

## CHAPTER 21

- Reading 21.1 **Radden, J. (1994). Recent criticism of psychiatric nosology: a review. *Philosophy, Psychiatry, & Psychology*, 1(3): 193–200. (Extracts 194, 197.)**
- Reading 21.2 **Reich W. (1999) ‘Psychiatric Diagnosis as an ethical Problem’ as reproduced in Reading 20.5.**
- Reading 21.3 **Bentall, R.P. (1992). A proposal to classify happiness as a psychiatric disorder. *Journal of Medical Ethics*, 18: 94–98. (Extracts pp. 94 and 97)**

## Reading 21.1

## EXERCISE 1

Two extracts from: Radden, J. (1994). Recent criticism of psychiatric nosology: a review. *Philosophy, Psychiatry, & Psychology*, 1(3): 193–200. (Extracts 194, 197.)

**Extract 1: page 194**

Our understanding of science has seen a marked transformation since the heyday of the realist “logical empiricism” to which earlier DSMs aspired. Widely accepted now is the new philosophy of science which rejects the goal of atheoretical science or scientific classification (Horwich 1993). We are offered no unmediated observation, this understanding insists; we cannot make unmediated observation statements about the physical world of science, let alone about a patient’s symptoms. Nor can there be an atheoretical classification of that world or those symptoms. Scientific classification must be expected to reflect theory and social norms; the question is not whether it does, but how, and upon which theoretical and normative tenets it grounds itself. DSM-III’s goal of an atheoretical classification (APA 1980) appears today to have been conceptually naïve.

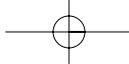
**Extract 2: page 197**

In addition to theoretical tenets, social norms also undergird any psychiatric taxonomy. The wounds from the wars over treating homosexuality as a mental disorder are still fresh (see Bayer 1981; Spitzer 1981); we shall not make that mistake again. Yet the matter is more complex, subtle, and systemic, as many feminists have demonstrated. The important Broverman studies showed that what are generally regarded as women’s roles and natural dispositions are suspiciously coincident with what is generally judged mentally unhealthy (Broverman et al. 1970, 1972).<sup>1</sup> Mental health norms, like gender norms themselves, appear to be gendered (Cayleff 1988; Ford and Widiger 1989; Gaines 1992; Mahowald 1992; Nuckolls 1992a, 1992b; Radden 1987; Ritchie 1989; Rosser 1992). In particular, there are a number of different diagnostic categories likely to reflect gender and gendered norms, categories, Russell demonstrates, of which women, should beware—not only masochistic personality, which has been widely challenged for its gender bias, and late luteal phase dysphoric disorder, which is explicitly sex linked, but also borderline personality, dependent personality disorder, and histrionic personality disorder (Ritchie 1989; Russell 1994). Finally, feminists such as Russell have offered a sociopolitical analysis of seemingly neutral criteria such as “distress,” “disability,” and “impairment of social functioning.” By placing the sources of the problem squarely in the patient, they show, such terms obscure social and contextual etiological factors (Russell 1994). (p. 197)

<sup>1</sup> Russell 1994 offers a clear-sighted defense of the Broverman findings in the face of critical objections to which they have been subject.

## References

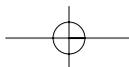
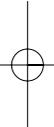
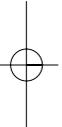
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## Reading 21.2

### EXERCISES 2-7

The readings for exercises 2-7 in chapter 21 are all from:  
Reich W. (1999) 'Psychiatric Diagnosis as an ethical Problem'  
as reproduced in Reading 20.5.



**Reading 21.3****EXERCISE 13**

Abstract (p 94) and concluding section (p 97) from: Bentall, R.P. (1992). A proposal to classify happiness as a psychiatric disorder. *Journal of Medical Ethics*, 18: 94–98.

**Extract 1: page 94****Author's abstract**

It is proposed that happiness be classified as a psychiatric disorder and be included in future editions of the major diagnostic manuals under the new name: major affective disorder, pleasant type. In a review of the relevant literature it is shown that happiness is statistically abnormal, consists of a discrete cluster of symptoms, is associated with a range of cognitive abnormalities, and probably reflects that abnormal functioning of the central nervous system. One possible objection to this proposal remains—that happiness is not negatively valued. However, this objection is dismissed as scientifically irrelevant.

**Extract 2: page 97****Possible objections**

I have argued that happiness meets all reasonable criteria for a psychiatric disorder. It is statistically abnormal, consists of a discrete cluster of symptoms, there is at least some evidence that it reflects the abnormal functioning of the central nervous system, and it is associated with various cognitive abnormalities—in particular, a lack of contact with reality. Acceptance of these arguments leads to the obvious conclusion that happiness should be included in future taxonomies of mental illness, probably as a form of affective disorder. This would place it on Axis I of the American Psychiatric Association's Diagnostic and Statistical Manual (20). With this prospect in mind, I humbly suggest that the ordinary language term happiness be replaced by the more formal description *major affective disorder, pleasant type*, in the interests of scientific precision and in the hope of reducing any possible diagnostic ambiguities.

There are two possible objections to the proposed inclusion of major affective disorder, pleasant type, as a psychiatric disorder. First, it might be argued that happiness is not normally a cause for therapeutic concern. Therapeutic concern has in fact been proposed as a criterion for diseases by Kraupl-Taylor because of the difficulties of formulating a less arbitrary criterion. However,

Kendell (15) has criticised this definition as worse than no definition at all because of its obvious circularity and because of the inevitable implication that diseases are culturally and historically relative phenomena. On this account, sickle cell anaemia, anorexia nervosa and psychopathy (to name but three unequivocal examples of disease described only in recent times) were not diseases before their discovery. In any event, once the debilitating consequences of happiness become widely recognized it is likely that psychiatrists will begin to devise treatments for the condition and we can expect the emergence of happiness clinics and anti-happiness medications in the not too distant future.

The second, related objection to the proposal that happiness be regarded as a psychiatric disorder points to the fact that happiness is not normally negatively valued. Indeed, it is testimony to the insidious effects of happiness on some of the greatest minds in history that some philosophers have argued that the pursuit of happiness is the ultimate aim of all human endeavours. However, it is notable that even some of those who have been rash enough to advocate the greatest happiness for the greatest number have been explicit in rejecting those extreme forms of happiness associated with gluttony of the senses (32). More importantly, the argument that happiness be excluded from future classifications of mental disorder merely on the grounds that it is not negatively valued carries the implication that value judgements should determine our approach to psychiatric classification. Such a suggestion is clearly inimical to the spirit of psychopathology considered as a natural science. Indeed, only a psychopathology that openly declares the relevance of values to classification could persist in excluding happiness from the psychiatric disorders.

**References**

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