CHAPTER 20

Values in psychiatric diagnosis

Chapter contents

In this chapter we will follow through the key point to emerge from earlier chapters in this part, i.e. that in psychiatric ethics, at least, we need to move on from the increasingly quasi-legal form that bioethics is taking in its connections with practice, to what we have called Values-Based Practice (VBP).

The essence of this move, as we indicated at the end of Chapter 18, is to start, not from prescribed values (encoded in the rules and regulations of quasi-legal bioethics), but from respect for the often very different values of the particular individuals and groups involved in particular clinical contexts. VBP, as we called the approach resulting from this move, is not a recipe for relativism and ethical chaos: to the contrary, it places strong constraints on practice, illustrated in Chapter 18 with the NIMHE Values Framework (Figure 18.6). VBP, furthermore, builds on and extends the tools for clinical decision-making provided by the framework of law within which health care operates. We outlined some of these legal tools in Chapter 19. We found that, in the context of mental health at least, the use of these legal tools in practice, no less than the quasi-legal tools of mainstream bioethics, involved value judgements.

Background: the medical model of diagnosis

What all this amounts to, then, on the ground as it were, is that health-care decision-making, although based firmly on evidence (broadly understood as including implicit as well as explicit knowledge), necessarily also involves making value judgements.

It is relatively easy to see that values as well as evidence are important in connection with issues of treatment choice. What we will find in this chapter is that in the area of *mental* health at least, values (as well as evidence) are important also to *diagnosis*.

From the perspective of the traditional science-based 'medical' model, the claim that values are important in diagnosis as well as treatment, may seem to involve a radical, even subversive, departure from the aspirations to scientific 'objectivity' on which the authority of health-care professionals has traditionally been taken to rest. Thus, we have encountered the medical (fact only) model of diagnosis at several points:

- it was implicit in the psychiatry versus antipsychiatry debate from which we started in the first chapter of Part I;
- it was made explicit in the conceptual work of Christopher Boorse, in his distinction between disease (as covering the science-based theoretical core of medicine) and illness (as bringing in values to medical practice, see Chapter 4);
- earlier in this part, the same medical model was shown to lie behind the focus in traditional bioethics on issues of treatment choice (recall Beauchamp and Childress' conclusion, that values are indeed involved in judgements of rationality but that this makes such judgements a matter of morals *not* medicine).
- and it is essentially the medical model of diagnosis, too, which lies at the heart of some of the particular difficulties of application of health-care law in mental health (Chapter 19).

Fact and value in psychiatric diagnosis

The traditional medical model, then, rests on the idea that, however crucial values may be in other areas of health care, diagnosis is a 'purely' scientific exercise. In psychiatry this amounts to the claim that *psychopathology* (symptoms) and the *classification* (of disorders), on which the *process of diagnosis* depends, must all be value-free.

It is with this claim that we will be concerned in this chapter and the next. Our conclusion, as already noted, will be that the traditional medical model, and the claim to value-free diagnosis on which it rests, is unsupportable; and that, to the contrary, diagnosis, although properly grounded on facts is also, and essentially, grounded on values. This conclusion, we will further indicate, set within the framework of VBP introduced at the end of Chapter 18, although currently of practical importance mainly for psychiatry, will become, under the pressure of twenty-first century medical-scientific advances, increasingly important in bodily medicine as well.

The conclusion that values are important in diagnosis, involving as it does 'adding values' rather than 'subtracting facts', is consistent with the additive nature of the full-field model of the conceptual structure of medicine to which we came at the end of Part I; it is consistent also with, and indeed spells out one element of, Jaspers' attempt to build a twin-track meanings + causes model of psychopathology (recall the values in/values out tension in his work that we traced in Chapter 10 at the end of Part II); and it is consistent with late twentieth century work in the philosophy of science, touched on at various points in Part III, showing the extent to which the scientific process, from observation and classification to explanation and theory construction, does not depend on merely passively recording data, but is instead actively shaped in complex judgements that resist full codification. It is also consistent, finally, with the view of psychiatric understanding in Chapter 15 and the subject matter of that understanding (to be explored throughout Part V), which resists assimilation to a model of -science that stresses only subsumption of events under natural laws and construes mental states as reducible to brain states. Instead, as we will see in Part V, whatever the close dependence of mental states on brain states, psychiatry trades in the normatively structured space of reasons as well as the realm of natural law.

All the same, the conclusion that values are important in diagnosis, *is* a radical conclusion, at least from the perspective of the traditional medical model. It is a conclusion, furthermore, as we indicate in the final session of Chapter 21, which, however well founded theoretically, is in part promissory on future R&D. As with most other parts of this book, therefore, in reading this chapter and the next, it will be important to engage actively with the arguments rather than approaching them passively, as the presentation of a settled *corpus.*

Plan of Chapters 20 and 21

Chapters 20 and 21 should be read as a pair. Chapter 20 sets up the problem: it shows that values (although not always recognized as such) are present, and in some (central) cases diagnostically determinate, in the 'best of the best' diagnostic tools of modern medical-scientific psychiatry.

Chapter 21 then goes on to tackle the problem: it shows that the shift, outlined in Chapters17 and 18 of this part, from quasi-legal bioethics to VBP, turns what would have traditionally been seen as the 'problem' of values in diagnosis, into an asset for balanced clinical decision-making.

The sessional structure of Chapters 20 and 21

The storyline of the two chapters runs thus:

- *Chapter 20, Session 1: the central place of values in psychiatric diagnosis—the case of Simon*. This session opens up the issues with a case study, involving a man called Simon, about delusion and religious experience. The differential diagnosis in this case suggests that, whatever the theoretical issues, values come into psychiatric diagnosis in its own scientific heartland, at the centre of the most scientific of modern classifications of mental disorder, the American DSM-IV.
- *Chapter 20, Session 2: generalization—the pervasiveness and importance of values in psychiatric diagnosis*. This session explores, (1) the pervasiveness of values in psychiatric psychopathology and classification, and (2) reviews key theoretical points from earlier chapters.

  The key message here will be the 'bottom line' of both Part I (concepts) and earlier chapters in this part of the book, namely, that values are important practically in psychiatric diagnosis, not because psychiatry is a primitive science, but because human values, in the areas with which psychiatry is concerned, are highly diverse.
- *Chapter 20, Session 3: bioethics and values in psychiatric diagnosis*. Unlike general bioethics, some of those working in psychiatric ethics have recognized the ethical importance of diagnosis. We look in detail at a key paper by Walter Reich from Sidney Bloch, Paul Chodoff and Stephen A. Green's ground-breaking *Psychiatric Ethics* (1999). We analyse the positive and negative points made by Reich about the ethics of psychiatric diagnosis.
- *Chapter 21, Session 1: philosophy, values, and psychiatric diagnosis*. This sets the contribution of philosophical value theory in context with other philosophical work on classification and diagnosis in psychiatry.
- *Chapter 21, Session 2: from fact-only to a fact + value model of psychiatric diagnosis*. Session 2 continues the analysis of Reich's paper (from chapter 20) but with an important new twist. Session 1 ended by identifying the origin of Reich's attitude to psychiatry (it is a mainly negative attitude) in the standard biomedical model. Session 2 moves 'beyond bioethics' to look at the way Reich's argument would run if we adopt the fact + value model developed in Part I of this book in place of the fact-only biomedical model.
- *Chapter 21, Session 3: reversing Reich*. This session applies the fact + value model to Reich's arguments against psychiatric diagnosis and shows, to the extent that they are indeed arguments *against* anything, they apply equally to diagnosis in bodily medicine.
- *Chapter 21, Session 4: practical applications—Values-Based Practice and psychiatric diagnosis*. The final session of Chapter 21 brings us to the practical applications of the recognition of the importance of values in psychiatric diagnosis. The approach here, again as anticipated earlier in this part, is of VBP, i.e. of values, as a key component of clinical decision-making, working alongside and inextricably linked to facts. This involves, in relation to diagnosis, communication skills and the 'user's' values, the role of different implicit models of disorder held by different members of multidisciplinary teams, and the importance of an 'open society' in psychiatry.

  The last session of Chapter 21 is a 'blue skies' session, looking at the clinical and research agendas that are opened up by recognizing and taking seriously the importance of values in psychiatric diagnosis. It includes a sneak preview of a report, dated 2010, and commissioned by the (imaginary) future Chair of the Taskforce charged with producing DSM-VI. We leave it to you to decide whether this will turn out to be science fiction or what the British science-fiction writer, Arthur C. Clarke, calls 'science faction'!

Do the exercises!

A final 'scene setting' point is to note is that recognizing and understanding the importance of values in diagnosis requires a considerable shift of mindset from the traditional medical model. The idea that diagnosis is, somehow, a value-free scientific aspect of medical expertise is so deep rooted, in all of us (not just doctors and lawyers), that, even if it is mistaken, a considerable effort is required to displace it. And not only to displace it but to work through the implications, positive and negative, of giving up the fact-only model and replacing it with a fact + value model.

There will be new ideas to tackle, therefore, as well as some new literature (although we will also be drawing on and taking a fresh look at materials from earlier chapters). Grasping new ideas requires practice. Hence many of the exercises in this and Chapter 21, starting with the case history of Simon (below, Exercise 1), are 'thinking exercises', not just readings. As we have several times emphasized, you will get much more out of these exercises if you take the time to do them for yourself. Remember that 'short cuts make long routes home'.

Session 1 The central place of values in psychiatric diagnosis: the case of Simon

The first reading in this session is a practical exercise in what is called in medicine 'differential diagnosis'. The idea is to read the case history of Simon and to write down your interpretation of what is going on. In the rest of the session we will be looking at the two very different interpretations of Simon's case offered by the two major psychiatric classifications of mental disorder, the ICD and DSM.

The case of Simon

The exercise is not a philosophical or indeed medical 'test'. Simon's story, exactly as reproduced here, is used by one of us (K.W.M.F.) in routine teaching sessions on diagnosis for trainee psychiatrists. So if you are a 'medic' or other health-care professional, imagine that you are seeing Simon in the context of your everyday clinical work. If you are not a health-care professional, imagine that he is a friend, colleague, or relative. Either way, the idea is to think *for real* about how you would understand his story and hence what you would do, or would want done, *in practice*.

EXERCISE 1 (20 minutes)

Read Simon Greer's case history (case 4.3) from:

Dickenson, D. and Fulford, K.W.M. (2000). Rationality, responsibility and values. Chapter 4, *In Two Minds: a casebook of psychiatric ethics*. Oxford: Oxford University Press. (Extract, p. 109–111.)

Link with Reading 20.1

Then write down:

1. your differential diagnosis, i.e. a list, in descending order of probability, of what you think could be going on, and
2. a few brief notes on your diagnostic reasoning, i.e. a few lines, again in note form, on the grounds for your interpretation(s) of Simon's case.

(This is based on a case described in Jackson and Fulford, 1997a.)

Note: there is a temptation here to jump straight to the 'answers' given below! But you will get much more out of this session, whether or not you are a health-care professional, if you spend some time thinking about Simon's story for yourself, and writing down your own views, before going on.

A differential diagnosis of Simon's case

Most psychiatrists reading Simon's story come up with a list of possible diagnoses along the following lines:

- schizophrenia
- hypomania (or bipolar disorder)
- schizoaffective disorder
- organic disorder (? drug induced)
- hysteria
- stress-induced disorder.

Similar lists are produced by other groups of health-care professionals (e.g. psychiatric nurses, social workers, etc.) and by lay or non-professional groups (with one exception, see below!).

Simon's experiences and the Present State Examination

Your own list may be different from the above but it is important to start from the fact that this is an entirely respectable set of possibilities, medically speaking. Indeed if a doctor, faced with Simon's story, failed to think of schizophrenia (top of the list) or some other psychotic condition (everything on the list except hysteria), he/she would justifiably be at risk for an action in negligence!

We looked at psychiatry's standard diagnostic reasoning, its two-step process from symptoms to syndromes, in Chapter 3. Applied to Simon's case, this two-step process runs roughly thus.

Step 1: identification of symptoms

Most psychiatrists pick out a clear symptom of schizophrenia (a 'first rank' symptom, as they are called) in Simon's account of his experiences of the 'wax seals' or 'suns'—this is what is called 'delusional perception', i.e. a set of delusional beliefs triggered by a normal perception. Psychiatrists also identify a possible further first rank symptom in Simon's account of his mind 'going on the fritz'. This could be 'thought insertion', the strange phenomenon we encountered in Chapter 3, the phenomenon of experiences that you are thinking and yet you experience as the thoughts of someone else.

Simon's account of his experiences have been 'rated' by people trained in the use of a research version of the standard psychiatric examination, the PSE (Present State Examination; Wing *et al.*, 1974). Such ratings consistently identify delusional perception, and, though less consistently, thought insertion.

The glossary to the PSE, as we noted in Chapter 3, defines over a hundred key psychiatric symptoms (and is thus a very useful source book for clear definitions of these symptoms). The PSE definitions of 'delusional perception' and 'thought insertion' show just how well Simon's experiences fit.

- *delusional perception*: PSE symptom 82 describes this as being 'based on sensory experiences' and involving 'suddenly becoming convinced that a particular set of events has a special meaning'.
- *thought insertion*: PSE symptom 55 describes this as 'the essence of the symptom is that the subject experiences thoughts which are not his own *intruding into his mind*' (emphasis in original).

Simon thus has one and possibly two clear 'first rank' symptoms, as defined by one of the gold standards of modern descriptive psychopathology. So what does this mean diagnostically?

Step 2: from symptoms to syndrome

The 'first rank' symptoms were originally thought to be diagnostic of schizophrenia but are now known to occur also in other psychotic

conditions. The differential diagnosis thus depends on associated symptoms: Simon's somewhat grandiose self-references suggest 'hypomania' or the hybrid 'schizoaffective disorder'; its late onset, in a middle-aged man, raises the possibility of organic disorder (i.e. of gross pathology, such as Alzheimer's disease, affecting the brain, or drug use); hysteria, psychotic symptoms that are unconsciously motivated, is suggested (to some) by the rather dramatic 'style' of Simon's presentation; and stress-induced disorder is suggested by the close temporal link to his highly adverse life situation at the time (acute stress not uncommonly induces brief psychotic episodes).

Simon: the ICD diagnosis

One gold standard for the second step in psychiatric diagnosis is the World Health Organization's ICD-10. As we saw in Part III (Chapter 13), a key stage in the development of modern classifications of mental disorders was the move, inspired by the advice to the WHO of the philosopher of science, Carl Hempel, from aetiology-based to symptom-based classifications of mental disorder. Hence the criteria for most of the diagnoses in these classifications are based on symptoms or clusters of symptoms.

The ICD-10 criteria for schizophrenia are given in Box 20.1. As you can see, leaving aside the other differential diagnostic possibilities, these criteria leave us in no doubt that Simon's most likely diagnosis is schizophrenia. The diagnosis requires the presence of at least one 'first rank' symptom, and Simon has two! (He also satisfies the other criteria of more than 1 month's duration, etc.).

So, the diagnostic bottom line, according to two gold standards of psychiatric diagnosis, the PSE and ICD, is schizophrenia (or some related psychotic disorder).

Box 20.1

Extract from: WHO (1992). *The ICD-10 Classification of Mental and Behavioural Disorders*. Geneva: World Health Organization, Geneva.

Although no strictly pathognomonic symptoms can be identified, for practical purposes it is useful to divide the above symptoms into groups that have special importance for the diagnosis (of schizophrenia) and often occur together, such as:

(a) thought echo, thought insertion or withdrawal, and thought broadcasting;

(b) delusions of control, influence, or passivity, clearly referred to body or limb movements or specific thoughts, actions, or sensations; delusional perception;

(c) hallucinatory voices giving a running commentary on the patient's behaviour, or discussing the patient among themselves, or other types of hallucinatory voices coming from some part of the body;

(d) persistent delusions of other kinds that are culturally inappropriate and completely impossible, such as religious or political identity, or superhuman powers and abilities (e.g. being able to control the weather, or being in communication with aliens from another world);

(e) persistent hallucinations in any modality, when accompanied either by fleeting or half-formed delusions without clear affective content, or by persistent over-valued ideas, or when occurring every day for weeks or months on end;

(f) breaks or interpolations in the train of thought, resulting in incoherence or irrelevant speech, or neologisms;

(g) catatonic behaviour, such as excitement, posturing, or waxy flexibility, negativism, mutism, and stupor;

(h) 'negative' symptoms such as marked apathy, paucity of speech, and blunting or incongruity of emotional responses, usually resulting in social withdrawal and lowering of social performance; it must be clear that these are not due to depression or to neuroleptic medication;

(i) a significant and consistent change in the overall quality of some aspects of personal behaviour, manifest as loss of interest, aimlessness, idleness, a self-absorbed attitude, and social withdrawal.

Diagnostic guidelines

The normal requirement for a diagnosis of schizophrenia is that a minimum of one very clear symptom (and usually two or more if less clear-cut) belonging to any one of the groups listed as (a) to (d) above, or symptoms from at least two of the groups referred to as (e) to (h), should have been clearly present for most of the time during a period of 1 month or more. Conditions meeting such symptomatic requirements but of duration less than 1 month (whether treated or not) should be diagnosed in the first instance as acute schizophrenia-like psychotic disorder and are classified as schizophrenia if the symptoms persist for longer periods.

Viewed retrospectively, it may be clear that a prodromal phase in which symptoms and behaviour, such as loss of interest in work, social activities, and personal appearance and hygiene, together with generalized anxiety and mild degrees of depression and preoccupation, preceded the onset of psychotic symptoms by weeks or even months. Because of the difficulty in timing onset, the 1-month duration criterion applies only to the specific symptoms listed above and not to any prodromal nonpsychotic phase.

The diagnosis of schizophrenia should not be made in the presence of extensive depressive or manic symptoms unless it is clear that schizophrenic symptoms antedated the affective disturbance. If both schizophrenic and affective symptoms develop together and are evenly balanced, the diagnosis of schizoaffective disorder should be made, even if the schizophrenic symptoms by themselves would have justified the diagnosis of schizophrenia. Schizophrenia should not be diagnosed in the presence of overt brain disease or during states of drug intoxication or withdrawal.

Simon's case history: outcome

The outlook, then, for Simon is not good. Schizophrenia of late onset, particularly associated with affective symptoms (suggested by his somewhat grandiose style), has a better prognosis than some. But schizophrenia is a severe illness, subject to relapse, and often associated with long-term loss of drive (the so-called 'negative' symptoms). So, what happened to Simon

EXERCISE 2 (10 minutes)

Read the second extract of Simon's story from:
Dickenson, D. and Fulford, K.W.M. (2000). Rationality, responsibility and values. Chapter 4, *In Two Minds: a casebook of psychiatric ethics*. Oxford: Oxford University Press. (Extract, p. 112.)

Link with Reading 20.2

- How does Simon's 'outcome' influence your diagnostic thinking?
- Does he really have schizophrenia?

The good outcome of Simon's story generally produces a split vote among mental health professionals. One reaction, perhaps the most common, is to say that he had a 'benign form' of schizophrenia. The counter to this is that he was not ill, after all, but undergoing a religious experience. Either way, the positive outcome of Simon's story comes as a shock to psychiatry. After all, the whole point of the careful description of symptoms and delineation of syndromes, on which modern psychiatric diagnosis is based, was to differentiate pathology from other, perhaps odd and unusual, but none the less non-pathological, states. This careful descriptive approach has been aimed precisely at clarifying the boundary between medicine and morals, here crucially instantiated in the difference between delusion and religious experience.

Simon's case, therefore, presenting with unequivocal symptoms of severe mental illness (as defined by the PSE and ICD), yet issuing in a highly adaptive rather than pathological outcome, prompts us to look more carefully at the diagnosis, and in particular at how we differentiate between spiritual experience and psychosis. The similarities between them have been recognized for many years. William James, the philosopher-psychologist who was one of the founding fathers of cultural anthropology, described 'delusional insanity' as 'religious mysticism turned upside down' (James, 1902). But how, then, are they to be differentiated?

Distinguishing delusion from religious experience

One approach is to rely on the general features distinguishing normal from pathological experience. We covered these in Chapter 4. The point was that all experiences occur in both normal and pathological forms—pain, nausea, etc. may all be normal as well as symptoms of illness. Psychologists, sociologists, and others, have studied the features that mark out the pathological: they include severity and duration, for example. Such features, however, are not sufficient to distinguish delusion from religious experience here, for Simon's experiences are extreme (in this sense, severe) and they continued for at least 18 months.

A further marker of pathology, again considered in detail in Part I, is maladaptiveness. Here we seem closer to Simon's case, something along these lines being reflected in phenomenological approaches to the distinction (Jackson and Fulford, 1997a, p. 62, list a variety of such approaches in a summary table). Maladaptiveness, furthermore, has been incorporated as a distinct criterion in another gold standard of psychiatric classification, the American DSM.

Simon: the DSM diagnosis

The ICD and DSM, although in many respects closely similar, differ in an important respect in the criteria by which they define psychotic disorders. The ICD, as we have seen, sticks with the traditional first rank symptoms (together with secondary criteria such as a minimum duration).

Box 20.2 DSM IV, summary diagnostic criteria for schizophrenia

Diagnostic criteria for schizophrenia

A. Characteristic symptoms: Two (or more) of the following, each present for a significant portion of time during a 1-month period (or less if successfully treated):
   (1) delusions
   (2) hallucinations
   (3) disorganized speech (e.g., frequent derailment or incoherence)
   (4) grossly disorganized or catatonic behavior
   (5) negative symptoms, i.e., affective flattening, alogia, or avolition

Note: Only one Criterion A symptom is required if delusions are bizarre or hallucinations consist of a voice keeping up a running commentary on the person's behavior or thoughts, or two or more voices conversing with each other.

B. Social/occupational dysfunction: For a significant portion of the time since the onset of the disturbance, one or more major areas of functioning such as work, interpersonal relations, or self-care are markedly below the level achieved prior to the onset (or when the onset is in childhood or adolescence, failure to achieve expected levels of interpersonal, academic, or occupational achievement).

C. Duration: Continuous signs of the disturbance persist for at least 6 months. This 6-month period must include at least 1 month of symptoms (or less if successfully treated) that meet Criterion A (i.e., active-phase symptoms) and may include periods of prodromal or residual symptoms.

During these prodromal or residual periods, the signs of the disturbance may be manifested by only negative symptoms or two or more symptoms listed in Criterion A present in an attenuated form (e.g., odd beliefs, unusual perceptual experiences).

D. Schizoaffective and Mood Disorder exclusion: Schizoaffective Disorder and Mood Disorder with Psychotic Features have been ruled out because either (1) no Major Depressive, Manic, or Mixed Episodes have occurred concurrently with the active-phase symptoms; or (2) if mood episodes have occurred during active-phase symptoms, their total duration has been brief relative to the duration of the active and residual periods.

E. Substance/general medical condition exclusion: The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition.

F. Relationship to a Pervasive Developmental Disorder: If there is a history of Autistic Disorder or another Pervasive Developmental Disorder, the additional diagnosis of Schizophrenia is made only if prominent delusions or hallucinations are also present for at least a month (or less if successfully treated).

The DSM's criteria are given in Box 20.2. This is taken from DSM-IV. The DSM gives detailed descriptions of all the conditions it covers together with boxes summarizing key diagnostic criteria (it is thus an excellent textbook in its own right).

Box 20.2 gives the summary box for schizophrenia. As you will see, besides the traditional first rank symptoms (defined more synoptically but in essentially the same way in DSM's Criterion A), DSM now includes a new criterion, Criterion B. This criterion, of 'social/occupational dysfunction' covers the 'maladaptation' element in the meaning of pathology and it is prima facie directly relevant to Simon's case.

EXERCISE 3 (10 minutes)

Read the criteria for schizophrenia in the DSM (look particularly at Criterion B) from Box 20.2.

- How does Criterion B affect your thinking about Simon?
- Does he have schizophrenia as defined in DSM?

Most people reading Criterion B in connection with Simon's case conclude that, by this criterion, Simon does *not* have schizophrenia. In so far as our information goes, far from showing a deterioration in social/occupational functioning, he was empowered!

DSM versus ICD

In the USA, then, as against the rest of the world, the gold standard tools of psychiatric diagnosis do not force us down the route of a diagnosis of schizophrenia (or other psychotic illness). In the USA we can say, consistently with the positive and empowering effects of Simon's experiences, that, idiosyncratic as they were, they are more appropriately understood in terms of religious or spiritual experience than in terms of pathology.

At first glance, this might seem to be very much 'one up' to evidence-based medicine. The justification for the American Psychiatric Association's determination to go their own way, and to develop a classification of mental disorders independently from the World Health Organization, was that it gave them the freedom to base their categories directly on best scientific evidence. Whereas the ICD, on this view, is in part a product of the compromises required for wide international acceptance.

The opening paragraphs of the Introduction to the DSM, as the next reading shows, reflect its overt commitment to a strongly evidence-based approach.

EXERCISE 4 (10 minutes)

Read the short extract from the Introduction to:

American Psychiatric Association (1994). *Diagnostic and Statistical Manual of Mental Disorders* (4th edn). Washington, DC: American Psychiatric Association. (Extract, p. xv.)

(We looked at a longer extract from the Introduction to DSM-IV in Reading 11.2.)

Link with Reading 20.3

- How many references (explicit or implicit) to evidence-based medicine can you spot?

In this paragraph alone there are two explicit references ('breadth of available evidence' and 'formal evidence-based process') and a number of implicit references (e.g. 'experts' twice; a 'wide range of perspectives', and 'consensus scholars') to an evidence-based approach in the DSM.

Values and Simon's diagnosis

This explanation, however, that the DSM has greater face validity in Simon's case than the ICD because ie is more evidence-based, fails to hold up when we look more carefully at Criterion B, the critical diagnostic criterion in Simon's case.

EXERCISE 5 (5 minutes)

Reread Criterion B from the DSM criteria for schizophrenia in Box 20.2 above. Is this an exclusively evidence-based criterion? If not, what else besides evidence (facts) is required to decide if Criterion B is satisfied in a given case?

Reading Criterion B with an eye sharpened philosophically by Part I of this book, it is manifestly an *evaluative* (rather than purely descriptive or factual) criterion: 'social/occupational *dys*-function' (rather than merely different functioning), which is 'markedly *below* the level previously achieved', or, in the case of children, they '*fail* to achieve' their expected levels.

Fact and value in Criterion B

The conclusion, then, seems inescapable that Criterion B, notwithstanding the strongly evidence-based ambitions of the DSM, involves a series of value judgements. As with all value judgements, the facts are crucial (we covered this in general in Part I and return to it in this context in Session 2). But the facts are only part of the diagnostic story. The differential diagnosis in Simon's case also turns, and turns crucially, on a series of value judgements.

Into the (values) maelstrom?

Psychiatrists are often resistant to the idea that Criterion B introduces a series of value judgements into psychiatric diagnosis. By the standards of the fact-only medical model, they have every reason to be! DSM, as we saw in Part III (in Chapter 11 and Chapter 13), is self-styled as the pinnacle of scientific psychiatric diagnostic classification. Rumour has it that Criterion B was excluded from the World Health Organization's ICD-10, despite every effort being made to harmonize the two classifications, precisely because those concerned believed that it would undermine the scientific credentials of psychiatry! The WHO instead produced a separate classification of functioning, the ICF, or International Classification of Functioning, Disability and Health (WHO, 2001). In the ICD, of course, if the arguments of Part I are correct, an evaluative criterion is present by implication. But in DSM, with Criterion B, it is made explicit. And Criterion B, as in Simon's case, is at the centre of the diagnosis of a condition—schizophrenia—which itself is at the centre of traditional psychopathology (see Chapter 2 for the philosophical map of psychiatry). This is why schizophrenia, in Thomas Szasz's phrase, is the 'sacred symbol' of psychiatry (Szasz, 1960).

If, therefore, even schizophrenia cannot be diagnosed without making value judgements, what hope is there for the rest of psychiatry? With schizophrenia, then, according to the standard fact-only medical model, go the hopes of psychiatry for elevation to full membership of the scientific medicine club.

EXERCISE 6 (10 minutes)

In the final exercise in this session, review for yourself the implications of the conclusion that Criterion B imports values into the centre of psychiatric diagnosis. Write down a few notes in particular on,

1. What escape routes there might be for the standard medical model? If there are no actual escape routes, what are the possibilities for 'damage limitation'? (Think here about the different approaches to description and evaluation in the debate about mental disorder, as we explored them in Part I.)
2. If there is no escape, if value judgements are irreducibly part of psychiatric diagnosis, what are the implications for psychiatric practice, in clinical work and research?

These are large questions! The answers (or some elements of some possible answers) to them will occupy us for the rest of this chapter and Chapter 21.

All the same, please think about them for yourself at this stage. We have recommended that you spend just a few minutes on each. But write down your own ideas, brainstorming as widely as you can, and only then move on to the next session.

Reflection on the session and self-test questions

Write down your own reflections on the materials in this session drawing out any points that are particularly significant for you. Then write brief notes about the following:

1. Does a values-based model of medical diagnosis add values or subtract facts?
2. What is a delusional perception (as defined for example in the PSE)?
3. What is the diagnostic significance of a delusional perception (as in ICD-10)?
4. What is the key difference between the ICD and DSM diagnostic manuals in their criteria for schizophrenia?
5. Is the DSM evidence-based, values-based, or both?

Session 2 Generalization: the pervasiveness and importance of values in psychiatric diagnosis

At the end of the last session we raised two questions, (1) whether there were any escape routes for the 'medical model' of psychiatric diagnosis, including damage limitation exercises, once values are recognized to be at the heart of its scientific classifications (in Criterion B), and (2) what the significance of these values is in practice, in clinical work and research in psychiatry.

Review of the gameplan

In this session we will be dealing with the first question, the 'escape routes': we will find that there is no escape for the medical model, essentially because the importance of values in psychiatric diagnosis brings it firmly within the brief of ethics (or at any rate values) as well as of science.

In the third session of the chapter we will review some of the established ethical literature on psychiatric diagnosis. The conclusion of the present session, though, that psychiatric diagnosis is value laden because human values in the areas with which psychiatry is concerned are diverse, will give this literature a rather different interpretation from that of conventional ethics, an

interpretation that is closer to the concept of VBP introduced in Chapter 18. This VBP interpretation will lead us, finally, in Chapter 21, back to the second question raised at the end of the last session, namely, to the practical implications of the importance of values in psychiatric diagnosis.

The great escape?

First, then, in this session, the possible escape routes for the medical model. We will explore two kinds of possible escape route, (1) via damage limitation, and (2) via philosophical value theory. Damage limitation, as we will see, amounts to arguing that values, if present in psychiatric classification and diagnosis, have only a limited scope of application. Philosophical value theory, as an escape route, amounts to drawing on descriptivist and other theories, to show that values, if present, can (or will be) reduced to scientific facts, and hence are (or will be) unimportant.

We will consider damage limitation first and then come back to possible escape routes based on the philosophical theories of description and evaluation introduced in Part I. We will find that, either way, there is no escape for the medical model! Values are both pervasive and important in psychiatric classification and diagnosis.

The pervasiveness of values in psychiatric diagnosis

Damage limitation, from the perspective of the medical model, means accepting that values come into psychiatric diagnosis but limiting as far as possible their scope of application.

What this amounts to, by the lights of the value-free model of science guiding the medical model, is the claim that psychiatric diagnosis is in principle as exclusively scientific as diagnosis in any other branch of medicine: and this claim is often combined, consciously or unconsciously, with the belief that as the brain sciences become more sophisticated, so the pervasiveness of values in psychiatric diagnosis will diminish, the end-point being that psychiatric diagnosis will eventually look no different from the 'scientific' diagnoses characteristic of the rest of medicine.

We will return to this line of thought in a moment. But one straightforward damage limitation exercise along these lines is to regard Criterion B, and its entailed value judgements, as a one-off, a (value-laden) exception which proves the (normally factual) rule of diagnosis.

Values and the DSM's evidence-based agenda

We have already seen (in Exercise 4) that the Introductory section of DSM-IV sets a strongly evidence-based agenda for its classification. In our full-field fact + value model, evidence is of course important. Our understanding of mental distress and disorder should be as evidence-based as possible. The point of Exercise 4 was to spell out the lengths to which the DSM-IV Taskforce went to adopt an evidence-based process to support the development of the new classification: we noted such phrases as 'breadth of available evidence', 'consensus scholarship', and 'formal evidence-based process'. And in the fact-only traditional medical-scientific model, being evidence-based means being values-free.

Values in or values out?

But what happens later, deeper into the body of the DSM classification? Are values in or out? Has the Taskforce been successful in excluding values from the DSM? Of course, we have already noted the values in Criterion B. And we consider the theoretical implications of these later in this session. But what about other categories of mental disorder in the DSM? Are these value-free? What about the classification as a whole? As a classification of mental *disorders* is DSM, as well as being evidence-based, value-free?

EXERCISE 7 (10 minutes)

Read the further short extracts (Introduction, pp. xxi–xxii; Personality disorders, p. 630; Paraphilias, p. 523) from:

American Psychiatric Association (1994). *Diagnostic and Statistical Manual of Mental Disorders* (4th edn). Washington, DC: American Psychiatric Association

Link with Readings 20.4, 20.5 (2 short extracts) and 20.6

The first extract is the DSM's definition of mental disorder. The second and third extracts are from the DSM's definitions of personality disorder and paraphilia, respectively. (Essentially similar passages in DSM-IV TR occur, respectively, at pps xxx/xxxi, 689 and 566.)

Can you identify any inconsistencies:

1. between the DSM's definition of disorder and its scientific self-image, and/or
2. between the DSM's definition of the general category of disorder, and its definitions of the particular conditions, personality disorder and paraphilia?

In both cases think particularly about the way DSM treats values. Is this satisfactory?

This double exercise has a direct message and an indirect message. The direct message is that DSM is inconsistent in the way it treats values, both upwards from its definition of disorder (to its scientific self-image) and downwards (to particular diagnostic categories).

An upward inconsistency

Thus, the definition in the first extract from Exercise 7 includes a caveat—that a diagnosis of mental disorder should not be made on the basis of social values alone, it 'must not be merely an expectable and culturally sanctioned response' (p. xxi). Well, fair enough: we come later in the chapter to the abuses to which psychiatry is subject once it is made a means of controlling social dissidence. But the point here is that this wording itself actually implies the importance of social values as a component of the definition of mental disorder in general and hence of particular mental disorders.

It is the word 'merely' that gives this away. If DSM were true to its fact-only scientific aspirations (as expressed in the first extract), it would have been sufficient to say, straightforwardly, that mental disorder should not be diagnosed on the basis of social values—finito. The categories of mental disorder, this wording would unequivocally say, like botanical categories (e.g. 'dog rose'), or chemical categories (e.g. 'oxygen'), are not social constructs.

Downward inconsistencies

The downward inconsistencies in these extracts are even more transparent. Thus, as just noted, the DSM definition of disorder says that mental disorder should not be diagnosed merely on the basis of social values. Yet in the second reading (the criteria for personality disorders) we read that '. . . impairment in social, occupational or other important area of functioning (Criterion C).' (first extract, 'Introduction', pp. xxi, xxii) . . . '. . . may not be considered problematic by the individual . . .' (second extract, 'Personality disorders', pp. 630). Similarly, in the third extract (the criteria for paraphilia, p. 523), we read that 'These individuals are rarely self-referred and usually come to the attention of mental health professionals only when their behaviour has brought them into conflict with sexual partners or society'.

Notwithstanding, therefore, its general restriction on diagnosing mental disorder on the basis of social values alone, DSM, in effect though of course not in intent, does just this for both these categories. True, they can both be diagnosed on other grounds: but they *can* be diagnosed, by DSM criteria, on the basis of social values alone.

True, also, DSM, in its definition of mental disorder (first extract, pp. xxi, xxii), adds an overarching general constraint on psychiatric diagnosis in the form of a criterion of 'clinical significance'. This constraint, in the second extract (p. 630), also appears in the first clause of Criterion C for personality disorder. But this further constraint, on closer inspection, amounts to no more than the tautological definition of mental disorder (considered in Part I), that mental disorder is what doctors treat. For the DSM gives no definition of clinical significance other than saying that it is 'an inherently difficult *clinical* judgement' (American Psychiatric Association, 1994, p. 7, emphasis added). To the extent, furthermore, that clinical significance is connected in DSM to 'distress or impairment in social, occupational, or other important areas of functioning . . .', p. 7), the implication (though, again, not the intention) is that the clinical judgements in question are (at least in part) *value* judgements.

Two messages

The direct message, then, of this double exercise is that DSM is, at best, inconsistent in the way it treats values. The indirect message is that these inconsistencies reflect a failure of awareness, namely a failure to recognize the pervasiveness of values in psychiatric diagnosis.

In this respect, then, the inconsistencies in DSM are the counterpart of similar inconsistencies that we found earlier in the book in the literature on concepts of disorder. In the latter literature we found that authors such as Boorse (1975), and more recently Wakefield (2000), had been inconsistent in arguing for a *value-free* scientific core to medical theory (respectively in the concepts of 'disease' and of 'dysfunction'), while, at the same time using these terms with clear *evaluative* connotations (see Part I; also Fulford, 1989, ch 3 on Boorse, and 2000 on Wakefield).

Values in or values out again

In the debate about concepts of disorder, as we saw in chapter 4, inconsistencies of this kind pointed to the importance of values in the meanings of ostensibly 'scientific' concepts such as disease and dysfunction. Boorse, Wakefield, and others, so the (linguistic analytical) argument went, might stipulate value-free definitions of these terms for theoretical purposes; however, they were unable to use them value-free in practice because the evaluative element in their meanings was essential to the (linguistic) work that the terms do.

A similar situation arises in DSM, then. The authors of DSM strive after a value-free, and hence in their terms scientific, classification of mental disorders. But the importance of the evaluative element in the definition of mental disorder, hence in the definitions of particular disorders, and hence in psychiatric diagnosis, makes it inevitable that values slip back in. Values, then, are 'in' psychiatric classification; and they are 'outed' (shown for what they are) by the very language of DSM (see Fulford, 1994, for a more extended discussion of this analytic point; and Sadler, 2004, for a comprehensive review of values in all areas of psychiatric diagnosis).

No damage limitation

There is little scope, then, for damage limitation. Values, it seems, contrary to the fact-only medical model, are not limited to Criterion B in DSM. They are pervasive throughout the classification and, it would seem, logically important (they are doing important linguistic work for us, as the prongs of a garden fork do important gardening work for us).

We should not be surprised at this conclusion, given our findings in the first session of the chapter, that Criterion B imports values into psychiatric diagnosis. As we noted above, Criterion B is at the heart of the diagnosis of a disorder (schizophrenia), which is at the heart of the broader category of psychotic disorder, which in turn is at the heart of psychiatry's descriptive psychopathology as a whole.

The map of mental disorders, introduced in Chapter 2, makes this clear. A key feature of the map, as we saw, is that it illustrates how mental disorders provide a bridge (a conceptual bridge, of course) between medicine and morals.

In Chapter 2, we noted that conditions on the edge of the map of psychopathology are more overtly value laden than those at the centre. This property of these 'marginal disorders' has been reflected here in the overtly evaluative criteria in DSM for personality disorders and paraphilias. But what Session 1 of this chapter

has shown us is that, when we look carefully, with a philosophically sharpened eye, at the criteria by which the central conditions (such as schizophrenia) are defined in DSM, these too, by virtue of Criterion B, include evaluative criteria. Add to this the overtly evaluative language with which the agenda of DSM is set up, and we are back with the conclusion of Part I, that values are indeed pervasive and important throughout all areas of psychiatry's psychopathology, hence in psychiatry's nosology (disease classification), and hence in psychiatric diagnosis.

DSM and ICD

DSM, it is important to add, is not in this respect less satisfactory than ICD. Precisely similar arguments apply to ICD. The evaluative element is more difficult to identify in ICD because of ICD's more synoptic treatment of psychiatric classification. The less said, as it were, the less chance of inconsistency! This is why, as noted in Session 1, the authors of ICD resisted the inclusion of a Criterion B. The authors of DSM, on the other hand, in seeking to make the basis of psychiatric classification and diagnosis as transparent as possible, have gone part way to exposing the evaluative element of meaning, which is there, albeit more deeply hidden, in ICD. (As noted above, the WHO has a separate classification of functioning, the ICF (World Health Organization, 2001).

The importance of values in psychiatric diagnosis

We return later in the chapter to the implications of making this evaluative element fully overt, of 'outing' it. First, though, we need to consider the other escape route. If values are there, and if they are pervasive in psychiatric classification, is there a way of eliminating them?

This will occupy us for the remainder of this session. In effect, we will be reviewing arguments about the concept of mental disorder covered in detail in Part I. We will not need the details of those arguments, however. We will be reviewing them briefly, therefore, and with an eye specifically to whether they offer escape routes for the medical model in respect of psychiatric diagnosis.

We will tackle this initially by way of a further case history, that of Elizabeth Orton. The ethical and philosophical aspects of Elizabeth Orton's case are discussed in detail in one of the sister volumes to this book, Dickenson and Fulford's (2000) *In Two Minds: a case book of psychiatric ethics*.

A suitable case for treatment

Elizabeth Orton was a 35-year-old lawyer with a 10-month-old baby, Anthony. She had called her Health Visitor for help after finding herself shaking Anthony. The Health Visitor had reported the incident to Social Services and the child protection machinery had been put into action. Anthony was placed on the Child Protection Register, and Elizabeth was obliged by Social Services to see a psychiatrist, Daniel Isaacson, on pain of Anthony being taken into care.

The background to the incident was that Elizabeth had felt trapped: she did not want Anthony and would have had him adopted if her husband, Tim, had not objected. Elizabeth had been depressed in the postnatal period but now appeared, and felt, normal. Tim, who was 50, was semi-retired. He normally took most of the responsibility for looking after Anthony but had been away for a few days before the 'shaking' incident.

In the next exercise we pick up Elizabeth's story at the point where a case conference has been convened between Health and Social Services.

EXERCISE 8 (25 minutes)

Read the extract from the case of Elizabeth Orton (case 3.1) in:

Dickenson, D. and Fulford, K.W.M. (2000). Basic concepts: your myth or mine. Chaper 3, *In Two Minds: a casebook of psychiatric ethics*. Oxford: Oxford University Press. (Extract, pp. 59–60.)

Link with Reading 20.7

This is a short extract but we have suggested 25 minutes for the exercise to allow you to think in detail about how and in what ways values are driving this case. Think, in particular, about the medical model of mental disorder. Who is influenced by it here? What would Thomas Szasz, from an antimedical model perspective, and R.E. Kendell, from a pro-medical model perspective, have made of this case? (You may like to refer back to Chapter 4 here.)

Models and values

In their casebook, Dickenson and Fulford discuss Elizabeth Orton's story as an example of the overuse of the medical model: by the lights of this model, her problem of lack of feeling for her baby is pathologized and a mental disorder requiring the intervention of a medical psychiatrist. Dickenson and Fulford contrast Elizabeth Orton's case with a second case (3.2, Sam Benbow) in which there is, on the face of it, *under*use of the medical model (Sam is a learning disabled man with a paranoid psychosis who needs treatment for a bodily condition).

As Dickenson and Fulford point out, getting the balance right, between over- and underuse of the medical model, involves a number of related concepts—autonomy, capacity, rationality, and so forth. Values, though, both in their own right and as elements in these related concepts, are crucially important.

There are certainly values aplenty washing about in this case. Elizabeth Orton's wish to offload Anthony; her husband, Tim's, equally strong determination to hang on to him (did he take early retirement to facilitate this?); Dr Isaacson's concern for the proper role of psychiatry; Social Services' over-riding concern with 'child protection issues'. We will see later in the chapter that these

values, and the conflicts between them, are crucially important practically. But the point for now is the way in which they are driving the model of Elizabeth's problem as a 'mental disorder'. The feeling, not of course expressly stated, is that for a woman to fail to 'bond' with her baby is such a negative condition that 'she must be mad.' This gender bias is clear, for example, in the Social Worker 'chair's' acknowledgement to Dr Isaacson that if the roles in the Orton family were reversed, if it had been Tim who had shaken the baby and Elizabeth who was available to look after him, he (Tim) would not have been referred to a psychiatrist!

Disease and dissent

Having just read the first part of this session, the value-ladenness of the issues in Elizabeth Orton's case will not come as a surprise. We will see in Session 3 that they are also no surprise when we consider the abusive use of psychiatry as a means of social control. Political dissenters in the former USSR were 'diagnosed' as suffering from delusions of reformism! There, as we will see, the dominant political values drove the pathologizing of political dissent. Dickenson and Fulford give the example of 'spermatorrhoea', a 'disease' of excessive sexual activity in Victorian England. In the Southern States of the USA before the abolition of slavery, running away was the disease of 'drapetomania'.

In each of these cases, then, dissent from a dominant value system (political, moral, and commercial, respectively), we might well conclude, was pathologized as disease. Small wonder, therefore, that Elizabeth Orton's dissent from 'family values' was pathologized similarly!

Szasz versus Kendell

But what would the two sides in the antipsychiatry versus psychiatry debate have made of this? As we saw in Part I, this debate was essentially between those who believed mental disorder to be no different (other than perhaps in the sophistication of its science) from bodily disorders, and those who believed mental disorders to be crucially different in some way from bodily disorders. A key component in this debate was how the two sides treated values.

Thus, both sides recognized that mental disorder is more value laden than bodily disorder. We have seen this in various ways in this part (the value-laden Criterion B, the many ways in which values come into DSM, etc., all have no counterpart in the classification of bodily disorders). But the protagonists differed radically over what they made of this. Those 'for' psychiatry, like R.E. Kendell (1975), believed that closer inspection showed the values in question to be epiphenomenal: Kendell argued for an evolutionary understanding of disorder according to which mental and bodily disorders were both defined by reduced life and/or reproductive expectations. Those against psychiatry, on the other hand, such as Thomas Szasz (1960) argued that the value ladenness of mental disorder showed it to be, in reality, not a matter for medicine at all but for morals. Bodily disorders, he said, were defined by factual norms of anatomy and physiology. Mental disorders, by contrast, were defined by 'psycho-social, ethical, and legal' norms. Mental disorders, so called, were therefore 'problems of living' in Szasz' view, no different from any other moral or life problem.

In Part I we found that, despite appearances, the key difference between Szasz and Kendell was not over mental disorder but over bodily disorder (they wrote about illness, in fact). It was because they adopted different definitions of bodily disorder that they came to different conclusions about mental disorder. This limits the practical utility of the debate. In Elizabeth Orton's case we can imagine the argument running thus:

> *Szasz*: 'we are judging Elizabeth Orton by ethical and social norms; there are no anatomical or physiological abnormalities here. Therefore she is not ill.'
>
> *Kendell*: 'but "failure to bond" between mother and baby will result in reduced numbers of offspring; hence this is a case of biological disadvantage; hence she *is* ill.'

From disorder to disease

There is simply no point of contact here, then, there is no shared frame of reference within which issues of the proper scope of application of the medical concepts can be resolved. In practice, of course, the debate would continue.

> *Kendell:* '. . . And there is little doubt that in a few years we will understand the bodily changes (in brain, endocrines, etc.) underlying failure to bond. We will then have the anatomical and physiological norms required by your theory.'
>
> *Szasz*: 'In which case, I will accept "failure to bond" as a disorder. But it will be a disorder as in *brain disease*, not a *mental illness*.'

(Szasz has said something similar of schizophrenia in a debate some years ago on BBC Channel 4 with Jonathan Miller.)

EXERCISE 9 (10 minutes)

Think about this last comment of (our fictional) Thomas Szasz. Is there something disturbing about his willingness to shift positions over Elizabeth Orton on the basis of, say, a brain scan finding?

This is a disturbing move for both theoretical and practical reasons. We examined the theoretical reason in Part I: to the extent that it relies on the demonstration of causation, it implies that an understanding of the bodily changes underlying *successful* maternal–foetal bonding (as opposed to *failure* to bond) will make that a brain disease too!

The point is that, absent a 'ghost in the machine', *all* human experience and behaviour must have a basis 'in the brain'. Yet all too often the discovery of a brain basis for some particular aspect of experience or behaviour is taken to be equivalent to proving that it is a disease. In Part I we considered this as a theoretical point. But it is also an increasingly practical point as the new neurosciences are extending our knowledge of brain functioning. The spectacle of barristers waving brain scans around in court to prove that their client was 'not responsible' is more and more a reality. In Part V, we will encounter an example of this with the

newspaper headline announcing the discovery of a change in the anatomy of the brain in women with anorexia—'It's a *real* disease, after all!' was the storyline (see Chapter 22). We will also be considering the case of 'Mrs Lazy,' whose brain tumour presented with the 'symptom' of giving up housework! (This case is also described in Fulford, 2000a.)

An evolutionary escape route? Boorse and Wakefield

Szasz's willingness to move from (moral) problems of living to (medical) brain diseases on the basis of findings 'in the brain', as we saw in Part I, points to the need for bringing in some way of distinguishing good from bad departures from the norms of anatomy and physiology. Rather as with Criterion B, in Session 1 above, it is not enough that there should be, merely, a *difference* in anatomy and physiology for us to talk of disease. The difference must be for the *worse*.

> *Kendell*: '. . . and the relevant direction of change, what 'for the *worse*' means in terms of anatomy and physiology, is defined by the evolutionary norms of survival and reproduction. *Failure* of maternal–foetal bonding is nothing if not "evolutionarily dysfunctional", by these criteria.'
>
> *Szasz*: 'Is it, though? Surely this depends on the way a particular society operates. It would be true if there were few women wanting to have babies. But in our over-crowded world, it may be adaptive for the maternal instinct to be in short supply! And as to the division of labour between the sexes, paternal-foetal bonding, in our world of equality of the sexes, may be even more adaptive. At the very least, then, your criteria, applied to human beings, are socially relative. Elizabeth Orton, far from being "evolutionarily dysfunctional" could be ahead of her evolutionary time!'

An evolutionary blind alley

This (again, entirely fictional) further exchange brings out one kind of difficulty with evolutionary arguments, that they are better *post hoc* than *propter hoc*, better at explaining what has been than at predicting what will be. It also points to their limited utility when applied to human beings. This is because, perhaps uniquely in our case, 'natural' selection is something we can to an extent take or leave alone. Culture, perhaps, is a product of evolution. But its effect has been to allow us to circumvent many of the checks and balances which, in a natural environment, defined 'fitness'.

A more radical critique of evolutionary arguments, though, at least as providing an escape route for the medical model in respect of psychiatric diagnosis, is that, in practice, they fail in their objective of excluding values. We looked at this point in respect of Boorse's version of the evolutionary approach to defining dysfunction in value-free terms in Part I. One of us (K.W.M.F.) has also set it out fully in his *Moral Theory and Medical Practice* (1989, chapter 3). What it comes down to is the gap, noted above, between the stipulative definition of disorder in value-free terms and its continued use, even by those concerned, with clear evaluative force. Boorse (1975), to repeat our example from chapter 4, defines disease value-free (*inter alia*) as a 'departure from functional norms' and then uses the term to mean the evaluative 'failure of functional efficiency'.

Wakefield (2000) is among the latest to explore the evolutionary approach. His line (on disorder) is to define function, and hence dysfunction, by reference to a particular kind of causal process characteristic of evolutionary systems, one in which an effect is part of its own causal explanation. This is a powerful approach. It suggests, for example, contrary to the (fictional) Szasz argument offered above, that Elizabeth Orton's failure to bond should be regarded as a disorder, whatever the virtues of her position in our particular culture, provided only that maternal–foetal bonding (as a product or effect of evolutionary causal processes) is itself part of the evolutionary causal process by which maternal– foetal bonding evolved. Given the survival value of maternal–foetal bonding in a 'natural' environment, this seems not unlikely! Yet Wakefield's definition (of dysfunction), even more transparently than Boorse's, incorporates the very evaluative element of meaning it aims to exclude. This element was implicit in earlier statements of Wakefield's views (see Fulford, 1999). It becomes explicit in a later version, his 'new black box essentialism'; in this version, for example, the relevant 'effects' are derived by Wakefield from those which are, he says, using an explicitly evaluative term, 'beneficial' to the organism concerned (Wakefield, 2000; see also discussion in Fulford, 2000b).

Evolutionary theory, then, turns out to be, not an escape route for the medical model, but a blind alley. Boorse and Wakefield seek to exclude values (at least from the core of medical scientific theory—both recognize that values come into medicine elsewhere); but their own continued use of evaluative language shows that, stipulate as they may, the value terms will just not go away!

A moral descriptivist escape route? G.J. Warnock

A further escape route is by way of moral descriptivism. Again, this is covered in detail in Part I but is worth summarizing here, if only to bring us back to the practical implications of these arguments for psychiatric diagnosis, as in Elizabeth Orton's case.

An important modern exemplar of moral descriptivism is the Oxford philosopher, the late G.J. Warnock. Warnock never worked on the medical concepts (he died a few years ago). Had he done so, the difference between his position and the Boorse/Wakefield position might have been characterized thus: Boorse and Wakefield seek to *exclude* values, thus distilling out a purely factual medical concept (of disease or of dysfunction, respectively); Warnock sought rather to *redefine* (some kinds of values) in terms of facts (strictly, evaluations in terms of descriptions, hence 'descriptivism').

Descriptivism of the G.J. Warnock brand thus allows us to have our cake and to eat it. In so far as the relevant value terms are definable in terms of facts, it allows us to regard them as matters for value-free science; but because the values are redefined (not excluded) the terms can still be used with clear evaluative force. 'Disease', then, and 'dysfunction', if expressing the relevant kind of value, can properly be regarded as scientific terms (defined by facts) while still being used to express values (implied by the same facts). Hence in a moral descriptivist medical model there is no

contradiction between defining disease (with Boorse) or dysfunction (with Wakefield) value-free, while continuing to use these terms (as both do use them) to express evaluative meaning.

A non-descriptivist model: R.M. Hare

Whether or not one can 'have one's cake and eat it', logically speaking, in this way, depends on whether moral descriptivism, the analytic ethics basis for a descriptivist medical model, is right. This in turn depends on the view one takes of a long tradition of argument in analytic ethics, the so-called 'is-ought' debate, stretching back at least to David Hume. Again, we outlined this debate in Part I but we will review the key points briefly here.

Thus, the 'is-ought' debate is concerned with the logical relationship, the relationship of meaning between description and evaluation. Warnock, as just noted, is among those who have concluded that it is at least sometimes possible to get an evaluation from a set of descriptions, an 'ought from an is'. Others, though, including David Hume, have argued that, however persuasive the psychological connection between a given description of a situation and an evaluation of that situation, there is always a logical gap between them.

A modern exemplar of the latter, non-descriptivist, position is another Oxford philosopher, R.M. Hare (see references in Part I and Reading Guide). Hare's position is sometimes called prescriptivism because he emphasized the prescriptive, or action guiding, meaning of value terms. Thus, to take a non-medical example (described fully in Part I), an eating apple may be sweet, crisp, and clean-skinned. Most people would commend such an eating apple, they would judge it to be a 'good eating apple'. But, Hare argued, the move from the description 'sweet, crisp, and clean-skinned' to the evaluative 'good eating apple' is a psychological not a logical move. The move is driven by our psychology: it just is the case that for most people a good eating apple is one that is sweet, crisp, and clean-skinned. These descriptions, then, for most people, are the (descriptive) criteria by which they judge an eating apple to be good. But 'good eating apple,' here, does not mean simply 'an apple that is sweet, crisp, and clean-skinned.' 'Good eating apple' means an apple that, in being sweet, crisp, and clean-skinned, is good for eating.

A watershed in models: from (negative) escape routes to (positive) assets

The difference here, between psychologically and logically connected meanings, may seem a rather fine one! But it has profound consequences for psychiatric ethics in general, and in particular for our understanding of the role of values in the areas of psychopathology, classification, and diagnosis. In the remainder of this session we will look briefly at its theoretical consequences, the kind of 'medical model' to which it leads. We will return to its practical consequences (psychiatric abuse) in Session 3.

A non-descriptivist model: the theory

A full account of the model of the medical concepts to which non-descriptivist value theory leads would take us well beyond the scope of this session. Such an account has been developed by Fulford in his *Moral Theory and Medical Practice* (1989, especially chapters 2–5) together with a recent article in *Philosophy, Psychiatry, & Psychology* (Fulford, 2000b). It is also covered in some detail in Part I.

So far as psychiatry is concerned, though, we can get a handle on a key advantage of non-descriptivism over descriptivism by thinking through the connection between descriptive and evaluative meaning, as we have just done for 'apple', for a second non-medical example, 'picture'.

EXERCISE 10 (20 minutes)

In this exercise we want you to try writing down a set of descriptive criteria for a good picture. To limit the exercise, think of yourself in a concrete situation, for example as a member of a committee choosing the pictures for a hospital ward or an academic common room. If you are working in a group, write your lists separately and then compare them. Don't spend too long on this exercise. Limit yourself to the suggested 20 minutes!

(If you have done Part I you may want to skip this exercise.)

Most people trying this exercise find it very difficult—hence the suggested 20-minute time limit! There are various kinds of difficulties involved: imaginative identification, the variety of scenarios, etc. But what they all come down to is a profound difficulty over deciding what the criteria for a 'good picture' should be.

In the case of eating apples, most people (more or less) readily agree on a (fairly) limited list of (quite) well-defined criteria (usually including the criteria 'sweet, crisp, and clean skinned' as above). In the case of pictures, by contrast, there is nothing approaching this level of agreement. Over what is a good apple, people agree. Over what is a good picture, people disagree. In other words, in the case of what is good or bad in pictures, there is nothing corresponding with the agreed descriptive criteria of 'sweet, crisp, and clean skinned' for good eating apples. A given individual at any one time may be able to point to some feature of a particular picture, some description of it, which leads him or her to judge it good or bad ('I like landscapes', 'what photographic detail!', 'its by so-and-so', etc.). But unlike apples, the descriptive criteria for value judgements of pictures vary widely, between individuals, between cultures, and for a given individual between different occasions.

With the contrast between apples and pictures in mind, we can now come back to bodily medicine and psychiatry.

Apples and pictures, bodily medicine and psychiatry

The quick, but key, point here is that in respect of diversity of values, medicine (or at any rate high-tech bodily medicine) is like apples, while psychiatry is like pictures. Again, this is covered in detail in Part I. Think of, say, a 'heart attack'. Involving as this does, pain, collapse, and imminent death, it amounts to a condition that is a bad condition for anyone. It may have good consequences, e.g. escape from a protracted and even more painful death from cancer. But in itself the condition is one which nearly

everyone would judge a bad condition to be in. In psychiatry, by contrast, the conditions with which we are concerned are defined by emotions, desires, volition, beliefs, and other areas of human experience and behaviour in which our values are widely diverse.

Diversity of values feeds through as one clear source of the difficulty of psychiatric diagnosis. In the traditional medical model, psychiatric diagnosis is difficult only because psychiatry's science is primitive. On this model, while the scientific difficulties are real enough, we have differences of values to deal with as well. Of course, the values are there (on this model) in all areas of medical diagnosis. But they can be ignored for practical purposes in bodily medicine to the extent that they are widely agreed upon and hence unproblematic in practice.

The dangers of descriptivism

Taking this point the other way shows up the dangers of a descriptivist medical model for psychiatry. Descriptivism works for practical purposes where human values are, as a matter of psychological fact, shared. Thus in the case of apples, it may (if Hume and Hare are right) be theoretically true that there is a gap between 'is and ought', but this makes little difference practically. The fact is that people tend not to disagree over whether a 'sweet, crisp, clean-skinned eating' apple is good. The danger, though, is in extrapolating the apple case to cases where people disagree. There is not much risk of this with pictures. They are just so different anyway. But there is a real danger of extrapolation from bodily illness (cases such as heart attacks) to mental illness (cases such as Simon's, in Session 1). The danger is of one group's or individual's values being imposed on another's. The danger, in short, is of an abusive imposition of values.

This was one aspect of the problem in Elizabeth Orton's case. As we will see later, her case is merely one of a range of similar cases driven by differences in gender and cultural values. These in turn are but an extreme form of abuses arising from neglect of values, which, the growing first-hand literature from the user movement makes clear, is generic to psychiatry.

We will be examining some of these abuses of psychiatric diagnosis in the next session and returning to what can be done about them in Chapter 21.

Reflection on the session and self-test questions

Write down your own reflections on the materials in this session drawing out any points that are particularly significant for you. Then write brief notes about the following:

1. Is there an escape route for the fact-only medical model by way of circumscribing the role of values in psychiatric diagnosis? or are values pervasive?
2. Is there an escape route for the fact-only medical model by way of an (express or implied) generic criterion of clinical significance?
3. Is there an escape route for the fact-only medical model in positing (actual or hypothetical) underlying bodily causes?
4. What is moral descriptivism?
5. Is there an escape route for the fact-only medical model in moral descriptivism.
6. Are there dangers in moral descriptivism for psychiatry?
7. Is there an alternative?

Session 3 Bioethics and values in psychiatric diagnosis

We noted at the start of this part, in Chapter 17, that psychiatry has been relatively neglected by mainstream bioethics. Like biomedicine, bioethics has focused on the more high-profile problems of high-tech medicine. This, we noted there, is something of a paradox, psychiatry being more not less ethically problematic than these high-tech areas. And one of the key ways in which it is more ethically problematic, is that ethical issues are raised by diagnosis in psychiatry as well as by the areas, mainly of treatment choice, on which traditional bioethics has focused.

The outcome of this story, in Chapter 18, was that, once the origin of the ethically problematic nature of psychiatric diagnosis had been correctly identified, not in psychiatry's (supposedly) primitive science but in the (legitimate) diversity of human values, then psychiatric ethics, far from being the poor relation of bioethics, becomes (to switch metaphors) a window on good practice in medicine as a whole. In yet another metaphor, psychiatric ethics is bioethics' ugly duckling (Fulford and Hope, 1993), relatively neglected by mainstream bioethicists but with the potential to emerge as the swan of the flock!

Psychiatric diagnosis as an ethical problem

The question that we need to consider now, though, is whether traditional bioethics, in considering psychiatric diagnosis, has been able to break away from the traditional fact-only medical model sufficiently to recognize the origin of the ethically-laden nature of psychiatric diagnosis in the diversity of human values. It is this question that will occupy us (along with a number of related questions) in the next reading. This is a classic paper by one of the key figures in bioethics responsible for putting psychiatric ethics, and the ethical problems of diagnosis in particular, on the map. It is by the American lawyer and human rights campaigner, Walter Reich. Reich was among those who first brought to the world's attention the abusive use of psychiatry for the control of political dissent in the former Soviet Union. His article picks out and generalizes the ethical lessons that he believes psychiatry should learn from this episode in its history.

We are going to spend some time on Reich's article because it has a number of important lessons for us, some positive, others negative. This first exercise involves reading it right through

quickly and as a whole. In later exercises, we are going to return to it for more detailed study of key passages.

EXERCISE 11 (60 minutes)

Read:

Reich, W. (1999). Psychiatric diagnosis as an ethical problem. In *Psychiatric Ethics* (ed. S. Bloch, P. Chodoff, and S. Green) (3rd edn). Oxford: Oxford University Press, pp. 193–224

Link with Reading 20.8

As just noted, you should read the article through as a whole. As you read it, make two checklists:

1. a list of positive points, i.e. of points made by Reich about the ethical aspects of psychiatric diagnosis that strike you as being true; and
2. a list of negative points, i.e. of points which Reich makes that are critical of psychiatry (explicitly or implicitly) and that strike you as not being true (because misdirected, inconsistent, stigmatizing, or for any other reason).

Note: The article is a scholarly tour de force and you could spend a week on these two lists! But we have suggested 60 minutes on the basis that you should read the article right through to get the 'feel' of the positive and negative points rather than trying to think through all Reich's arguments at this stage. We will be returning to particular sections of the article in more detail later on.

As with all our exercises, there is a temptation to 'cheat' here, to jump straight to the lists given below rather than reading the article yourself! Given the 'skills development' nature of philosophy outlined at the start of this book, we hope you won't do this! Also, in particular for this exercise, you may well come up with different lists from ours, and indeed with a different conclusion. So don't take our observations for granted!

A list of positives

Reich's article pulls together a series of crucially important points about psychiatric ethics. Some of these we have covered already in the book, some are still to come. It is a reflection of the importance of diagnosis in psychiatric ethics that it should act, in the hands of a skilled commentator, as a centre of gravity for the whole subject!

Positive points from Reich's article include:

1. *Psychiatry is ethically laden*: Reich emphasizes the ethically-laden nature of all aspects of psychiatry from its emergence as a separate discipline up to the present day (p. 193).
2. *Diagnosis is ethically central*: he gives a clear statement not just of the pervasiveness of ethical issues in psychiatry, but of the *central place in all these issues* of psychiatric diagnosis—he writes 'common to all these activities is one psychiatric act: diagnosis' (p. 193).
3. *A classification of misdiagnoses*: he provides a useful *summary and categorization* of the different ways in which psychiatric misdiagnosis may be ethically problematic; abstracting from pp. 194–195, we can list these as:
   - *'honest' errors*—mistakes despite observing good practice;
   - *culpable errors*—mistakes due to inattention, lack of training, etc.;
   - *purposeful misuse*—deliberate false diagnosis in full knowledge of what one is doing;
   - *non-purposeful misuse*—the 'issuing' (Reich's term) of an incorrect diagnosis without being aware of what one is doing;
   - *intermediate cases* (not his term)—a spectrum of cases falling between purposeful and non-purposeful.
4. *Non-purposeful misdiagnosis ethically central*: he spells out the perhaps surprising fact that *non*-purposeful misdiagnoses are the most ethically significant . . . '. . . though purposeful misdiagnosis should be a serious concern, it is the *other* kind—misdiagnosis that results not from the wilful misapplication of psychiatric categories, but from primarily *non-purposeful* causes—that deserve the greatest scrutiny' (p. 194, emphasis in original).
5. *Many empirical difficulties*: his account provides what amounts to a useful summary of the empirical *difficulties* of psychiatric diagnosis. These, as set out in his sections on 'The inherent limitations of the diagnostic process' (pp. 195–196) and 'The power of diagnostic theory to shape psychiatric vision' (pp. 196–205), include many of the issues we considered in Part III. They include reliability (agreement between observers and on different occasions), reliance on symptoms and subjective assessments, different 'schools' of thought on classification, cultural diversity, the influence of social factors, and the 'theory-laden' nature of diagnosis.
6. *The lessons of Soviet psychiatry*: he makes clear that the experience of Soviet psychiatry is a *cautionary tale* for the subject (this occupies most of pp. 196–205, his section on 'diagnostic theory' influencing 'psychiatric vision')
7. *Implications of psychiatric diagnosis*: he spells out the wide range of crucially important *implications* of psychiatric diagnosis. The subheadings in Reich's section on 'The beauty of diagnosis as a solution to human problems' (pp. 205–217) make up a valuable checklist: diagnosis is: (1) explanation, mitigation, exculpation (this is one of the areas we covered particularly in Chapter 19, on legal aspects); (2) reassurance; and (3) the humane transformation of social deviance into medical illness. Psychiatric diagnosis is also (though it is less clear what is 'beautiful' about the rest of Reich's list): (4) a means of exclusion and dehumanization; (5) a self-confirming hypothesis; and (6) a vehicle of discreditation and punishment.

   Reich sums up the positive attributes of psychiatric diagnosis at the start of his 'beauty' section (p. 205) thus '. . . [psychiatric

diagnosis] can turn the fright of chaos into the pleasure of certainty; the shame of hurting others into the pride of helping them; and the dilemma of moral judgement into the clarity of medical truth'.

8. *Origin of ethical problems in human nature*: Reich locates the origin of the ethical problems with psychiatric diagnosis in the nature of human beings. In the concluding section of his chapter (p. 218, penultimate para), he writes 'Psychiatrists have to understand that . . . all abuses of diagnoses are a psychiatric problem in considerable measure because they are a *human* problem . . . '(emphasis in original).

A list of negatives

The second half of this exercise was to develop a checklist of negative points made by Reich against psychiatry. One reason that we suggested you made the lists in parallel, and while reading the whole article through quickly, is because most people find it easier (on first reading) to identify negatives than positives.

Taken at first blush, indeed, Reich is negative about psychiatry *full stop*. We could find only one overtly positive comment in the whole article, the suggestion (in the second paragraph of his opening section, p. 194) that psychiatry has '. . . the potential for causing good as well as harm.' But the rest of the chapter is all about harm. We return later to just why Reich should adopt this highly critical tone.

Parallel lists

The negative 'set' of Reich's article ties in with the second reason for asking you to make the lists in parallel, namely that they are parallel lists. Everything that we have included in our list of positives is also capable of being read, and indeed is presented by Reich as, a negative. Actually, there are a great many more negative points! You will probably have found your own list of negatives to be a long one. But the (Reichean) negative of (our) positive list runs roughly thus:

1. *Psychiatry is ethically-laden*. Reich presents the ethically laden nature of psychiatry as a matter of ethical criticism . . . 'it is *criticised* for ethical abuses in every sphere of its activity.' (p. 193, emphasis added).
2. *Diagnosis is ethically central*. Having clearly identified the ethically central place of psychiatric diagnosis (as in our list of positives), Reich continues in terms that, although capable of being read neutrally (though not positively), invite negative connotations; 'It is the *prerogative* to diagnose that enables psychiatrists to *commit patients against their wills*', he writes, 'that delineates the populations *subjected* to their care, and that *sets in motion* the *methods* they will use for treatment' (p. 193, emphases added). The image this phraseology conjures up is not of the caring doctor seeking to the best of her ability to use her skills to help people in trouble! It is of a powerful figure wielding authority over an unwilling population that is 'subjected' to methods of treatment following mechanically on ('set in motion' by) a divine right ('prerogative') of diagnosis.
3. *A classification of misdiagnoses*. Again, read neutrally, Reich's classification of misdiagnoses is a 'positive' in his paper. But in this section his negative set against psychiatry is made fully explicit. The section starts (top of p. 194) with 'of course, the ethical problem of diagnosis stems from its capacity for misuse—that is, the knowing misapplication of diagnostic categories . . . '. This puts people '. . . at risk for the harmful effects of psychiatric diagnosis.' The (relatively) neutral list of the consequences of psychiatric diagnosis is now converted into an overt list of harms—'loss of personal freedom', 'subjection to noxious psychiatric environments and treatments', the possibility of 'lifelong labelling', etc.
4. *Non-purposeful misdiagnosis ethically central*. For Reich, then, the 'ethical problem' of psychiatric diagnosis is the knowing exposure of people who are not ill to unpleasant treatments. The implication is that psychiatric treatments (like other medical treatments) have harmful side-effects, and that it is unethical to expose people to these side-effects vicariously. This is no different in principle from, say, a surgeon 'non-purposefully' carrying out an abdominal operation on someone who doesn't need it. This, one must hope, does not happen very often. Yet, as we noted in our positive list, Reich continues by suggesting that it is misdiagnoses that are 'primarily *non-purposeful* that deserve the greatest scrutiny' (p. 194, his emphasis).

There is an apparent conflict here, then. Reich starts by claiming the ethical problem of diagnosis stems from 'the *knowing* misapplication of diagnostic categories' (p. 194, as cited above, but with emphasis now added). But he goes on to say that the bigger problem is non-purposeful misdiagnoses, i.e. misdiagnoses of which the psychiatrist is *unaware*.

A new diagnostic entity?

Reich resolves this conflict, however, a couple of paragraphs later (p. 195), with a psychoanalytic idiom of dissociation. . . . Sometimes he writes (p. 195) 'such awareness (that the psychiatrist in question is issuing an incorrect diagnosis) is altogether absent . . . sometimes, however, awareness would be present were it not for the efforts of the psychiatrist, through the use of various techniques of denial and self-delusion, to escape the moral self-condemnation that would result from such awareness.'

The bottom line, then, is that the ethical problem of diagnosis is the misapplication of diagnostic categories by psychiatrists who, but for dissociative splitting, would be well aware of what they are doing. The ethical problem of psychiatric diagnosis is, in psychiatric diagnostic terms, a problem of what we might call 'dissociative misdiagnosis'. (Recall the example of hysterical paralysis, in Chapter 3, a paralysis caused by motivations that, like those hypothesized by Reich in the case of psychiatric misdiagnosis, are split off from awareness (dissociated) because they are too painful to tolerate consciously.)

This is not, as they say, a pretty picture! It is a picture, it is important to add, with which many in the user/survivor movement would identify. But right or wrong, it is a picture that demands some explanation. Why should psychiatrists, particularly, need the 'use of various techniques of denial and self-delusion'? Why not surgeons? Why not lawyers? Why not human rights campaigners? We return to this question in a moment. But Reich offers a detailed explanation of his own. There are, he says, 'three sources' of non-purposeful misdiagnoses (p. 195)—empirical problems, theory-ladenness, and 'beauties'. We can 'map' these respectively on to points 5–7 of our list.

5. *Many empirical difficulties*. The first of Reich's 'sources' of non-purposeful misdiagnoses is the empirical difficulties presented by psychiatric diagnosis. These, as we noted in our positive list, are well recognized, not least by psychiatrists. Properly understood they are one aspect of the particular *difficulty* of clinical work and research in psychiatry (the factual aspect). As we saw in Part III, these difficulties are the basis of the need for a more sophisticated understanding of science in psychiatry than in other, conceptually simpler, areas of medicine (such as abdominal surgery). They are also why, as we will see in the first part of the next chapter, the American philosopher, Jennifer Radden, devotes so much of her detailed review of philosophical aspects of psychiatric nosology to the philosophy of science.

   But in Reich's account, these difficulties are transformed into *deficiencies*. The pejorative language is unremitting. Psychiatric diagnosis shows '*vulnerability* to error', its reliability is '*poor* or *questionable*', it 'may *suffer from* bias', and so on (p. 195, emphases added). 'At best', Reich concludes this section, 'psychiatrists are no better than their tools; and they must acknowledge the *limitations* of these tools as the starting point of their own (limitations)' (p. 195, emphases added).

6. *The lessons of Soviet psychiatry*. Reich's second source of non-purposeful psychiatric misdiagnoses is 'the power of diagnostic theory to shape psychiatric vision' (the title of this section of his chapter, p. 196). As we noted above (in our positive list), and as we will see in Chapter 21, the institutionalized abuse of psychiatric diagnosis in the former Soviet Union is a cautionary lesson for psychiatry. But the lesson drawn by Reich, is not the positive lesson that there is more to good diagnostic practice in psychiatry than good science. The lesson drawn by Reich is the negative lesson that psychiatrists are poor scientists.

   There are, he says, 'yet other vulnerabilities (i.e. other than problems of reliability) that are even more subtle, more pervasive, and more difficult to recognize . . .' He then reminds us of his guiding theme that the essence of the ethical problem of diagnosis in psychiatry is the misfeasance of psychiatrists. 'Again', he continues, 'the danger is misdiagnosis—non-purposeful but still damaging—and the ethical problem is the degree to which psychiatrists *allow themselves* to ignore the forces and circumstances that lead to, and make use of, such misdiagnoses' (p. 196, emphasis added).

   What, then, are these 'forces and circumstances' to which psychiatric diagnosis is so vulnerable? One factor is plain social bias; however, psychiatrists are 'at least dimly aware of these problems' (p. 196). The rest of the section follows with discussions of the 'reification' of categories, the influence of dominant paradigms (the 'Moscow school' in the Soviet case), and so forth. All, then, fair comment so far as it goes. But entirely begging the question of why psychiatry should be more 'vulnerable' in these respects than doctors in other areas of medicine (or indeed other sciences); and why indeed Soviet psychiatry should have been more vulnerable than psychiatry in other countries. Again, we return to this 'why?' question in a moment.

7. *Implications of psychiatric diagnosis*. This is the third of Reich's sources of the ethical problem of psychiatric diagnosis. It is the least and also the most contentious part of Reich's chapter. It is the least contentious in that it spells out, forcefully, some of the non-medical implications of psychiatric diagnosis. Psychiatrists, influenced as they (rightly) are by the medical model, need reminding of these.

   It is the most contentious section, though, because the 'beauties' of psychiatric diagnosis, as Reich calls them, are presented by him as false beauties. They are indeed the most powerful of the sources of psychiatrists' tendencies to 'denial and self-delusion'. There is no doubt that the 'medical model' is overused by psychiatrists (no doubt, from the evidence of the user literature, for example). But there is an equal and opposite danger from the critics of psychiatry of underuse of the medical model. The importance of this balance is underlined in Dickenson and Fulford's casebook (2000), with the balancing cases of Elizabeth Orton (overuse of the medical model) and Tom Benbow (underuse of the medical model.)

   Like any other area of medicine, then, fine judgements have to be made in psychiatry between the goods and harms involved in a given clinical situation. If, as Reich suggests, psychiatrists are more vulnerable to getting such judgements wrong, it is not enough to catalogue the harms involved. We have to explain *why* they are more vulnerable.

8. *Origins of ethical problems in human nature*. This recurring question, why psychiatry should be so peculiarly vulnerable to the abuses Reich so fully (and accurately) documents, comes to an explicit focus in the concluding section of his chapter.

   We can see this by completing the quote given earlier in our positive list. That quote ran 'Psychiatrists have to understand that . . . all abuses of diagnoses are a psychiatric problem in considerable measure because they are a *human* problem, . . .' (p. 218, emphasis in origin). The passage continues '. . . and probably stem less from the *corruption* of the profession than from the needs and vulnerabilities of us all.' (emphasis added).

For Reich, then, identifying the origins of the ethical problems raised by psychiatric diagnosis in human nature, means identifying them in our *fallen* nature—the 'needs and vulner-

abilities of *us all*' (p. 218, emphasis added). We will suggest in a moment that this (now bleakly negative!) interpretation is wrong. But even if it were right it would still beg the question of why psychiatric diagnosis should be more ethically laden than diagnosis in other areas of medicine. Is Reich suggesting that psychiatrists are more 'corrupt' than other doctors? If so, why? Why, in Reich's terminology, do psychiatrists misdiagnose purposefully more than other doctors? Or is Reich suggesting rather that psychiatrists have the same 'needs and vulnerabilities' as everyone else? If so, why do they misdiagnose *non*-purposefully more than other doctors?

Reflection on the session and self-test questions

Write down your own reflections on the materials in this session drawing out any points that are particularly significant for you. Then write brief notes about the following:

1. Note four positive points about psychiatric diagnosis in Walter Reich's article? (We listed eight.)
2. From Reich's own perspective, are these points positive or negative points about psychiatry.

Conclusions: new tools from Values-Based Practice?

In this chapter we have illustrated the central place of values in psychiatric diagnosis drawing particularly on psychiatry's own scientific classifications, the ICD and DSM. In the final session we focused particularly on Walter Reich's work because he is one of the few, in the bioethical literature, to take seriously the ethical, or more broadly evaluative, issues raised by the diagnosis of mental disorders.

Reich's essentially negative 'take' on psychiatric diagnosis, we will argue in the next chapter, arises from his implicit adoption of a traditional fact-centred medical model. In adopting this model, Reich is in line with similar fact-centred medical models adopted not only in biomedicine (as we saw in Part I), but also in bioethics itself (Chapter 17) and in medical law (Chapter 19). Such a model, we have repeatedly emphasized, is appropriate, up to a point, for values-simple areas of health care, i.e. areas of health care (notably in high-tech acute medicine) where the operative values are largely shared. But *mental* health, as we have seen, is above all a values-*complex* area of health care, an area in which human values far from being largely shared are highly diverse.

Psychiatric ethics, then, we argued in Chapter 18, requires, in addition to the tools of traditional bioethics, a further set of tools, a set of tools developed as a response to the complexity of values in mental health, the tools of VBP. It is to the application of the tools of VBP to psychiatric diagnosis that we turn in Chapter 21.

Reading guide

Delusion and spiritual experience

The story of Simon was first described by the British psychologist, Mike Jackson, in his DPhil with Gordon Claridge at Magdalen College, Oxford, and subsequently published in Jackson (1997) 'Benign schizotypy? The case of spiritual experience' (in *Schizotypy: relations to illness and health* edited by G.S. Claridge). The role of values in distinguishing delusion from spiritual experience was explored, with several case studies (including that of Simon described here) by Jackson and Fulford (1997a) in their article in *Philosophy, Psychiatry, & Psychology* on 'Spiritual experience and psychosis', with commentaries by Littlewood (1997), Lu *et al*. (1997), Sims (1997), Storr (1997), and the authors' response (Jackson and Fulford, 1997b); also, in a shortened from in Jackson and Fulford, 2002a. The significance of Simon's case for our understanding of the role of values in diagnosis particularly in cross-cultural psychiatry is explored in Fulford's article *From Culturally Sensitive to Culturally Competent Mental Health Care: a seminar in philosophy and practice skills* (1999). For a valuable edited collection on the relationship between psychiatry and religion, see Bhugra (1996) *Psychiatry and Religion*.

The issues were developed further in a special issue of *Philosophy, Psychiatry, & Psychology* (Volume 9(4), December 2002), with articles and cross commentaries critiquing Jackson and Fulford's original paper, respectively, by Caroline Brett (2002a) from the perspective of the mystical tradition, and by Marek Marzanski and Mark Bratton (2002a) from that of the theological tradition. Brett (2002b) commented on Marzanski and Bratton, while Marzanski and Bratton (2002b) commented on Brett. An additional commentary on Brett was given by the philosopher Michael McGhee (2002) and on Marzanski and Bratton by the theologian, Stephen Sykes (2002). Both main authors responded to the commentaries (Brett, 2002c; Marzanski and Bratton, 2002c). Jackson and Fulford (2002b) wrote a short paper giving an overview response to the issues raised by both sets of papers.

Abuses of psychiatric diagnostic concepts

For a detailed reading guide on ethical and conceptual aspects of the abusive uses of psychiatry, see chapter 3 of Dickenson and Fulford's (2000) *In Two Minds: a casebook of psychiatric ethics. Psychiatric Ethics* (edited by Bloch, Chodoff and Green, 1999) includes a number of relevant chapters: in particular, Paul Chodoff (chapter 4) reviews a number of high profile abuses of psychiatry in Nazi Germany, Japan, and in the USSR. More detailed accounts of each of these are to be found in chapters 22 (by Benno Mueller-Hill), 23 (by Timothy Harding), and 24 (by Sidney Bloch) of the second edition of *Psychiatric Ethics* (Bloch and Chodoff, 1991). Alan Stone's *Law, Psychiatry, and Morality* (1984) explores legal implications of the abuse of psychiatry.

That psychiatry remains vulnerable to abusive manipulation is graphically illustrated by the American psychiatrists

Alfred Freedman and Abraham Halpern's (1999) description of the growing involvement of psychiatrists in executions in some parts of the USA, and by ongoing concerns about potential misuses of psychiatric diagnostic concepts in widely different cultural and political systems: see, for example, (1) in the UK recent debate about new mental health legislation (e.g. Szmukler and Holloway, 1998; Bindman *et al.*, 2003), and (2) concerns about the possible political uses of psychiatry in China (see Human Rights Watch, 2002). The need for a dynamic 'open society' in mental health to reduce the risks of such abuses is noted by Birley (2000).

Values in diagnosis: (1) The ethics literature

As already noted, Bloch and Chodoff's trail-blazing edited collection on *Psychiatric Ethics* has been unusual in the ethical and bioethical literature in tackling head-on and explicitly the importance of values in psychiatric diagnosis. The casebook sister volume, Dickenson and Fulford's *In Two Minds*, includes the story of Simon (chapter 4, though first published in Jackson and Fulford, 1997), and, in chapter 3, cases illustrating both overuse and underuse of the medical model, the values-aspects of which are explored here in chapter 20.

The *Philosophy and Medicine* book series published by Kluwer under the general editorship of Tris Engelhardt and Stuart Spicker has included a number of important volumes on philosophical and ethical aspects of classification and diagnosis, in particular Volume 40, *The Ethics of Diagnosis* (edited by José Luis Reset and Diego Gracia, 1992), which includes historical, anthropological, and sociological perspectives. Volume 15 of the *Episteme* book series (also from Kluwer), on *Diagnosis: philosophical and medical perspectives* (Laor and Agassi, 1990) includes a number of relevant chapters, in particular chapter 4, 'Ethics of diagnostic systems', which examines the issues from the novel perspective of systems analysis. A further useful collection is an issue of *The Journal of Medicine and Philosophy*, edited by Kopelman (1992), on 'Philosophical issues concerning psychiatric diagnosis' (Volume 17, number 2).

Bill Fulford, Tom Murray, and Donna Dickenson's (2002) *Many Voices* (the introduction to their edited collection on healthcare ethics and human values) provides a bridge between ethics and Values-Based Practice. The collection is of classic texts, newly commissioned articles and patient narratives, structured around the stages of the clinical encounter, and illustrating the diversity of human values involved in all aspects of health care. The introductory chapter discusses how respect for different values complements and extends the resources of traditional 'ethics' for clinical decision-making.

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