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Why Dysfunctional *Medical* Flaws Have Cramped Psychiatrists Since 1980

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Abstract: In 1980, the American Psychiatric Association published the third edition of its *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III, 1980). This departed radically from its two previous editions (DSM-I, 1952 & DSM-II, 1968). It proved an unexpected best seller, which might have raised an eyebrow or two. This paper compares the two standard medical texts, the ICD-10 and DSM-IV (1994) to illustrate quite how extensive these changes were, and to demonstrate how far they deviate from ordinary medical practice, which, for the purposes of clarification is here boiled down to five basic tasks. Having applied these five to abdominal pains, verbatim extracts from the two texts cited, are compared to see how each fares against the other. Further implications for psychiatric practice in general are discussed in the light of the wider "philosophical" differences revealed. Is medical practice even possible, without taking aetiology, reaction and Patient Agency into full and open consideration? Consciousness is the pinnacle of our biosphere—as a recent paper emphasised—time it received the awe it is due.

Keywords: DSM-psychiatry's nemesis, diagnoses which illuminate, non-organic psychiatric aetiologies, Patient Agency, obvious stress reactions.

1. Background

The Economist [1] heartily disapproved of DSM-5 [2]. When an authoritative publication with an unparalleled global reach, prints a deeply wounding cartoon (Fig. 1), with the comment that "the DSM has become a monster", perhaps it is time to pause for thought. There is now something approaching an industry protesting that, as The Economist puts it in its review, "In the eyes of many critics it is a vehicle for misdiagnosis, over diagnosis, the medicalisation of normal behaviour and the prescription of a large number of unnecessary drugs" (loc cit). The thrust of the current paper, however, is different. It is based on a High Court case which turned on the *medical* differences between ICD-10 and DSM-IV. Having been asked for a medico-legal opinion in a relatively straightforward psychiatric case, it became clear that some simplification of the standard medical approach would be needed, if the jury was to be furnished with a clear picture of the psychiatric issues involved—without this, the chances of obtaining a balanced verdict would shrink.

The expert witness stand is an inclement environment at the best of times, with a steep, not to say harsh, learning curve. It is not an odyssey to be undertaken lightly. Accordingly, long hours were spent in preparation, filtering out what really happened in any and every medical consultation, and then simplifying this down to five basic tasks. It is not claimed that the result is exhaustive—clinical interactions are rather too complex for that—but they answered the call for a robust model, which stood some chance of surviving intact, against the relentless, indeed ruthless, buffeting of energetic and highly skilled cross-examiners.

Drawing on twenty years experience as a family doctor, the following emerged as the five basic tasks present, or at least due, in every medical consultation in any and all specialties, both psychiatric and non-psychiatric. They are (1) **symptoms**, depicted

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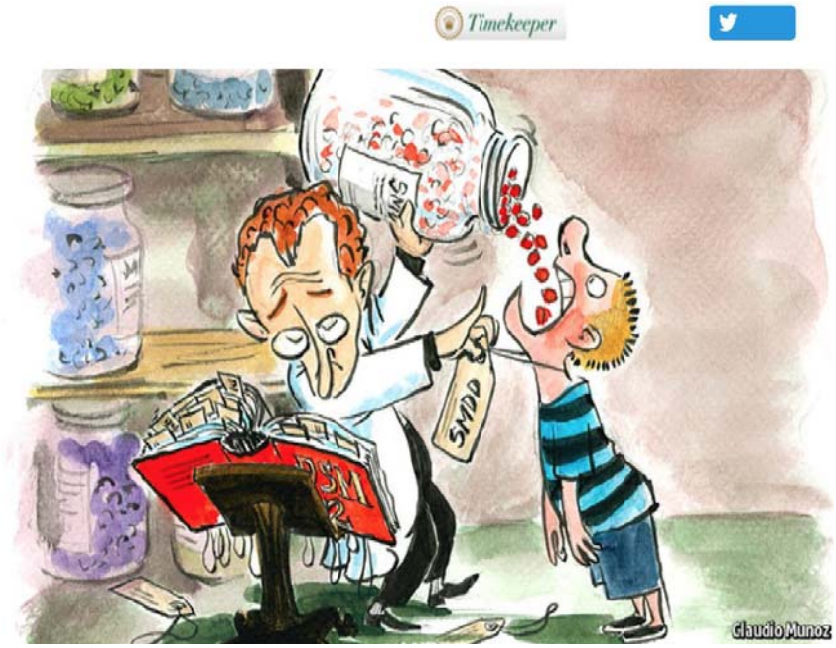

Fig. 1 ***The Economist May*** **18th 2013.**
DSM-5 **By the book** May 18th 2013 | NEW YORK | From the print edition *The Economist.* The American Psychiatric Association's latest diagnostic manual remains a flawed attempt to categorise mental illness.

here as "medical questions" which are what brings the patient to the doctor in the first place; (2) **diagnoses**, here portrayed as "medical solutions", or partial solutions; (3) patient **agency**—what the patient believes, thinks or does; (4) **aetiology**, or causative factors, never single always multiple; and (5) **reaction**—being ill is always more stressful than being well, so the clinician needs to assess how this particular individual is *reacting* under these particular circumstances.

Conventionally the ICD-10 and the DSM-IV are generally thought of as being so essentially similar as to be interchangeable—indeed the latter claims, in writing, that this is actually the case [3. p829]. However, as this paper reports, on closer examination, despite some inevitable overlap, radical differences between them, are not difficult to find. Nor is this merely in detail, but rather in what might be called their very philosophy, a point that should prove of wider interest.

2. Method

The method adopted in this paper is to take the five basic tasks mentioned, in turn, and then highlight first how the ICD-10 would cope with them, and then the DSM-IV.

Before embarking on the stormier sea of psychiatry, it might help to apply these five basic tasks to something more obvious, and more general. Since pain is the most frequent symptom of all in general practice [4], applying the five tasks to say abdominal pains, should clarify their relevance.

With abdominal pain, the obvious medical questions, the ***symptoms*** (1) are—where is the pain coming from? What is it like? How urgent is it? Does it need an operation? It should be stressed that these are what prompt the patient to seek medical attention. The medical challenge is to provide some sort of solution or partial solution (2)—this is termed the ***diagnosis***. The clinician is called on to be as real and as accurate as possible, if worse is not to ensue. It is therefore incumbent on the clinician to take fully into account, what the patient believes to be the case, or what precautions they have already taken—i.e. (3) **Patient Agency**. The key to effective diagnosis is **aetiology** (4)—with abdominal pains, laparotomy

promptly confirms the pathology, thereby sharpening diagnostic acuity, and improving healthcare all round. Patient **reaction** (5) is especially significant. Some patients have high pain thresholds, others low—failure to take this variable fully into account could render medical intervention stillborn.

3. Results

A passage from ICD-10, taken as an example of others, covers the last three of these five tasks, so is quoted here in full [5 p 145]. I have highlighted these points, by number, in bold.

F43 Reaction to severe stress, and adjustment disorders

> "This category differs to others in that it includes disorders identifiable not only on grounds of symptomatology and course, but also on the basis of one or other of two causative influences **(4)**—an exceptionally stressful life event producing an acute stress reaction **(5)**, or a significant life change leading to continued unpleasant circumstances that result in an adjustment disorder.
>
> "Less severe psychosocial stress ("life events") may precipitate the onset or contribute to the presentation of a very wide range of disorders classified elsewhere in this work, but the etiological importance **(4)** of such stress is not always clear and in each case will be found to depend on individual, often idiosyncratic, vulnerability **(3)**. In other words, the stress is neither necessary nor sufficient to explain the occurrence and form of the disorder. In contrast, the disorders brought together in this category are thought to arise always as a direct consequence of the acute severe stress **(5)** or continued trauma. The stressful event or the continuing unpleasantness of circumstances is the primary and overriding causal factor **(4 & 5)**, and the disorder would not have occurred without its impact. Reactions **(5)** to severe stress and adjustment disorders in all age groups, including children and adolescents, are included in this category,"

"Reaction" appears a number of times, and is seen to have a direct bearing on the pathology. "Individual, often idiosyncratic, vulnerability" is something of a mix between items **(3)** and **(5)**, but clearly needs, to be taken fully into account, according to the ICD-10. Causative factors are also prominent by their frequency—indeed any clinician would be surprised were they not so. Item (4), aetiology, would seem, in general medical terms, to be an indispensible part of medical practice, wherever and whatever its nature. The point needs emphasizing in view of its explicit ejection from DSM-IV, as per below.

(1) Symptoms or "medical questions"

If DSM-IV is scrutinised through the lens of these 5 basic tasks, then symptoms, here characterised as "medical questions", predominate throughout. Indeed the whole book might be said to consist of nothing else—page after page of symptoms or medical questions, here gathered not primarily for patient benefit, but largely for insurance and statistical purposes, indeed the full title confirms that that is the book's primary function—it is a *Diagnostic and **Statistical** Manual of Mental Disorders.* Even a diagnosis as seemingly obvious as "psychosis" is really little more than descriptive of what the patient's symptoms are—it carries little or no "medical solution" (2), not even a "partial solution".

Indeed were the above 5 basic tasks to be followed, strictly, then there are no diagnoses in this volume at all—there are no "medical solutions", merely lists of further questions. In this strict sense, even as commonplace a diagnosis as "depression" is really little more than re-stating what the patient already has, and adds little by way of any "medical solution", or partial solution. Clearly there is much conventional support for the type of "diagnostic formulation" presented and favoured by the DSM-IV—and again, taken on its own, it might not signify—but cumulatively, the problems build.

(2) diagnoses or "medical solutions", or partial solutions

Whereas the ICD-10 text included above, gives promising guidelines as to where to look for plausible medical solutions, the DSM-IV fails to do so—partly, of course, because of its ejection of aetiology, to which we shortly come, but also perhaps, because its primary function is statistical, and not therapeutic. Until this is remedied, this would seem to be an insurmountable medical flaw.

(3) patient agency—what the patient does or can do.

Now we need to cite verbatim texts from the DSM-IV itself. This writer has to admit to blank astonishment on first reading these passages with care and focus, and to find these points set out so clearly in black and white. Of course readers must judge for themselves, but these excerpted texts might raise a few medical eyebrows. Thus on page xxi, we find:

> "... 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 …"

According to *the Economist* review cited earlier, this book is regarded as the "psychiatrist's bible". As such, it might reasonably have been expected to honour the mind, or at least elements of mental faculties. To work hard, as this paragraph clearly showed that its authors did, to actually remove the term "mental" from the title altogether, does rather open the whole book to a critique, perhaps not as severe as the one which appears here, but at least somewhat along these lines. It is difficult to see what other reasonable interpretation can be given to the phrase "**unfortunately**, the term persists in the title of DSM-IV" (emphasis added).

And then to add insult to injury, we have the obfuscation of "reductionistic anachronism of mind/body dualism". Even an advanced high school student of philosophy could do better than that. Reductionism needs countering in its own right, certainly, but to advance it here in defence of an entirely deterministic view of human beings, begs rather too many questions for comfort. This point is especially telling since its ulterior motive would seem to be to open the way for an entirely "organic" or nerve-tissue based aetiology, to which we shortly come. Perhaps the DSM-IV would prefer to obliterate the mind from psychiatric practice entirely—certainly there are abundant pointers in that direction—but, if this is the case, then it should be clearly stated as such, so that those who prefer to address mental issues per se, may discount the denigration thus propounded by this so-called "psychiatrist's bible".

What is indisputable is that without a "mind" the whole question of patient agency is decapitated—it simply cannot exist in this text. Again, how many medical practitioners could realistically continue their daily work without it?

(4) aetiology, or causative factors

A robust constitution is required to penetrate deeper into the entrails of this "psychiatrist's bible". Surely one of the joys of medical practice, in general, is teasing out causative factors which underlie what afflicts that particular patient, at that particular time. Many "health" problems can be understood and often enough corrected by well-informed lay people. Only those which defeat these common sense "solutions" are likely to bring that individual to medical attention. This is decidedly not how the DSM-IV sees the issue. On page xvii, we read

> "... DSM-III introduced a number of important methodological innovations, including ... a descriptive approach that attempted to be neutral with respect to theories of etiology..."

It might be generally supposed that pursuit of ever more detailed aetiology has been a prime medical focus since before Hippocrates—only in this way, can anything remotely resembling a cure be envisaged. Scurvy was inexplicable, before Vitamin C became well understood—so to applaud as an "important methodological innovation" a determined attempt to remain "neutral with respect to theories of etiology" would seem to cut medical practice off at the knee.

But there is worse. Having asserted a neutrality with respect to aetiology, and having eschewed as much of the mind as it could—something has to fill the gap these deliberate omissions open up. And to fill that gap, without a smidgeon of objective evidence, we read on page 10:

> "... 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."

Now, though this seems an odd way to keep faith with a "neutral" aetiology, it does encourage the view, currently dominant in much psychiatric discourse, that the brain predominates over the mind. This is not the place to argue the contrary, but it is inescapable that this approach to aetiological research, with this elevation of "organic psychiatry" overall, does tend to diminish medical interest in social or domestic factors. Again, if this is what the DSM-IV stands for, it should surely be more widely known, so that those preferring a different line, could have their say.

It is a commonplace in psychiatry that the aetiology of most mental disorders is obscure. Again this is not the place to argue either way. But it is unhelpful to conclude, as the DSM-IV does with enthusiasm but scant objective evidence, that medical personnel need no longer trouble themselves with the brain/mind conundrum. This, after all, is an issue that has been argued over by philosophers for millennia. Could the DSM-IV writers really suppose their clientele would benefit from foreclosing all such philosophy?

(5) reaction

The idea that mental breakdowns result from a severe reaction to stress is a commonplace among the general population. The very term "breakdown" implies as much. Over a period of two decades in general practice, the phrase "we are none of us super (wo)men" came to be used regularly, coupled with the less comfortable axiom—"stress is a killer". Now these are valid in general practice, though they do take a while to learn. Yet here in DSM-IV we see on page xvii:

> "... The use of the term **reaction** throughout DSM-I reflected the influence of Adolf Meyer's psychobiological view that mental disorders represented **reactions** of the personality to psychological, social, and biological factors..." (emphasis added)

DSM-IV makes the assumption, *ex cathedra*, that Meyer's view was wrong—it seems at least reasonable to suppose that most clinicians might not concur.

Nor, when considering reactions in general, should it be difficult to suggest that death and dying of themselves, augment stress. And having done so, it is easy to conclude that reacting to these terminal events could be highly significant, psychiatrically. Yet on page xxi we read:

> "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."

It is what makes "loved ones" so emotive.

Finally in this section, we have an overt textual contradiction. Thus in DSM-IV, page xvii, we find:

> "DSM-II was similar to DSM-I but eliminated the term reaction."

Yet a mere glance at DSM-II shows it replete with "reactions". Here are a few [6 p 81]:

> "DSM-II Code Numbers and Titles
> 307* Transient situational disturbances
> 307.30* Adjustment reaction of adult life*
> 307.30 Adjustment reaction of adult life
> 307.00* Adjustment reaction of infancy*"

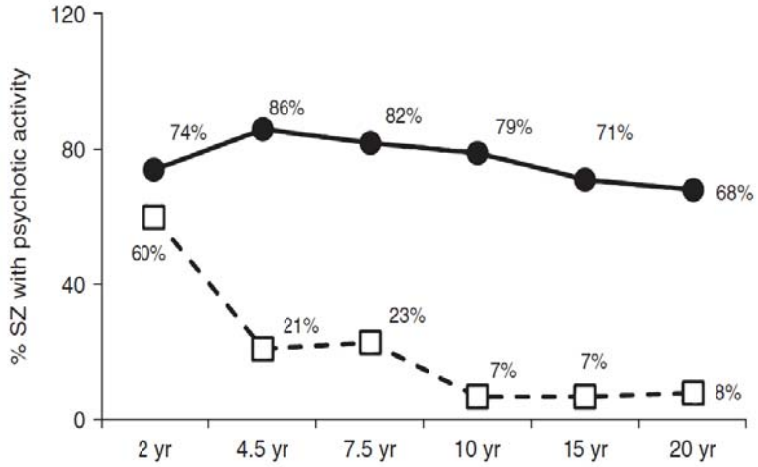

Fig. 2 Twenty-year longitudinal assessment of psychosis in schizophrenia patients (SZ).●, always prescribed antipsychotic mediations; □, not prescribed psychiatric medications at any assessment.

4. Discussion

The major change in psychiatric thought, initiated by DSM-III in 1980, should, by now, 41 years later, be covered in glory. But this is not so, *clinically*. Harrow, in an exemplary study [7] showed convincingly that psychotic symptoms persisted vastly more (up to 10 times as often) in those receiving 20 years of mandated psychiatric medication, against those not (Fig. 2). How many more reports such as those of Harrow, are needed to nudge us back to an earlier philosophical frame? Does elementary *medical* flaws in DSM-IV contribute?

There are other items to bring to this discussion, especially from ICD-10, but enough textual data have been presented to call the current "psychiatrist's bible" into question. Mention of the word "bible" raises the spectre that those who question "holy writ" riska fiery fate. Can a saner ethos prevail before then?

"Psychiatry" comes from the Greek—"doctor of the soul". "Mind" is better covered by the Greek word "nous". Opinions will vary as to what may or may not be covered by the word "soul", but at least the notion of consciousness should be available for wider discussion, not foreclosed for narrow myopic quasi-medical reasons. Further exploration of this issue is available [8], with a wider webinar on this, and related issues [9]

5. Conclusion

The ICD-10 does, in strictly *medical* terms, differ markedly from DSM-IV. There are profound philosophical discrepancies which could impact on the excellence of mental healthcare. How these can best be addressed, needs to be far more widely discussed—closing off profound medical issues in the way described, is an illservice to medicine in general, both for the psychiatrist and the non-psychiatrist alike.

It is likely that some readers will take exception, even serious exception, to the notion that DSM-psychiatry could possibly be flawed in the way described. Clearly for doctors trained in the current mode, any deviation from it, will raise hackles. But where medical interpretations differ, the printed text does not. And since 1980, it has been readily available for both scrutiny and debate. Healthy professional controversy can make for progress, provided it is given a courteous and open hearing.

Consciousness is the most intriguing entity in the entire universe, bar none [8]. And if in 1978, as reported [10], the Board of the American Psychiatric Association did in fact deliberately decide to deflect the noble profession of psychiatry away from talk therapy, then, by doing so, they inflicted a profound disservice not only on psychiatric patients, but also on generations of *psychiatrists*. Is there enough

professional clarity and resolve to restore consciousness to its full glory? Either among today's psychiatrists themselves, or their more general medical colleagues? And if not now, when?

References

[1] The Economist. 2013. *DSM-5 by the Book*. New York. Accessed May 18th 2013. https://www.economist.com/news/science-and-technology/21578024-american-psychiatric-associations-latest-diagnostic-manual-remains-flawed

[2] DSM-5. 2013. *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.). Washington DC: American Psychiatric Association.

[3] DSM-IV. 1994. *Diagnostic and Statistical Manual of Mental Disorders* (4th ed.). Washington DC: American Psychiatric Association p 829

[4] Johnson, R. A. (Bob) 1980. "Real Time Retrieval of Clinical Data." Ph.D. thesis, University of Manchester Institute of Science and technology, UK.

[5] ICD-10. World Health Organization. 1993. *The ICD-10 Classification of Mental and Behavioural Disorders: Diagnostic Criteria for Research*. World Health Organization: Geneva.p145

[6] DSM-IV. 1994. *Diagnostic and Statistical Manual of Mental Disorders* (2nd ed.). Washington DC: American Psychiatric Association p81

[7] Harrow, M., Jobe, T. H., and Faull, R. N. 2014. "Does Treatment of Schizophrenia with Antipsychotic Medications Eliminate or Reduce Psychosis? A 20-Year Multi-Follow-Up Study."*Psychological Medicine* 44(14): 3007-16.

[8] Johnson, B. 2021. "The Simple Science of Psychiatry, Psychodrugs and of WAR—Friendless Childhoods Foment Warring Adults." http://www.davidpublisher.com/Public/uploads/Contribute/611a6424395e0.pdf

[9] Johnson, B. 2021. https://drbobjohnson.substack.com/p/all-crime-and-all-psychiatry-come?justPublished=true.

[10] Breggin, P., and Rowe, D. 1993. *Toxic Psychiatry. Drugs and Electroconvulsive Therapy: The Truth and the Better Alternatives: Why Therapy, Empathy and Love Must Replace the Drugs*. New York: Harper Collins.