.

And the central flaw in Einstein-type Science is that there’s no room in a mathematically correct cosmos for initiative, creativity, imagination—nor strictly for healing, fun or delight. If you know what’s going to happen next, and you know this with 100% certainty, then boredom is just round the corner. But if you once concede that Uncertainty is the essence of our inanimate world, then insecurity beckons. The way through, at least the one I Trust, is to rely on others’ views, to foster their ‘intent’, to cleave as close to the Truth as you (and they) can—this is the only prospect for peace-of-mind, for Certainty that is available to any of us—at least that’s my take on these complex circumstances—what are the chances that you can bring yourself to *trust* it?

Appendix

HEALTH WARNING: psychiatric drugs have multiple powerful effects on brain tissue, that’s what they’re designed to do—*never* stop them abruptly—their withdrawal effects can be far worse than the disease (think “going cold turkey” or DTs)—expert help is required to undo inexpert psychiatry.

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