arguments. Other people’s arguments are not taken seriously. They are treated with a mixture of chop logic and scorn. Taken seriously, Professor Szasz’s own Therapeutic State would be a cruel world with psychiatry confined to “psychiatric relations between consenting adults” with money, of course, to pay for this expensive experience. There will be no room for bewildered, deluded and impoverished people, for Professor Szasz will have abolished “fake hospitals” offering only “bureaucratic incarceration” or “psychiatric rape”. The mixture of sophistication and cruelty becomes increasingly irritating and forces me to return the verdict which he has already passed on a book published by the unfortunate chairman of the National Advisory Council of the American Civil Liberties Union: “In my opinion these passages constitute some of the purest and most concentrated extracts of mistake, misinformation and just plain bunt that the reader is likely to find in the literature on crime and mental illness”.  

JLT BIRLEY


The publication of the third edition of the DSM, DSM III, in 1980 represented the official endorsement of a fundamental change in American psychiatry during the previous ten years. Until the early 1970s mainstream American psychiatry had been preoccupied with psychodynamic theories to an extent never witnessed on this side of the Atlantic. Then, the appearance of large cross-national studies showing the diagnostic imprecisions inherent in this system forced its assumptions to be examined seriously. The growth of the neurosciences also served to draw attention to the importance, long recognised in Europe, of careful diagnosis based on a system of clearly defined symptoms. In 1974 the American Psychiatric Association appointed a task force of eminent academics and clinicians to assemble what was to become the manifesto of this revolution: the DSM III.

After several drafts and extensive field trials, the final document has become a best seller in America. Intended to supplant the ICD 9 used in Europe and elsewhere, it now forms the basis for American diagnostic practice and research. It is a huge work, five times the length of its ICD cousin which is actually included as an appendix. Each mental disorder, of which it lists over one hundred, merits sections outlining demographic data, natural history, aetiological factors and differential diagnosis. In addition, the defining operational criteria themselves are clearly listed for each disorder. In deference to the ICD corresponding disorders are given the same numerical coding wherever possible, although the nomenclature is often highly divergent. New categories abound, particularly amongst the non-psychotic disorders. Recent research probably justifies some of these (panic disorder and bulimia, for example), but certainly not all. In their transatlantic passage many traditional disorders perish, some to be superceded by a handful of smaller offspring: the global term hysteria is replaced by a dozen or so separate, clearly defined terms such as conversion disorder. Other disorders are rechristened: neurotic depression becomes dysthymic disorder. In some cases obsolete terms are disinterred and redefined: melancholia and delirium, for example.

To clinicians outside psychiatry such a wholesale transformation of a classificatory system might seem extraordinary. Certainly, many of the elders of European psychiatry regard the DSM III with mistrust, seeing it as at best unnecessary and at worst a wilful rejection of attempts to establish a proper international classification. However, the DSM III is first and foremost a genuine attempt to promote diagnostic reliability, at which it undoubtedly succeeds. Unfortunately, reliability is not the same thing as validity and many of the new disorders lack respectable epidemiological data to support them. Even with the major psychoses, defining criteria appear which are essentially arbitrary: a diagnosis of schizophrenia is not allowed unless the age of onset is under forty-five and symptoms have been present for six months. There are subtle but important changes in the usage of certain central terms: the word “organic” serves no longer to describe symptoms, but to imply aetiology.

For all this, DSM III is a document of immense importance, not least because of its popularity. It is now used in almost all American research in psychiatry and no one wishing to keep abreast of the literature can afford to be without access to a copy. All medical libraries should own a reference copy, but should be warned about the flimsy binding; there is a more robust hardback version available which is not listed here. Individual readers would be best advised to opt for the complete version, which is actually very readable. The smaller versions include only the unfeathered bones of the diagnostic criteria and, of the two, the ring-bound “desk reference” better value. The “casebook” comprises two hundred worked examples and is really only intended for the trainee diagnosticians.

SW LEWIS


This 229 page book presents a modern review of the anatomy of the orbit, and incorporates clinical cases, radiographs, CT scans and useful clinical footnotes to each section. The first nine chapters deal with the embryology, the bones of the orbit and the chapter on the radiology of the orbit. This is followed by chapters on the anterior orbit, the lacrimal system, the connective tissue planes and then a review of the muscles, nerves and blood vessels of the orbit. Chapter 10 is planned to accompany a dissection of the orbit, and coloured illustrations from Bassett’s Stereoscopic Atlas are used.

It is refreshing for the clinician to reconsider the anatomy of the orbit and this book by two oculoplastic surgeons is stimulating and easy to read. The spectrum is fairly wide so that Koornneef’s work on the connective tissue septa in the orbit is related to its clinical relevance, the absence of lymphatics in orbit is considered and clinical evaluation of the lacrimal system is included. The ability of radiological techniques to conquer the visualisation of the finer aspects of orbital anatomy should nudge most clinicians dealing with orbital disease to browse through this book.

MD SAWNDERSON