CHAPTER 21

From bioethics to values-based practice in psychiatric diagnosis

Chapter contents

Before tackling the bioethical literature on psychiatric diagnosis in detail, we will briefly summarize the story so far as set out in the last chapter.

In Chapter 20

In Session 1 of Chapter 20, the case of Simon showed that values are inherent in psychiatric diagnosis, not peripherally but at the very heart of traditional psychopathology, in the differential diagnosis of schizophrenia. That value judgements are involved in this differential diagnosis is implicit in ICD. It is explicit in DSM, in the DSM's additional Criterion B of 'social/occupational dysfunction'.

The long Session 2 in Chapter 20 then showed that there is no escape for the traditional fact-only medical model. Simon, still less Criterion B itself, is not an 'exception that proves the rule'. To the contrary, (1) values are pervasive throughout psychiatric classifications, such as ICD and DSM, and, (2) in-depth philosophical analysis (covered in more detail in Part I), showed that the values concerned cannot be defined away. Even the most promising of medical models (based on moral descriptivism) founders on the diversity of human values involved in psychiatric diagnosis; and for similar reasons, (3) advances in neuroscience, leading to better understanding of the brain basis of human experience and behaviour, will make it more, not less, important to take seriously the evaluative (as well as factual) elements in psychiatric diagnosis.

In this chapter

Psychiatric diagnosis, then, is a matter for ethics (values) as well as science (facts). It was with the ethical literature on psychiatric diagnosis, and the work particularly of Walter Reich, that we were concerned in the final Session 3 of Chapter 20.

That literature, we will argue in this chapter, has been deeply influenced by the traditional fact-only medical model. This is consistent with one of our key conclusions earlier in this part about the bioethical literature in general, in so far as it has been concerned with psychiatry. In this chapter we will find that it is true also of the bioethical literature as it has been concerned specifically with psychiatric diagnosis. The challenge, though, is to work out in practical terms the implications of substituting a fact + value model of diagnosis for the fact-only traditional medical model.

It is this challenge that provides the storyline of this chapter. We start, in *Session 1*, with a brief review of philosophical issues generally in psychiatric classification and diagnosis (covered also in detail in Part III (Chapters 13 and 14) and how work in philosophical value theory in particular fits with these. *Session 2* then returns to Reich's observations on psychiatric diagnosis from Chapter 20 but with a view to adding values to (what we will argue is) Reich's fact-only bioethical medical model. Moving, then, from bioethics (fact-only) to values-based practice (VBP) (fact + value), reverses Reich's arguments. *Session 3* shows that instead of the value-laden nature of psychiatric diagnosis being grounds for criticism, it is grounds for a positive approach to working effectively with values, as well as science, in psychiatric diagnosis. This leads, finally, in *Session 4*, to the practical applications of VBP (many of them still promissory) to clinical work and research on psychiatric classification and diagnosis.

Session 1 Philosophy, values, and psychiatric diagnosis

A brief review and notes from Parts I and III

We will start with a review article by the American philosopher, Jennifer Radden. Radden is one of the founding members and a past Chair of the American Group, the Association for the Advancement of Philosophy and Psychiatry. This article, published in *Philosophy, Psychiatry, & Psychology* in 1994, appeared not long after DSM-IV (APA, 1994). The issues reviewed were 'hot' then and they are 'hot' now!

EXERCISE 1 (20 minutes)

Read the two short extracts from this review article:

Radden, J. (1994). Recent criticism of psychiatric nosology: a review. *Philosophy, Psychiatry, & Psychology,* 1(3): 194, 197

Link with Reading 21.1

It is well worth studying this article as a whole. It is short but very clear and provides an authoritative overview of the philosophical issues surrounding psychiatric classification in the wake of the publication of DSM-IV. It thus sets the ethical literature in context with other philosophical aspects of psychiatric diagnosis

Two points to think about are:

1. The overall links suggested by these extracts between this part (on ethics) and Part III (on science)
2. Looking to the future, do you agree with Radden's prediction about homosexuality?

Other philosophical areas

An important feature of Radden's review is that, besides values, she covers a wide range of other areas of philosophy relevant to psychiatric diagnosis. Indeed values as such have only a limited place! Thus, if you read the article as a whole, you will find, *inter alia*, philosophy of science, the mind–body problem, the philosophy of action, phenomenology, and, not least, conceptual analysis.

Remarkable by its absence, on the other hand, is traditional ethics (as distinct from philosophical value theory, concerned with concepts). This is a further reflection of the divide between ethics and science in medicine. We will follow up various aspects of this divide later in this session.

Links to other chapters

If, however, values (as dealt with in philosophical value theory) have a limited place in this review, pride of place goes to philosophy of science; and much of what Radden says here concerns, by way of developments in the subject in recent years, the significance and importance in science of value judgements.

This of course connects directly with the storyline of Part III on the philosophy of science, namely that a more sophisticated understanding of science is necessary to underpin clinical work and research in psychiatry. It also reflects the way in which, in all areas of psychiatry, including diagnosis, science and ethics, properly understood, are complementary. Both: (1) are expressions of human values and interests (Chapter 13); (2) depend on the same kind of complex judgement that cannot be completely captured in a codification or algorithm (Chapter 14); (3) are underpinned by an ineliminable element of tacit knowledge (Chapter 14); and (4) involve normative elements (Chapter 15).

Besides values, Radden touches on rationality, in her comments on psychosis. We explored legal concepts of rationality in Chapter 19; and the related ethical concepts of autonomy and capacity, in relation to involuntary treatment, in Chapters 17 and 18. Values turned out to be important in both contexts, legal and ethical. Rationality is also impatant to understanding the particular *kind* of negative evaluation by which the medical categories of disorder are defined: i.e. illness is distinct from ugliness, foolishness, wickedness, etc.

We covered this question, of the particular kind of value expressed by the medical concepts, at a conceptual level in detail in Part I. Although not the express focus of this chapter on psychiatric diagnosis, the range of issues it raises is clearly highly relevant to the implications of diagnostic assessment for the overtly ethical issues (involuntary treatment, mental illness as an excuse in law, civil capacity, and so forth) that we have covered in earlier chapters. It is also the basis of an enriched model of the internal structure of psychiatric classifications (Fulford, 1989, chapters 4, 9 and 10). We return to rationality in Part V where it plays an important role—throughout the part—in the debate about whether mental states can be reduced to brain states and whether meanings can be subsumed under the realm of scientific laws.

From bioethics to values-based practice

Radden's (1994) article, as we noted above, in reviewing the philosophical problems raised by psychiatric classification and diagnosis, has (rightly) as much to say about the philosophy of science and other areas of philosophy, as about ethics. There is, none the less, an ethical literature on psychiatric diagnosis. Indeed an important characteristic of the specifically psychiatric ethical literature is that, unlike other areas of bioethics, it has recognized the ethically laden nature of diagnosis.

We ended the last chapter with a detailed discussion of an article by an exemplar of the psychiatric ethical literature on diagnosis, Walter Reich (1999). This article illustrated the largely negative stance towards psychiatric diagnosis that the bioethical literature has tended to share with the biomedical literature (as in Part I). In the rest of this session we are going to continue our examination of Reich's account of psychiatric diagnosis. This, as we will see, will lead us from the negative stance of bioethics to the more positive stance of Values-Based Practice.

The best of bioethics?

Before returning to Reich's (1999) paper, though, it is worth reminding ourselves why we are spending so much time on it. The last session of Chapter 20 may have seemed critical of Reich. In a sense it was: it was critical of Reich's antipsychiatric mind-set. However, we have focused on his article because it is a closely argued and exemplary statement of one clear position on psychiatric diagnosis. It has been the same with other articles that we have looked at in detail. We have focused on them because they present a strong position clearly and with authority. We may disagree with that position (you may not!). But our aim is to engage with the *best* statement of the position in question.

Reich, as we noted earlier, is among the few, and perhaps the best, of traditional bioethicists to have clearly identified and sought to analyse the central ethical significance of psychiatric diagnosis. He is not one of those who, in the image adopted by one of us elsewhere, has a blind spot for this crucial aspect of psychiatric ethics (Fulford, 1993).

But Reich puts a largely negative spin on this. His account, broadly, is that psychiatrists are vulnerable to self-deception. This in turn is partly due to the limitations of psychiatric science, partly to the theory-ladenness of psychiatric classification, and partly to the seductions (the 'beauties' as Reich called them) of psychiatric diagnosis. However, psychiatric science (although as we saw in Part III, certainly harder) is no more limited than any other area of science. It is also no more and no less theory-laden. And Reich offers no explanation for why psychiatrists more than any other group of doctors should be seduced by the 'beauties' of diagnosis. So what is his model of psychiatric abuse? Why does he think psychiatrists make unethical diagnoses, in general (Reich claims) and particularly in the Soviet case?

EXERCISE 2 (20 minutes)

Re-read the short section in:

Reich, W. (1999). The inherent limitations of the diagnostic process. *Psychiatric Ethics* (3rd edn), (ed. S. Bloch, P. Chodoff, and S. Green). Oxford: Oxford University Press, pp. 195–196

Link with Reading 21.2

How far does this reflect a standard fact-only medical model? If you have read Part I, think in particular about the assumptions we found lying equally behind pro- and antipsychiatry positions in the debate about mental illness.

The biomedical model in biomedical ethics

This short section captures the nub of Reich's assumptions about psychiatry and its ethically problematic nature. There are various ways of thinking about this. The essence of it, though, is the traditional medical model, a model built on such paradigms as cardiology and gastroenterology, in which medicine is assumed to be based on value-free scientific theory with ethics coming in only in the 'appliance of science', with treatment. This is reflected in the literature on concepts in the two assumptions we identified in Part I in the debate about mental illness.

- *Assumption 1*: that mental illness is *the* problem
- *Assumption 2*: that physical illness, relatively speaking, is *not* a problem.

Thus, Reich, although he calls this section the limitations of 'the diagnostic process', actually writes exclusively about the limitations of the *psychiatric* diagnostic process. The first paragraph reviews literature on the unreliability of psychiatric diagnosis. The second tells a story of 'these limitations being eased' by the introduction of 'relatively objective criteria' but with the warning that 'In the absence of clear, conclusive, and universally accepted criteria, such as physical evidence for the presence of, say, one or other type of schizophrenia or affective disorder, such diagnostic approaches . . . provide important, though by no means certain, safeguards against diagnostic error.' (p. 196). In other words, when psychiatry has brain diseases on a par with physical medicine, this source at least of diagnostic error, will disappear. Reich is very close, then, in this passage, to Szasz's position: show me the brain cause of schizophrenia, Szasz says, and I will accept it as a disease; but it will be a *brain* disease not a mental illness.

In the next session, we continue our analysis of Reich's paper by looking at how his assumption of the standard fact-only medical model of diagnosis has shaped his attitude to psychiatry. This will lead to the different 'spin' on the bioethics literature, anticipated in the introduction to this chapter, which is generated by a fact + value model, a model that adds values rather than subtracting facts, as developed in Part I.

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. On what area of philosophy does Radden particularly focus in her review of philosophical issues in psychiatric classification and diagnosis?
2. What assumptions about psychiatric diagnosis does Reich share with both Szasz and Kendells in the debate about mental illness?
3. Does a values-based understanding of psychiatric classification and diagnosis, add values or subtract facts?

Session 2 From fact-only to fact + value model of psychiatric diagnosis

At the end of Chapter 20 we identified the origin of Reich's antipsychiatry mind set in his assumption, which he shares with a majority of bioethicists, of the standard fact-only medical model of diagnosis. By the time we get to the end of this session we will have moved beyond bioethics, from a fact-only to a fact + value model.

Our route from fact-only to fact + value model will be by way of the list of points (positive for us, negative for Reich) that we examined in the last session of Chapter 20. Reich's assumption of a fact-only model, we will suggest, has led him (and with him, bioethicists in general) to look the wrong way for an explanation of the vulnerability of psychiatric diagnosis to abusive misuses. It is not the 'fact' side of diagnosis that is the origin of this vulnerability. It is the 'value' side. Recognizing this will lead, in Session 3 of this chapter, to a very different agenda for avoiding (or at any rate limiting the scope for) abusive misuses of psychiatric diagnoses, and, in Session 4, to the practical applications of this agenda in terms of Values-Based Practice.

The fact-only medical model: converting positives into negatives

In the first exercise in this session, then, we will start by looking through Reich's arguments again, this time looking for direct evidence of the fact-only biomedical model at work in his ethical thinking.

EXERCISE 3 (30 minutes)

In the next exercise on this important article, run through the positive and negative lists again, that we produced in Chapter 20. Review Reich's position. How far is it driven by a traditional fact-only medical model of diagnosis? How does a fact + value model convert his negative points into positives? This is another potentially open-ended exercise. But again, don't spend too long on it. Just try to pick out a few examples of the medical model at work.

Then think about a further question. If the medical model is at work here, why might it lead us, in psychiatric ethics, dangerously astray? You might like to refer here to the reading by Fulford *et al.* (1994) linked with Exercise 14 in Chapter 18.

Once the 'medical model' lying behind Reich's article is identified, the many ways in which he converts potential positives about psychiatry into negatives, fall into place. We will review these briefly using the same list (up to point 7) as in the last session. They illustrate a number of important points about psychiatric ethics and the need to break away from the traditional (fact only) to a more comprehensive (fact + value) model of diagnosis in medicine.

1 *Psychiatry as ethically laden*. In a model that emphasizes science, the pervasiveness of ethical issues in psychiatry is necessarily (as Reich finds it) suspect. Psychiatry just doesn't 'look' scientific. It's a problem! In a fact + value model, on the other hand, psychiatry, in displaying these ethical issues so prominently, points lessons for medicine as a whole. The prominence of ethical issues in psychiatry, in a fact + value model, thus ceases to be a problem and becomes an asset (see Chapter 18, especially final session).

2 *Diagnosis as ethically central*. The value-ladenness particularly of psychiatric *diagnosis* is (as, again, Reich finds it) a *particular* problem for the fact-only medical model. As we saw in chapter 4 (notably in the work of Christopher Boorse), the more sophisticated versions of this model are fact-*centred* rather than fact-only. They make medical theory—Boorse's 'disease theory'—a matter of value-free science, and they recognize ethical issues but only as arising in the practical fringe.

In such models, therefore, diagnosis (above all) should be value-free. Whereas in a fact + value model, we should positively expect values as well as facts to be operative in diagnosis.

3 *A classification of misdiagnoses*. The difficulty for the medical model with the value-ladenness of psychiatric diagnosis, is clearly evident in Reich's notion of what we called above, dissociative misdiagnosis. Guided by a fact-centred medical model, ethical issues have to arise for Reich in the *application* of theory in practice, in this case the application of disease concepts in the diagnostic process. The paradigm of unethical practice, on Reich's medical model, is deliberate misapplication (what he calls purposeful misdiagnosis).

Reich, like most antipsychiatrists, draws the line at openly accusing psychiatrists as a profession of wilful misdiagnosis. Yet, on his model of the ethical issues, he is unable to let psychiatrists off the hook altogether—they are not completely or innocently unaware of what they are doing. Hence he ends up with the halfway house of the dissociative model, with psychiatrists using '… various techniques of denial and self-delusion …' (p. 195, as quoted above—and well worth a repeat quote!).

4 *Non-purposeful misdiagnosis ethically central*. A fact + value model, on the other hand, puts an entirely different interpretation on the ethically central place of non-purposeful misdiagnoses. The fact-only (or fact-centred) model, as in Reich's article, has to contrive a compromise between the paradigm of unethical practice as *purposeful misdiagnosis* (with malice aforethought, as it were) and the *non*-purposeful misdiagnoses that Reich rightly identifies as the focus of ethical concern in psychiatry.

In a fact + value model, on the other hand, non-purposeful misdiagnoses arise, directly, from a failure to attend equally to the evaluative as to the factual elements in diagnosis. Psychiatrists do not intentionally neglect the values involved in psychiatric diagnosis, nor do they 'use techniques of denial and self-delusion'. They are simply unaware of the relevant values (at least for what they are). Our opening session in Chapter 20, concerned with the story of Simon, illustrated this in detail. It showed that the relevant values, in psychiatric diagnosis, are there (overtly so, in the case of Criterion B), but tend to be neglected (for the reasons derived, mainly, from R.M. Hare's work in philosophical value theory, in Part I).

This in turn is not a matter of dissociative thinking. It is, on this model, a reflection of the dominance of the fact-only model of medicine. If there is a 'weakness' (Reich's word) here, among psychiatrists, it is not a moral weakness. It is an inattention to a key aspect (the evaluative aspect) of the medical concepts. If this is a weakness, it is a *conceptual* weakness. And it is a 'weakness', as we have several times noted, which is shared by bioethics as much as by biomedicine!

5 *Many empirical difficulties*. In a fact + value model, however, there is really no weakness among psychiatrists. Or rather, psychiatrists are no 'weaker' conceptually than anyone else. As we saw in Part I, it is a general characteristic of us all that we are better at using concepts than at defining them; this is because our powers of direct conceptual introspection are limited and we thus tend to focus on limited aspects of the full meanings of complex high-level concepts; we suffer Wittgenstein's 'delusions of language' (*illusions*, really, as we called them in Part I, i.e. distorted or one-sided understandings of our high-level concepts); and the fact-only medical model, we argued in Part I, is simply this—a one-sided understanding of the high-level *medical* concepts (disease, illness, etc.).

The fact-only medical model, as a one-sided understanding of the medical concepts, has two consequences, one negative, one positive. The negative consequence is the point noted earlier, that in explaining the value-ladenness of psychiatric diagnosis, there is a tendency to look the wrong way. It is assumed that, as medical theory (on this model) is essentially value-free scientific theory, the 'problem' must be inadequate science. More values equals less science, is the equation suggested by this view.

Reich on psychiatric science

Reich (1999), as we noted in the last exercise, makes the equation of 'more values equals less science' explicit in his brief section on the limitations of diagnosis. Reich's 'limitations' are *scientific* limitations. His 'diagnosis' is *psychiatric* diagnosis. The cure, then, of psychiatry's ethical problems with diagnosis, is better science. And better science, for Reich, means the introduction of 'objective criteria …' (like those in bodily medicine), 'clear, conclusive, and universally accepted criteria, such as physical evidence …' (p. 196, again well worth a repeat quote).

Reich, along with many others, casts the difficulties of psychiatric science as *deficiencies*. He thus regards these scientific deficiencies (limitations, he calls them) as an important source of psychiatry's tendency to (dissociatively) misdiagnose. Hence, on his view, Soviet psychiatric science must have been a good deal more 'limited' than psychiatric science elsewhere in the world.

Reich's negative view of Soviet psychiatric science

But *was* Soviet psychiatric science really any different from psychiatric science generally in the 1950s and 1960s? In their article on Soviet abuses (in Chapter 18, linked with Exercise 14), Fulford *et al.* (1993) showed that the psychopathological concepts involved were no different from those employed in 'the West' at the time. Notably, the notorious Soviet 'sluggish schizophrenia' was equivalent to the 'Western' 'latent' or 'simple schizophrenia'. This indeed was born out by the international collaborative study of schizophrenia, the International Pilot Study of Schizophrenia (the IPSS), which is cited at length by Reich, but which actually treats these diagnostic concepts, the Soviet sluggish schizophrenia and Western simple schizophrenia, as equivalent.

There is a clear suspicion of implicit bias, therefore, in Reich's account, mediated through a distorting pair of (fact only) retrospective spectacles! This bias becomes overt in point 6, in Reich's critical account of Soviet psychiatric science.

> 6 *The lessons of Soviet psychiatry*. Reich, like many others in Britain and America (and indeed in many other countries outside the former Soviet Union) looks to poor science for the origin of the abuse of psychiatric diagnostic concepts. As we saw in Chapter 18 (linked with Exercise 14, the reading on Soviet disease concepts by Fulford et al., 1993), a variety of factors, including, though not limited to, poor standards of applied or clinical science, were involved in these abusive misdiagnoses becoming widespread in the final (and fading) decades of the Soviet empire. But the development of psychiatric science, as such, was no more and no less 'sound' than in non-Soviet countries at the time, notably in Reich's own USA.

This comes through clearly in Reich's (1999) account (p. 198) of the career of the chief 'conspirator', Andrei Snezhnevsky. This reads as the career of a man gaining power and influence for some (unstated) reason of his own. Well, maybe he did. But Snezhnevsky's career parallels that of many other influential figures in the history of medicine. Indeed Reich's account would fit that of a correspondingly powerful leader of research over a similar period at the Institute of Psychiatry in London, Professor Sir Aubrey Lewis. (We looked in detail at Lewis important on clasification in chapter 13.).

EXERCISE 4 (10 minutes)

This is a 'fun' exercise, though with a serious point. Go back to the description of Snezhnevsky's career in Reich's (1999) article, i.e. the para starting 'This Soviet diagnostic system . . .', p. 198.

See how much of it you can translate directly into Aubrey Lewis' career. If you are not familiar with Aubrey Lewis' career, just imagine how it might have been.

A powerful way to do this exercise is to print out the page from Reich's article and then do a direct translation of the key words: i.e. translate 'Snezhnevsky' into 'Lewis', 'Soviet' into 'British', and 'Moscow' into 'London', etc.

Reich on Aubrey Lewis

The following are some of the passages in Reich's account of Snezhnevsky's career that we believe can be transposed directly to an account of the career of Aubrey Lewis. We have shown substitutions of Aubrey Lewis' career for that of Snezhnevsky by square brackets.

Thus, Reich writes, [Aubrey Lewis] was '. . . head of the Institute of Psychiatry [of the UK], . . . the central psychiatric research institution in that country . . .' and 'chairman of . . . probably the most prestigious institute [in the UK] for advanced and training degrees.' '[He] dedicated [its] resources [*inter alia*] to the problem of schizophrenia' . . . [he and his staff] doing 'clinical research designed to elaborate its details'. 'By the early 1970s many of his former students and trainees were in charge of the nation's academic psychiatric centres . . .' and so 'The pattern of psychiatric teaching and research in centres far from [London] felt the effects of his guidance and views, exerted through his role as an influential member of review committees for government committees responsible for the approval of research and training grants'. The result was that 'By the middle and late 1970s the hegemony of the [London School] in the realm of psychiatric theory and practice, particularly diagnostic theory and practice, was almost complete: it was clearly the dominant force in [British] psychiatry, and its diagnostic system was the standard [British] approach to the diagnosis of mental illness'.

We should not be surprised by the parallels here. As we saw in Part III especially in the outline of Kuhn's work, and of the sociology of science in Chapter 16, it is in the nature of science that, like any other area of human activity, it is subject to political and professional power structures, to the influence of scientific 'top dogs'—remember Max Planck's quip that 'new scientific theories are not born, old scientists just die'! In more recent psychiatric history, many perceive the American Psychiatric Association (the APA), and the DSM in particular, playing just the role of power broker in which Reich castes Snezhnevsky.

New York and Moscow

Reich's account of Soviet psychiatric science, then, although certainly shared by many in 'the West', is biased, in the sense that much of what he says by way of criticism of Soviet psychiatric science applies, *mutatis mutandis*, to Western psychiatric science too. This comes through particularly clearly in the criticisms Reich makes specifically of Soviet psychiatry's diagnostic system.

Thus, Reich argues that '. . . its (Soviet psychiatry's diagnostic system's) definitions of the schizophrenic disorders . . . employed such broad and loose criteria that it permitted the diagnosis of schizophrenia in cases in which, in the West, there would be no finding of any mental illness'. Well, it is true that Soviet criteria were broad; but no broader than many systems 'in the West'. Indeed, although not cited by Reich, the first clear evidence that different apparent prevalences of schizophrenia around the world reflected different diagnostic criteria came from the US–UK Diagnostic Project. This showed that much broader criteria were being used in America (New York) than in England (London). It

was this that led to the IPSS (as above), which compared diagnostic concepts in nine countries.

The IPSS is actually cited by Reich. But he uses its findings to further criticize Soviet science. He suggests that Moscow emerges as a deviant centre, whereas, in fact, the most deviant centre (in terms of rates of diagnosis) was Washington. Moreover, as to the concept of schizophrenia, the IPSS showed

- that a core condition, defined by the particular symptoms, which now figure in both ICD and DSM, and which symptoms were also the basis of the classical Schneiderian definition of schizophrenia, could be clearly identified in *all nine centres*;
- that Washington, as well as Moscow, had adopted relatively broad criteria for schizophrenia, as compared with the narrower criteria used not only in London but in Columbia, Czechoslovakia, Denmark, India, Nigeria, and Taiwan;
- that the concept of 'sluggish schizophrenia', which Reich criticizes, is the direct counterpart of comparable subtypes of schizophrenia (called 'simple' or 'latent') in other systems. As noted above, these categories (sluggish, simple, latent) were treated as equivalent by the IPSS. Indeed, the only difference (so far as the IPSS is concerned) between Washington and Moscow was that this category of schizophrenia (sluggish/simple/latent) when put through a computer diagnostic algorithm, was reclassified mainly as paranoid and manic psychoses in Washington, and as personality disorder in Moscow. (Remember that we are concerned here only with the *vulnerablility* of psychiatry to abusive practices as these may arise from its scientific basis. Other factors—poor training, etc—may well have been involved in abuses becoming widespread—see Fulford *et al*., 1993.)

7 *Implications of psychiatric diagnosis*. As we saw earlier, the extent of the 'non-medical' implications of psychiatric diagnosis, from the perspective of a traditional bioethics working within the (tacit) assumptions of the fact-only medical model, is, merely, the other side of the coin of psychiatry's (supposedly) limited science.

One side of this coin, on this view, is that psychiatric diagnosis lacks the objective certainties provided to bodily medicine by (cardiological, gastroenterological, etc.) science. *Wobbly* psychiatric science makes for *wobbly* diagnoses, which in turn leave room for *unethical* diagnoses. This is the nub of Reich's treatment of the role of psychiatric science in the former Soviet Union—it is incompetence-mediated conspiracy!

The other side of the coin, then, is that less science in psychiatric diagnosis, on this fact-only model of medicine, means more non-medical implications, and it is these, that in Reich's section on the 'beauty of diagnosis as a solution to human problems,' generates his catalogue of ethical, legal, and social implications of diagnosis.

Adding value to fact

As we noted earlier, Reich's catalogue of the 'beauties' of psychiatric diagnosis is a valuable feature of his article. The ethical, legal, and social implications he describes are certainly there in psychiatric diagnosis. Moreover, influenced as psychiatrists themselves are by the fact-only medical model, they are insufficiently aware of these implications.

Among the 'beauties' of diagnosis, however, Reich fails to include curing illness. Curing illness is remarkable by its absence from his catalogue. Surely curing illness (or as a step towards curing illness) is at the heart of what is important and attractive (beautiful) about medical diagnosis. But of course it is absent from Reich's catalogue because Reich is concerned with what he regards as *false* beauties—non-scientific, and hence, on this fact-only model, non-medical implications of diagnosis, implications that, those wedded to this model believe, find their way into the space left vacant by the lack of an adequate psychiatric science.

Diversity of human values

In a fact + value model, by contrast, the 'beauties' are real beauties; or rather, the values implied by Reich's use of the word 'beauty' are part of, rather than external to, diagnosis. In a fact-only model, the values (and hence the implications catalogued by Reich), are contingent on the lack of an adequate science. But in a fact + value model, they are (partly) *constitutive* of the diagnostic process itself.

Diversity of human values: theory and practice

This brings us back then, to the point on which we have settled so many times in this book—that the difference between psychiatry and bodily medicine (as two ends of a spectrum) is not in scientific adequacy but in diversity of human values. This difference is important theoretically: it gives us the 'psychiatry first' message of Part I, that psychiatry is at the cutting edge intellectually in medicine, rather than, as it is perceived to be in the standard fact-only medical model, scientifically backward.

This in turn makes the difference between fact-only and fact + value models important practically. On Reich's model, the practical point of emphasizing what he regards as the 'non-medical' implications of psychiatric diagnosis, is to warn psychiatrists against being led astray by non-scientific will-o'-the-wisps. The practical point of these same 'non-medical' implications in a fact + value model, by contrast, is to make us face up to and take seriously the diversity of human values as they bear on the process of diagnosis in psychiatry.

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. What model of medicine lies behind Reich's essentially negative take on psychiatric diagnosis?
2. What dangers might there be in adopting this model?
3. What view does Reich take of Soviet psychiatric science?

4. Could his view of Soviet psychiatric science apply equally to British and North American psychiatric sciences?
5. Why does Reich seek to subtract values from, rather than to add values to, psychiatric diagnosis?
6. What alternative is there if we are concerned, like Reich, to reduce the risks of abusive uses of psychiatric diagnostic concepts?

Session 3 Reversing Reich

In the final two sessions of this chapter we are going to fill out the key point made at the end of the last session, about taking seriously the diversity of human values as it bears on psychiatric diagnosis, in two way. First, in this session, by reversing Reich's arguments, i.e. by seeing how far Reich's criticisms of psychiatric diagnosis apply to bodily medicine as well. Then, in the final session of this chapter, we will return to the practical implications of taking the values involved in psychiatric diagnosis seriously within the framework of values-based practice.

Reich's argument applied to bodily medicine

First, then, reversing Reich's argument. Reich takes what he calls the non-medical implications of psychiatric diagnosis (i.e. ethical, legal, and social implications) to be substitutes for the (scientific) implications of (genuinely) medical diagnosis.

If Reich is wrong, therefore, if his *non*-medical implications are in fact (partly) constitutive of the diagnostic process itself, then they should be present to some degree at least in diagnosis in bodily medicine as well as psychiatry.

EXERCISE 5 (15 minutes)

In this exercise, we want you to flick though Reich's list of 'beauties' and to see whether you can think of situations in bodily medicine in which diagnosis has the same implications as those attributed by Reich to psychiatric diagnosis, albeit not necessarily to the same degree.

As with other exercises in this session, you could write a whole essay on this! Don't spend too long on it, though; skim through Reich's psychiatric list and come up with a few bodily medicine counterparts.

Here are a few examples we have come up with:

- *Diagnosis as explanation, mitigation, and exculpation* (Reich, 1999, pp. 205–207)—well, what about an 'off-work' certificate from the family doctor for a bad back?
- *Diagnosis as reassurance* (pp. 208–209)—this depends, presumably, on what is diagnosed! But diagnosis does indeed 'reassure' to the extent that knowing 'what is wrong' reassures in bodily medicine no less than in psychiatry.
- *Diagnosis as the humane transformation of social deviance into medical illness* (pp. 209–210)—a tougher one this. But it follows from 'mitigation and exculpation' above; so, what about epileptic automatism in cases of violent murder? This is a well-established legal excuse.
- *Diagnosis as exclusion and dehumanization* (p. 210)—in a word, AIDS.
- *Diagnosis as a self-confirming hypothesis* (pp. 213–215)—but isn't it always, to some extent? People with physical disabilities are increasingly pointing to the way in which their disability operates as a self-fulfilling prophecy: 'poor old so-and-so, he can't manage that'; so he *doesn't* manage it; so it becomes *true* that he can't manage it!

(Reich's case history, p. 214, by the way, is an example of the self-fulfilling nature of psychiatric diagnostic labels that rivals Rosenhan's classic study! See in Part I, Rosenhan, 1973.)

- *Diagnosis as discreditation and punishment*—as Reich rightly identifies, calling someone 'mad' is a powerful way of discrediting them. Any label, though, can discredit whether it is bodily or psychological: try 'obese' for size here! Or 'midget'; even 'asthmatic'; not to mention 'syphilitic'; or 'the liver in bed 3', as hospital staff sometimes refer to their patients.

  As to punishment, this takes us into the area of what Reich calls purposeful misdiagnosis. Purposeful misdiagnosis is clearly unethical if it is done for reasons not connected with the patient's best interests. Purposeful misdiagnosis may be ethical, of course, or arguably so, if well motivated. But, again, this is true equally of bodily medicine as of psychiatry. Thus, a false diagnosis of schizophrenia in Soviet Russia may have been well motivated, e.g. saving the person concerned from a slow death in Siberia: Bloch and Reddaway in their seminal work on the abuse of psychiatry in the USSR (1997) noted such cases. But this is no different in principle from a false diagnosis of heart disease saving the person concerned from, say, the military draft. Conversely, either false diagnosis, whether of schizophrenia or of heart disease, could be ill motivated; and among ill motivations a desire to punish the person concerned would be ill indeed.
- *Diagnosis as the reflection of social trends*. Reich's highly pertinent example here, of false memory syndrome, illustrates the 'witch hunts' that can result when, as he puts it '. . . diagnostic procedures (are) distorted . . .' (p. 217).

But is that not just the point? Reich's example is indeed an example of *distortion* of the diagnostic process. The hysterical over-reaction of psychologists, therapists, and others, as well as psychiatrists, described by Reich, was a distortion driven by the fashions of the time. Psychiatrists, in fact, as Reich records, although like every other group including some followers of fashion, were also among the most forward in *condemning* the over-reaction. And the history of medicine is full of over-reactions in other areas, bodily as well as mental. How many of

us, over 50, lack tonsils because of a fashion for tonsillectomy in the 1940s and 50s; many think we are over the top on vaccinations nowadays, etc., etc.

Reich, right or wrong?

8 *The origins of ethical problems in psychiatry*. Fashions, then, as we saw in Part III, are as influential in science, including medical science, as in any other area of human activity.

So does this mean that Reich, to return to the eighth point on our list, is right after all to identify the origin of the ethically problematic nature of psychiatric diagnosis in the frailty of the flesh, in the 'needs and vulnerabilities of us all' (p. 218), the 'needs and vulnerabilities' in question being, on this interpretation, fashions?

EXERCISE 6 (20 minutes)

Think about this question for a few minutes before going on.

In thinking about this, it may be helpful to refer back briefly to, (1) the opening paragraph of Reich's (1999) conclusions (p. 217), and (2) Session 1 of this chapter.

One way to do this exercise is in the form of a diagnostic formulation. If you are a psychiatrist, or have read Chapter 2 (Part I), you will be familiar with this way of unpacking a medical problem into four main points: (1) diagnosis (i.e. an accurate description of the problem); (2) aetiology (origins of the problem); (3) treatment (what to do about it); and (4) prognosis (likely outcome).

Reich's diagnosis of the problem

In our view, there is a sense in which Reich's diagnosis of the problem is right, and a sense in which it is wrong. Reich is right, in our view, to emphasize that the Soviet experience is not unique: it is an experience that has a key lesson for us all—diagnosis in psychiatry *is* peculiarly vulnerable to abuse. This is a vulnerability that is shared by psychiatrists as a whole. To this extent, then, to the extent of his diagnosis of the problem, we can agree with Reich.

We can agree with Reich further, when it comes to his account of the origin (or aetiology) of the problem, to the extent that (in this passage at least) he identifies this, not in some aberrant property of psychiatric diagnosis, still less in Soviet psychiatric diagnosis, but in human nature.

Where Reich is wrong, however, again in our view, is, as we suggested earlier, in identifying the origins of the vulnerability of psychiatric diagnosis in our *fallen* human nature. This identification runs as a key theme through his chapter and it surfaces explicitly in his conclusions. We have quoted some of this before but it is worth quoting again.

Thus he opens his conclusions (p. 217) with examples of people coming to psychiatrists to circumvent the law . . . 'they have sought (psychiatric) diagnosis to help them get abortions or evade the military draft'. Seeking a psychiatric diagnosis is an effective strategy, we find later in the paragraph, in part because '. . . the law itself has a certain weakness for diagnosis . . . (it is) . . . partial to its charms . . .' (p. 217). And the paragraph finishes, as we noted a moment ago, with an overt reference to corruption—the ethical problems of psychiatric diagnosis, Reich concludes, '. . . probably stem less from the corruption of the (psychiatric) profession than from the needs and vulnerabilities of us all.' (p. 218).

Reich's aetiology

To continue the 'diagnostic formulation' approach, then, while we share Reich's descriptive diagnosis, we disagree with his proposed aetiology. We agree with Reich's description of psychiatric diagnosis as being more ethically-laden (or at any rate more values-laden) than diagnosis in other areas of medicine; we agree, too, that the Soviet experience of abusive uses of psychiatric diagnosis for coercive purposes of social control, is a signal (writ large) of its more ethically-laden nature. But we believe Reich's aetiology, his theory of the origins of such abuses, in the frailty of human nature, is wrong.

This is essentially because, as we saw in the preceding session, his proposed aetiological factors fail to explain why psychiatrists in general *are*, and Soviet psychiatrists in particular *were*, more liable to make socially-coercive uses of diagnosis than any other group of doctors. Reich's three (proposed) aetiological factors—diagnostic process, diagnostic theory, and diagnostic 'beauties'—fail to stack up: (1) the supposed deficiencies of psychiatric science are not deficiencies but *difficulties* (and Soviet psychiatry was no less 'scientific' than psychiatry in the USA at the material time); (2) the theory-ladenness of psychiatric 'vision', similarly, is not unique to psychiatry (as we saw in Part III, there is no such thing as theory-free data); and (3) the 'beauties' of psychiatric diagnosis, in so far as they *are* beauties (recall that three of Reich's 'beauties' were not beautiful at all!), are beauties of diagnosis in *all* areas of medicine.

Reich's treatment

We will return in a moment to what we believe is the correct aetiology. But before coming to this, it is important to consider the extent to which Reich's formulation of the problem of psychiatric diagnosis, if it is wrong at the level of aetiology, leads to the wrong treatment and indeed to the wrong prognosis.

EXERCISE 7 (20 minutes)

What has Reich (1999) to say (explicitly or implicitly) about the treatment for and prognosis of, the ethical problems of diagnosis? We have covered this already, at least in principle. But spend a few minutes drawing together your own thoughts on this. Concentrate on Reich's conclusions. Could his views on treatment and prognosis be counter-productive?

If the aetiology of the ethically-laden nature of psychiatric diagnosis is, essentially, human frailty, then the cure, essentially, is

to stiffen up standards. This is Reich's 'treatment'. Of the three aetiological factors he proposes, two demand scientific stiffening (diagnostic process and diagnostic theory) and the third ethical stiffening (diagnostic 'beauties'). Thus the cure, on Reich's view, for the abuse of psychiatric diagnosis is: (1) to work towards a less defective scientific base for psychiatry; (2) to be less easily influenced by psychiatric theory; and (3) to stiffen our moral resolve in the face of the seductive 'charms' of psychiatric diagnosis.

There is much here with which, transposed from negative to positive, we can agree, both scientifically and ethically. Certainly, we need better science; and greater awareness of the theory-ladenness of science, from observation through to theory choice, will contribute to this. Similarly, a balanced ethical approach to the use of psychiatric diagnostic labels is also essential: recall here, again, Elizabeth Orton's case from Dickenson and Fulford's (2000) 'In Two Minds' (above), in which, consistently with Reich's concern with the false beauties of diagnosis, the psychiatrist (it was the psychiatrist, note) felt that a *medical* understanding of her problem was *in*appropriate; but also the balancing case of Tom Benbow, in which a failure to use the medical model was abusive (case 3/2 in Dickenson and Fulford, 2000).

The devil, though, is in the detail, scientific and ethical. Better science, for Reich, means a psychiatric science that is closer to the paradigm of physical medicine—recall his references to the need for 'clear, physical criteria'. Reich sees these as providing greater 'objectivity' (his term quoted above), which, in turn, is the antidote required to stop our vision being shaped by theory. Better ethics, on the other hand, for Reich, means more moral fibre—strengthening the role of law, reinforcing ethical rules, and reducing the occasions of sin. As Reich puts it, in his concluding section, 'only the most stringent efforts on the part of psychiatrists, and the most serious attention on the part of their teachers, will keep them from yielding unknowingly to those beauties—indeed, will keep psychiatrists from failing to recognise that they even exist' (p. 218).

Reich's prognosis

Reich, as we have several times noted, is not alone in this negative formulation of the ethically-laden nature of psychiatric diagnosis. And the dangers, scientific and ethical, are indeed very real. But they are the dangers, to which we have returned many times, of a fact-only (or fact-centred) medical model. We can summarize these under prognosis (likely outcomes):

- *Scientific dangers*. The danger arising from psychiatry modelling itself on physical medicine is that it could actually hold back the development of psychiatric science (the paradigm of liver disease is not necessarily transferable to the brain, see Part III).
- *Ethical dangers*. Ethically, the danger of the (unreconstructed) medical model is, as we put it earlier, that it looks the wrong way. In looking solely to value-free science for psychiatric diagnostic theory, it fails to recognize that the ethical difficulties arise from its evaluative (ethical) rather than the descriptive (scientific) element in diagnosis. Aside from the inherently pejorative attitude to psychiatric science implied by this, it thus has the consequence that ethicists (lawyers, psychiatrists, and lay people) end up 'waiting for Godot', waiting for an illusory 'bodily medicine' of psychiatry that will, somehow, resolve the ethical (or more broadly, evaluative) problem of psychiatric diagnosis. While, in the meantime, all that ethicists and lawyers can do is to thump the ethical drum, exhorting psychiatrists to greater moral endeavours, hedging them around with ever more detailed rules, and subjecting them to ever more radical external regulations.

The ineffectiveness of the fact-centred medical model was evident, in the reading from Fulford *et al.*'s (1993) study of Soviet psychiatry (see the reading linked with Exercise 14 in Chapter 18). The key lesson of this study, as we saw in Chapter 18, is that Soviet psychiatry in general, and the work of Snezhnesky and others on schizophrenia in particular, was guided by a hard-line biological medical model, a model no different, other than in the extra hardness of their hard-line, from the medical model prevalent in the West—prevalent then, and, as we have suggested, prevalent now!

Adding values to science in psychiatric diagnosis

The lesson of Soviet psychiatry, then, is that a more hard-line 'scientific' approach to diagnosis in psychiatry, far from being a protective factor in relation to the abuse of psychiatric diagnostic concepts, may actually be a risk factor, a factor that increases rather than decreases the risks of abuse, a factor that makes the prognosis for psychiatric abuse *worse*.

Science as a factor making the prognosis worse?

The idea that science makes matters worse is counter-intuitive from the perspective of the traditional fact-only medical model, whether in biomedicine or (as in Reich's case) in bioethics. It is entirely consistent, though, with a fact + value model. For, as we have suggested in this chapter, and as Fulford *et al.* (1993) argue in their paper, the fact-only medical model excludes what is essential to an understanding of the abuse of psychiatric diagnosis, the evaluative element in the meaning of the medical concepts. The medical model is indeed 'looking the wrong way'. It is looking to the factual element in diagnosis when it should be looking to the evaluative element.

Why? Because, if everything we have said in this chapter and the last on diagnosis, and in earlier sections of the book both on concepts (Part I) and on psychiatric ethics in general (in Chapters 17 and 18), if all this is right, then the vulnerability of psychiatric diagnostic concepts to abuse arises, not from the (supposed) scientific weakness of psychiatry, nor from the (supposed) ethical weakness of its practitioners, but from a failure to recognize, and hence take seriously, the diversity of values in the areas of human experience and behaviour with which psychiatry, as a medical discipline, is concerned.

Ethics as a factor making the prognosis worse?

So far as the science side of Reich's treatment is concerned, then, there is evidence (as well as an a priori expectation) that a reliance on science, or science at least as conceived in the traditional fact-only medical model of diagnosis, could well make the prognosis for abuses of psychiatric diagnosis worse. What about the ethics side of Reich's treatment, though? What about stiffening up the ethical rules and regulations governing psychiatry? Surely, you may say, this couldn't be ethically counter-productive? Or could it?

EXERCISE 8 (5 minutes)

Can you think of any examples of bioethics being perceived as counter-productive by practitioners (i.e. any 'practitioner', whether as a professional or user, concerned with mental distress and disorder in practice)?

This is a brief 'brainstorm' exercise only! Think about psychiatry in general, not just diagnosis, and write down your answers.

Two examples of traditional bioethics being seen by many practitioners as increasingly counter productive, are confidentiality and research. These are both areas in which many practitioners, users and professionals, increasingly feel that ethicists, in demanding ever tighter regulation, have gone, as one of us has put it elsewhere, a 'rule too far' (Fulford, 2001). The 'rule too far' for Fulford is over confidentiality. The British psychiatrist, David Osborn, has made a similar point in relation to standards of consent in psychiatric research (Osborn, 1999).

What Fulford and Osborn both have in mind is partly a matter of the rules and regulations in question becoming, merely, impractical. The French bioethicist, Ann Fagot-Largeault, gives an example of this in connection with involuntary psychiatric treatment. French mental health law, as Fagot-Largeault describes, came late to the 'autonomy' party. But it then went to such lengths to protect patient autonomy that, as Fagot-Largeault puts it, patients 'escaped' before they could even be assessed (cited in Fulford and Hope, 1996).

But there is also a deeper reason why ethics, of the quasi-legal 'rules and regulation' variety, may be counter-productive, a reason connected with the diversity of human values, as to why we should be concerned about the growing hegemony in bioethics of rules and regulations, at least in psychiatry.

EXERCISE 9 (10 minutes)

Think about this 'deeper reason' for yourself before going on. What is it? The point we are after here follows from the fact that bioethics itself, at least to the extent that in practice it takes the form of rules and regulations, is driven by values.

This is one of those points that ought to be obvious but is not. We have asked you to think about it to bring out the fact that it is not obvious. The fact that it is not obvious is itself an important observation, important for all psychiatric ethics, not just diagnostic ethics.

No value-free ethics

To cut to the quick, then, the point (the 'obvious when you think about it' point) is that rules and regulations themselves *express particular values*. This is unproblematic in many areas of bodily medicine in which, as we have seen at several points in this book, the values guiding practice are widely agreed upon. This is one reason, then, why a 'rules and regulation' approach from traditional bioethics has been effective in bodily medicine. The rules and regulations in question express shared values.

But it is also the reason why we should be chary of the rules and regulation approach in psychiatry. For psychiatry, if what we have suggested in Part I of this book is right, lacks the value uniformity that is a necessary precondition for the rules and regulation approach to be effective practically. In psychiatry, values, far from being shared are characteristically diverse. Hence in psychiatry, the more tightly the rules are drawn, the more encompassing the regulations are made, the more abusive they will become. For in psychiatry, a rule or regulation expressing a *given* value, will necessarily be at variance with the very *different* values of many of those to whom the rule or regulation is intended to apply.

The paradox of unethical ethics

In psychiatry, then, there is a built-in mismatch between the 'rules and regulation' approach, dependent as it is on uniformity of values, and the diversity of values by which psychiatry is characterized.

In bodily medicine, to put the point metaphorically, what is sauce for the goose is (by and large) sauce for the gander. Whereas in psychiatry, to switch metaphors, one person's meat is (not uncommonly) another person's poison. Hence, to extend these metaphors, rules and regulations in attempting to specify and to enforce a particular set of values, may well be providing sauce for the goose and gander alike in bodily medicine (i.e. because the operative values are largely shared); however, in psychiatry, just in that a rule or regulation is providing meat for one person, it may well be providing poison for another (because in psychiatry our values are often *not* shared).

This apparently paradoxical result, of an ethically motivated approach being responsible for abusive outcomes, as noted immediately above, follows directly from the diversity of human values operative in psychiatry. But is it, really, so paradoxical? To explore this idea we will return to a consideration of bodily medicine.

EXERCISE 10 (10 minutes)

This is another thinking exercise! Can you think of examples, not necessarily in medicine, where ethically motivated actions have led to abusive outcomes?

With any examples you come up with, ask yourself 'why?', why did they have this result? And how does this help to explain why bioethics is increasingly being perceived in some contexts as being in certain respects counterproductive.

Ideology in ethics

The examples we have in mind are of ideologically motivated actions, political, religious, etc. Missionaries, of whatever persuasion, can do a great deal of good. But they can also do a great deal of harm: classic examples are the effects of Christian missionaries, particularly in the Victorian and Edwardian eras, on so-called 'primitive' cultures; think also about the Inquisition, and witch trials (see Chapter 7, History of Mental Disorder).

As to the 'why?' the common factor, surely, is blind conviction, the belief that one's own values, whether political or religious, are in some absolute sense, right. A degree of conviction is motivating, of course. But having the 'courage of your convictions' can all too easily slide into bigotry.

Faced with the legitimate diversity of human values, the fear, in respect of psychiatric ethics in general (Chapter 18), and in respect of psychiatric diagnosis in particular (earlier in this chapter), is of relativism. The fear, as we put it chapter 18, is that we will be precipitated into the 'maelstrom', at best subject to chaos, at worst paralysed by uncertainty. But the lesson of history, in medicine and psychiatry as in politics and religion, is that it is from absolutism, not relativism, that we have most to fear (Fulford 1998, 2000 and 2000c).

From good idea to bad ideology?

It is this lesson, too, that bioethics is at risk of forgetting. In the early days of bioethics, it was appropriate that a tough line was taken in facing down the dominant medical ideology of paternalism, of 'doctor knows best'. 'Doctor knows best' may have been an appropriate ideology when there was not much that doctors could do, for better or worse, other than to give hope through the reassurance of authority. But as technology advanced, especially in the middle years of the twentieth century, extending the range of resources available, and with it the possible goods and harms of different treatment choices, so the values of the patient became increasingly pertinent. Hence it was important that medical paternalism was increasingly balanced with patient autonomy. Bioethics, in its early days, helped to promote that balance. But what we are now faced with is an ideological over-reaction; bioethicists telling everyone else, patients and professionals alike, what to do. We are faced, in other words, with a new ideology, an ideology not of 'doctor knows best' but of 'ethicist knows best'.

It is not only in psychiatry that bioethics is perceived by many to be getting, as it were, too big for its boots. As we noted in Chapter 18, one of the first to point this out was the social scientist, Priscilla Alderson, from her work on the way children and parents were involved in consent issues in surgery: as she put it, patients increasingly find themselves 'doubly disenfranchised', originally by the expertise of the health-care professional, and now by the expertise of an increasingly professionalized bioethics (Alderson, 1990).

Ideology in diagnosis

This is one of the areas, then, in which psychiatry, through its intrinsic diversity of values, could lead the way in medicine. But what way should we go? How do we avoid the equal and opposite extremes of value relativism (anything goes) and value absolutism (what I say goes)?

One way to avoid these extremes, a way increasingly adopted by health-care professionals and users alike, is to 'get round the rules'. High profile cases regularly hit the headlines (e.g. the case in the UK of a woman denied a baby by AID from her dead husband by the Human Fertilization and Embryology Authority). But these cases are the tip of an iceberg of dissent. Social workers, for example, as the British forensic psychiatrist, Christopher Cordess (2001) notes, faced with what they see as rules on confidentiality that prevent them doing their job properly, put their job before the rules. Researchers, similarly, are increasingly rebelling against unrealistic regulations on consent (Osborn, 1999, see above). There is indeed a particularly urgent need for research ethics committees to become partners in promoting good research rather than seeing themselves primarily as protecting patients from bad research (Dickenson and Fulford, 2000, chapter 10).

The counterpart for psychiatric diagnosis of these negative ethical strategies, is adapting one's diagnostic assessment to the 'rules and regulations' defined by the categories in the official classifications. In countries (such as the USA) in which access to health care (for example through insurance) is dependent on a recognized diagnosis, this may be a positive counterpart of the negative abuses illustrated by the Soviet case. But is there a better way? It is to this question that we turn in the last session of this chapter.

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. How many of Reich's negative points about the 'beauties' of psychiatric diagnosis could be applied, appropriately modified but essentially unchanged, to diagnosis in bodily medicine?
2. What is Reich's 'diagnosis, aetiology and treatment' for the misuses of psychiatric diagnosis as guided by the Soviet experience?
3. Could stiffening up scientific standards make matters worse?
4. Could stiffening up ethical 'rules and regulation' make matters worse?

Session 4 Practical applications: values-based practice and psychiatric diagnosis

As we have seen, one important consequence of recognizing the diversity of human values in psychiatry, is the need for improved clinical skills. This is embodied in the model of Values-Based Practice (VBP) in two key principles (which in turn relate to the four skills areas and the 'alliance' model of service delivery (summarized in Box 18.1, Chapter 18). Thus, the two key principles are:

- *the patient's values*: to take seriously and to identify the values of each individual patient (Principle 4 of VBP)
- *the multidisciplinary team*: as providing a balance of values (Principle 5 of VBP).

To these we should add a third implication, namely, the need for:

- *an open society* as the basis of service delivery, national and international, in psychiatry, to ensure a dynamic of effective checks and balances.

We will now consider how these consequences work out in psychiatry in relation to diagnosis, (1) in clinical work, and then, (2) in research.

Values-based diagnosis in clinical work

The three consequences of taking the diversity of values in psychiatry seriously are self-evident enough, at least once they have been worked through (as in Chapter 18 and our earlier materials in Part I). Applying them to diagnosis, though, rather than to the better recognized ethical issues raised by treatment choice (the area of traditional bioethics, see Chapter 17), takes us into the 'blue skies' of new research and of work that is still (largely) waiting to be done. None the less, some general points, anticipating the results of this further research, can be made.

1. *Patient's values in psychiatric diagnosis*. If the values operative in psychiatry are diverse (if they vary from person to person, from culture to culture, and from time to time), and if values come into diagnosis, then it is clear that coming to an understanding of the values of individual patients should be part of the process of diagnostic assessment.

Asking about values

Easily said, not so easily done! For a start, there are generic practical difficulties, i.e. difficulties standing in the way of *any* advance in practice—vested interests, lack of resources, time pressures, and so forth.

But there are also difficulties specific to diagnosis. In the first place, there are difficulties of communication. It is one thing to recognize the principle of starting from an understanding of a patient's values in diagnosis. It is quite another to know how we should go about this in practice.

As with values in any other area, however, we have two main sources of information, the person concerned, and background knowledge and experience of similar people in similar situations.

EXERCISE 11 (20 minutes)

Think about the first of these sources of information, the person concerned. Write down a few questions that you might ask in exploring the values of, say, Simon (in Session 1 of the last chapter), in the context of a diagnostic assessment.

You don't have to be a health-care professional to do this! Write down your own ideas verbatim, i.e. the words you would actually use.

It is surprisingly difficult to ask people directly about their 'values'. We rarely do this, in fact, our values being implicit in and shaping everything we do and say. But here are a few suggestions…

- 'Sometimes with [experiences of this kind], as well as being frightened/anxious about it, people find it helpful in some ways. Are there any good/positive aspects to your experiences (as well as bad/negative aspects)?'
- 'Do you find that [your experiences] stop you doing things you want to do, or are they sometimes helpful to you?'
- 'Is [the experience] comforting or supportive in some ways?'
- 'Do you have any ideas about where [the experience] comes from?'

These are, though, just suggestions. This is an area in which there is no research evidence on which to base practice. Our suggestions may make sense; yours may make better sense. But there is as yet no body of evidence on the effectiveness of methods for assessing the evaluative aspects of diagnosis, comparable with the twentieth century evidence available on the effectiveness of methods for assessing the descriptive aspects of diagnosis. And as we saw in Part III (Chapter 13) the lesson of the research leading up to the development of such diagnostic 'tools' as the PSE (a structured interview schedule) and the ICD and DSM (modern classifications of mental disorder), is that the 'obvious' is often far from obvious. It required considerable research effort to establish which aspects of the descriptive elements in diagnosis were reliably identifiable; and this has left us with unresolved questions of validity, not to mention practical utility.

So, this is one area in which research is urgently needed. Exactly what form such research should take is itself an open question. We return to some early initiatives in this area in the next section.

Other sources of information about values

Clinically, however, we have to start somewhere, and in the absence of research on the evaluative aspects of diagnosis comparable with that available on its descriptive aspects, something along the lines suggested above might reasonably become part of routine diagnostic assessment.

Questions of value, furthermore, in the individual case, can now be backed up with a large and growing body of information on the values of users of services in general. We reviewed some of the sources of this information in Chapter 18. It includes official reports, social science research, epidemiological studies, and, above all, first-hand narrative accounts. Additional examples are given in the guide to further reading at the end of this chapter.

Problems with value differences

2. *The multiagency team and psychiatric diagnosis.* Individual patient's values, as we have seen, are important especially in psychiatric diagnosis, because of the inherent diversity of values relevant particularly to *psycho*pathology. There is an aspect, though, specifically of *psycho*pathology, which makes the diversity of values in psychiatry a two-edged sword, and particularly in diagnosis.

EXERCISE 12 (10 minutes)

What do you think we have in mind here? Think back to Chapters 17 and 18, in which we explored the aspects of involuntary psychiatric treatment which make it so uniquely difficult ethically.

A key difficulty turned on an aspect of psychopathology that is central to the categories of mental disorder most often involved in involuntary treatment. What aspect was this? And how does it connect through value diversity to the role (a new role, as we will see) for the multidisciplinary team?

The relevant aspect of psychopathology, in a word, is 'insight'—or rather, 'loss of insight'. Loss of insight as we saw in Chapter 3, is the defining feature of that range of psychotic symptoms—delusion, hallucination, and thought disorder—by which such central categories of mental disorder as schizophrenia, are defined.

It is the psychotic disorders, furthermore, as we found in Chapter 18, that are most often involved in involuntary psychiatric treatment. This is essentially because loss of insight involves a very radical disturbance of rationality in which the person concerned is taken to lose their ability to make autonomous choices. Much the same considerations, as we saw, lie behind the corresponding place of psychotic disorders as the central case of mental disorder as a legal excuse ('not guilty by reason of insanity').

Values and other diagnostic concepts

That easy formula, 'not guilty by reason of insanity', relies on a series of difficult concepts—rationality, capacity, responsibility—that we explored in Chapters 18 and 19, and all of which are central to psychiatric diagnosis. As we saw in Part I, values are necessary but not sufficient to define diagnostic and psychopathological concepts. A disease, illness, or disability, is not just a *bad* condition to be in (other things being equal), it is a bad condition in *the specifically medical sense of bad*, a sense different from, e.g. ugliness, wickedness, foolishness, etc.

It is important to remind ourselves of this periodically as many of the most difficult ethical issues in psychiatry turn not just on questions of value but on questions of the particular kind of value expressed by the medical concepts. With mental disorder as a legal excuse, for example, the issue is not (just) 'good or bad?', but '*mad* or bad?'; and in involuntary treatment (for depression, say), it is not (just) 'good or bad?' but '*mental disorder* or sad?' (see generally, Part I and earlier in this part).

That said, though, all these diagnostic concepts (rationality, capacity, etc.), in so far at least as they are part of psychiatric diagnosis, do involve questions of value. They are not *sufficiently*, but they are *necessarily in part*, defined by values. And the rub is this. Value diversity in psychiatry means that, above all in psychiatry, a key aspect of diagnostic assessment (loss of insight and its related set of concepts) will involve *conflict* of values. In the case of involuntary treatment, for example in Mr AB's case at the start of Chapter 17, the problem is precisely that the patient wants one thing and everyone else wants the opposite.

A balance of evaluative perspectives

So, what to do? Again, there is no magic formula. Good communication is a key, and it is increasingly recognized that with time and care, a stand-off can often be avoided. But there will always be cases where, when everything is understood, there are still irreconcilable differences.

Our options, when conflicts of values arise in diagnosis, are exactly as Dickenson and Fulford (2000) discuss for psychiatry and health care in general. What is required, Dickenson and Fulford argued, to limit the scope for abuses, is a *balance of evaluative perspectives*.

This is where, as Principle 5 of VBP emphasizes (see Box 18.1), a well functioning multiagency team may be helpful. In the traditional fact-only model, in which diagnosis is an exclusively scientific process reserved to doctors, the multiagency team provides a range of skills relevant to treatment. In a fact + value model, the multiagency team retains this role but takes on, in addition, a new role, to provide *a balance of evaluative perspectives in diagnostic assessment*.

The 'multiagency team', it is worth adding, should be broadly understood in this context. It should include, subject to issues of confidentiality, people from backgrounds that are similar to those of the person concerned. There is a growing recognition of the importance in psychiatry of a culture (and gender) de-centred approach to diagnosis, a key component of which is the balance of values provided by a well-functioning multi-agency team (Colombo *et al*., 2003a and b).

Values and the organization of psychiatry

3. *The 'open society' and psychiatric diagnosis.* With patient-centredness, then, and a balance of evaluative perspectives (combined, remember, with all the descriptive aspects of diagnosis emphasized in the traditional fact-only approach), are we out of the woods? Why, as Dickenson and Fulford (2000) suggest, do we need the third element, their 'open society'?

In a short but important chapter in Dickenson and Fulford (2000) J.L.T. (Jim) Birley, draws on a lifetime of experience of psychiatry in an international context. In particular, he was the founder President of the *Geneva Initiative for Psychiatry*, an organization set up by a Dutch social scientist, Robert van Voren, originally to oppose the abusive uses of psychiatry in the former USSR, and now to promote initiatives aimed at restoring clinical standards in post-Soviet psychiatry.

Dangers of consensus

Jim Birley's (2000) bottom line is that an 'open society' in psychiatry is necessary if we are to avoid the closed systems, institutional or political, in which abuses are so likely to arise. Translating this into terms of values, the 'open society' provides a dynamic of mutual checks and balances as the basis of what one of us has called elsewhere, "dissensus" (Fulford, 1998). It was the closed nature of a totalitarian society that, as we saw, allowed a political value system to become (largely unawares) dominant in psychiatric diagnostic assessment in the former Soviet Union. But there is the same danger at all levels in psychiatry, through national organizations, to local institutions, and of course, on into multiagency teams. (Note that in Simon's case (Exercise 1, chapter 20), his cultural peers did not endorse his experiences.)

At all levels, then, the danger is consensus, the hegemony of the values of the many over the values of the few or indeed the one. An 'open society' is not an absolute barrier to such abuses. But the lesson of history is that it is a necessary if not sufficient protection all the same.

Values-based diagnosis in research

In addition to the growing body of theoretical work on values in psychiatric classification and diagnosis, outlined in this and earlier parts of the book, a number of early initiatives have been taken in applied research. Central to applied research will be the development of research methods equal in reliability and validity to those developed in the twentieth century to support work on the descriptive elements in diagnosis (described in Part III). Just what reliability and validity mean in this context is itself a moot point. Thus, in Chapter 13 we discussed the relationship between reliability, validity, and the very idea of natural classification. While there are fairly agreed practical tests of reliability, there is disagreement and debate in the philosophy of science about how to assess the validity of a scientific taxonomy. This will again find an echo in the field of values.

Research methods

A research methods meeting in London in 2003, funded by a section of the Modernisastion Agency in the UK's National Health Service, the National Institute for Mental Health in England (NIMHE), brought together stakeholders, including users of services, with researchers (some of whom had been directly involved in the research on the descriptive aspects of diagnosis). Building on a wider meeting organized by John Sadler in 1997 in Dallas (Sadler, 2002), the London meeting focused directly on candidate methodologies for clinical and research work on the role of values in diagnostic assessment. Exemplars of such methods include:

1. phenomenology (Stanghellini, 2000, 2004)
2. formal survey methods (Schwartz, in press)
3. semistructured interviews (Tan *et al.*, 2003)
4. surveys (Jackson, 1997)
5. combined linguistic-analytic and social science methods (Fulford and Colombo, 2004)
6. hermeneutics (Widdershoven and Widdershoren-Heerding, 2003)
7. discursive analysis (Sabat and Harré, 1997; Sabat, 2001).

The London meeting established an informal network of researchers and stakeholders and agreed a 'platform statement' for research in this area (reproduced in Fulford, 2005).

In addition to the work of individual members of the network (see Reading Guide), ongoing research on values in psychiatric diagnosis has included a further NIMHE-funded meeting on values in the diagnostic assessment of decision-making capacity, drama-based approaches to improving cross-cultural understanding, extensions of the combined philosophical and social science work on models of disorder, educational research, and an initial appraisal of a new interview schedule for general clinical use.

A research agenda

Besides research directly on the evaluative element in psychiatric diagnosis, balancing earlier work on the descriptive element, what other lines of research are opened up by the recognition of the diversity of values in psychiatric diagnostic concepts?

The research agenda opened up by the recognition of values in psychiatric diagnosis is discussed in the final section of Jackson and Fulford's article in *Philosophy, Psychiatry, & Psychology* (1997). This is the article in which Simon's story (set out earlier in this part) was first described, and it includes other similar cases.

A wide research agenda

In the final section of their paper, then, Jackson and Fulford (1997) look briefly at the research agenda opened up by cases like Simon's. The essential point for future research made by Jackson and Fulford, is that once the place of values in psychiatric diagnosis is recognized, *values themselves become a key variable*. In many areas of bodily medicine, the values 'variable' is for practical purposes a constant (i.e. because, and to the extent that, the human values operative in bodily medicine are shared values). But wherever values are diverse they become a variable in the research design, and in some cases a key variable. Jackson and Fulford's list of research areas in which values may be a key variable includes

- psychopathology
- epidemiology
- cognitive-behavioural therapy
- neuroscience

From the point of view of research, neuroscience illustrates the 'values is a key variable' point particularly clearly. Brain imaging research that fails to distinguish people like Simon from people with schizophrenia (because they both have psychotic experiences) conflates two very different syndromes. Such research is also missing a methodological trick, namely the opportunity to compare psychotic experiences as they arise in normal as well as in pathological contexts.

Cognitive-behavioural therapy is particularly interesting clinically as the basis of a 'cognitive problem solving' model of psychotic experience. According to this model, psychotic experience as such is not pathological. As in Simon's case, and others described by Jackson and Fulford, it may be a mechanism for *resolving* problems. This mechanism can go wrong, of course, and where it goes seriously wrong, psychotic experience (like any other kind of experience) may be pathological. But the cognitive problem-solving approach aims to move people from the pathological to the adaptive end of this spectrum. And the point for diagnosis, is that exactly how a given individual's psychotic experience develops may be critically determined by how people react to it on first presentation. Some people are indeed ill (and on this model, they may indeed be helped by neuroleptics and other medical treatment). But an *assumption* of pathology, as the fact-only medical model requires, may be, as Reich argues above (see his 'beauties' of diagnosis), a self-fulfilling prophecy.

Futures perfect and imperfect in psychiatric diagnosis

Persuasive as the arguments, theoretical and practical, might be for recognizing the importance of values in psychiatric diagnosis, it is important to recognize how radical a departure this is from the traditional fact-only medical model.

Future imperfect

Richard Bentall, a professor of psychology, brought this point home to psychiatry a few years ago with an article provocatively titled 'A proposal to classify happiness as a disease' (1992).

EXERCISE 13 (15 minutes)

Read the two extracts from this short article:

Bentall, R.P. (1992). A proposal to classify happiness as a psychiatric disorder. *Journal of Medical Ethics*, 18: 94–98

Link with Reading 21.3

Bentall writes in the great tradition of the psychiatry/ antipsychiatry debate. But what do you make of his concluding point about the implications of values in psychiatric classifications?

Bentall wrote this article as a dig at psychiatry. In fact, it caused quite a stir (it made the National Press!) and the *British Journal of Psychiatry* published a number of commentaries on it. What is eye-catching about it (besides being very well written) is the central claim that happiness should be a disease. Of course, mania is pathological happiness. But what Bentall claims is that by the criteria of medical psychiatry, happiness *as such*, no less than depression, should be classified as a disease.

His point then is the antipsychiatry point from Part I, that the scientific criteria adopted by medical psychiatry (including evolutionary criteria, as in Kendell's (1975) pro-psychiatry position, are incapable of distinguishing happiness (normal, everyday happiness) from disease. The point that he *could* have made is the linguistic-analytic point that, if these criteria fail to mark this distinction, it must be marked by something else ('must' in the sense that the distinction is there, it is part of the 'logical geography' of ordinary usage, and hence has to be explained or explained away; it can't simply be denied—see generally, Part I on ordinary language philosophy). If the distinction is not marked by facts, then, why not by values? This indeed is the burden of Bentall's concluding comment that '. . . only a psychopathology that openly *declares* the relevance of values to classification could persist in *excluding* happiness from the psychiatric disorders.' (p. 97, emphases added).

The implication of Bentall's concluding point is that psychiatric diagnostic classification is either absurd (because making happiness a disease) or unscientific (because value-laden). Behind his ingenious arguments, then, is the 'medical' model, an exclusively 'scientific' model of genuinely *medical* disorder, which, as we found in Part I, was behind both Szasz (as representing antipsychiatry) and Kendell (representing pro-psychiatry).

But if values are the relevant criterion for distinguishing between non-pathological happiness and happiness as a disease, this has the further consequence that happiness could, after all, be a disease! This is essentially because of the open-endedness of the possibilities (logical possibilities) for evaluation. Recall from Chapter 6, that non-reductive theories of the relationship between fact and value (description and evaluation) allow the possibility (the logical though not the psychological possibility) that anything may be evaluated positively or negatively. Hence, just as homosexuality, partly in response to changes in social values, has disappeared from DSM, so it is possible that it could once again, in the future, reappear! This is repugnant to *us*. But that reflects *our* values. And if homosexuality can reappear in DSM, why not heterosexuality too. And, by extension, happiness.

Future imperfect in the UK

These examples may seem fanciful. But there was an example of the risk of just such a shift in the boundary between medicine and morals in a recent proposal by the UK government to make psychiatrists responsible for people perceived to be dangerous. An early draft of this proposal was framed in such a way as to risk making dangerousness *per se* a disease (Department of Health, 2002). This was not the intention of the proposals and it is not the effect of subsequent draft legislaion (Department of Health, 2002). But there were many parallels between the 2002 proposals and the Soviet case—a 'no nonsense' medical-scientific model, and an

over-riding political value (to protect the public from dangerous 'psychopaths'). Like the Soviet case, too, it was well-intentioned. There *is* a real need for public protection in some cases. But pathologizing dangerous behaviour carries all the potential for abuse that pathologizing political dissent had in the USSR.

Planning for dissensus

The boundary between mental disorder and mental difference, then, as we found in Part I, is variable. And it is variable partly because human values are variable. The way to avoid abusive misdiagnosis, then, is not to deny this variability but to acknowledge its origin and to establish processes, both in the evolution of psychiatric diagnostic concepts and in day-to-day clinical diagnostic practice, which seek as far as possible to track and to respond to the values involved.

The 'mistake', then, to return to Radden's (1994) term in the first exercise in this chapter, was not the original inclusion of homosexuality in DSM, nor indeed its subsequent removal. The mistake is not, as such, to include or exclude this or that category. The mistake is the failure to recognize the diversity of human values and their relevance to the validity of a given diagnostic category in a given (personal and social) context. Rather than seeking to exclude values, therefore, our response, as we have several times noted, should be to improve the processes—the clinical skills and forms of service delivery—which will support what might be called in the language of VBP, dissensual diagnosis, an approach that combines meticulous attention to the facts with a balanced approach to the diagnostic values relevant in individual cases.

Future perfect?

The idea that values are present in medical diagnosis, and substantively so in psychiatric diagnosis, is, from the perspective of the traditional medical model, radical—*dangerously* radical, some may think! (See, for example Robert Spitzer's (2005) carefully argued concerns: as the chair of the DSM-III Taskforce, Spitzer was a key figure in the twentieth century scientific development of psychiatric classification—see chapter 13). Yet the incorporation of an explicitly evaluative element into psychiatric diagnosis would not, as such, alter it radically. There are other reasons for thinking that future classifications of mental disorders might look rather different from our current ICD and DSM. But these have to do with other conceptually problematic elements of psychiatric diagnosis (capacity and rationality, as noted above; see also Fulford, 1989, chapters 4 and 9). But the incorporation of values as such would leave our classifications in many respects more or less unchanged.

EXERCISE 14 (20 minutes)

This is a short two-part exercise.

1. Go back to Box 20.2 in Chapter 20, the summary diagnostic criteria for schizophrenia in DSM. Try rewriting these criteria to make the evaluative element fully explicit.
2. Then look at the extract from Fulford's (2002a) futuristic 'Report to the Chair of the DSM-VI Task Force'.

The figure in the extract from Fulford's article is an imaginary version (in a future DSM-VI) of the diagnostic criteria in Box 20.2 in Chapter 20 (from the current DSM-IV). Two key points to note are,

1. *Descriptive*: the DSM-VI criteria are identical to those in DSM-IV in so far as the criteria are descriptive. This emphasizes the fact that there is nothing 'antiscience' in a fact + value view. Everything that is genuinely factual remains intact and indeed is clarified.
2. *Evaluative*: the (imaginary) changes in the DSM-VI criteria are in the 'value added' component of the fact + value view. The DSM-VI criteria spell out explicitly what is implicit in DSM-IV, that value judgements are involved in applying Criterion B. The summary box also includes indications of possible steps involved in a diagnostic process leading to a balanced judgement on the relevant values.

Fulford's article (2002a) is of course largely an exercise in futurology. As we have noted, much of the research programme implied by the recognition of the place of values in diagnosis is waiting to be done. By casting his article in this form, however, Fulford sought to emphasise that such research, far from being dangerously radical, would be in important respects no more than a twenty-first century continuation of the development of psychiatry in the twentieth century.

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. What three principles of values-based practice are particularly important for psychiatric diagnosis in clinical practice; and why?
2. What further principles are important in research contexts; and why?
3. In what areas of research are values-based (as well as evidence-based) approaches relevant?
4. In what way would the criteria in classifications like the ICD and DSM differ in a values-based as well as evidence-based classification?

Session 5 Conclusions: values-based diagnostic assessment and user empowerment

This chapter has been something of a Star Trek expedition. We have set out 'to boldly go' into new territory about the role of values in psychiatric diagnosis. This is above all an area, as we

have several times emphasized, in which there is no settled view, no party line.

An ongoing debate

Nor, if everything we have looked at in earlier chapters is right, should there be a settled view. In the debate about the concept of mental disorder (of which the questions explored in this chapter are a part), there is mature opinion on both sides, both for and against the view that values are ineliminable. These views reflect, consciously or unconsciously, deep lines of research both in philosophical value theory (the 'is-ought' debate, about the logical relationship between description and evaluation, see Chapters 4 and 6) and in the philosophy of science (the debate about the relationship between normatively based understanding in the social sciences and the subsumption under natural laws exemplified in the natural science: the space of reasons versus the realm of law as described in Chapter 15). These debates, in turn, as debates in the philosophy of psychiatry, are but the latest manifestations of a tension running through the history of psychiatry, between medical and moral interpretations of mental disorder, going back over 2000 years (see Chapter 7).

The role of philosophy

We should not have expected 'answers', then, in the sense of conclusions to which everyone of 'good sense' will subscribe. This is an area in which, rather, the role of philosophy is, as we put it in Chapter 6, to avoid premature closure. The role of philosophy is to say 'hang on a minute', to prevent us settling for wrong answers, answers that, although easy to understand and comfortable to cling to, are, at best, incomplete: the extremes of the psychiatry versus antipsychiatry debate, we argued in Chapter 6, offered answers of this kind—out and out assimilations of mental disorders respectively to bodily disorders on the one hand, or to morals on the other.

Two caveats

Two points, though, made in earlier chapters, bear repetition. They amount to final caveats:

> *Caveat 1: value added not science substracted*. The model of mental health practice guiding this book is of an enriched health-care discipline in which values are added to facts (or more formally, evaluations to descriptions) rather than values ousting facts (or vice versa). There is nothing in this 'full-field' view, as we called it in Chapter 6, which is antiscience.

True, our model of science may have to be more sophisticated if it is to incorporate evaluation alongside description. But that is because human beings are a more complex 'object of study' than, say, plants or rocks. Hence as we said at the end of Chapter 6, everything that is genuinely descriptive in psychiatry is no less important in a 'full-field' view than in the traditional medical model.

There is a sense indeed in which the descriptive element is even more important in a full-field model. For as we saw in Part I, and again in Part III, in a full-field model, the descriptive criteria for mental disorders serve two roles. In a full-field model, descriptions, (1) define particular conditions, and (2) serve as criteria for the value judgements involved in taking a given condition to be a *bad* condition, a *dis*order.

> *Caveat 2: user empowerment not practical paralysis*. The danger with 'value added', as perceived within a traditional fact-only model of diagnosis, is 'relativism', replacing the certainties of science with the paralysis of uncertainty in the minds of professionals. In a fact + value model, by contrast, 'value-added' brings with it empowerment of those on the receiving end of diagnosis, those who use rather than provide services.

Concerns about relativism, as we have seen, although understandable enough, reflect a mistaken view of the way values work in practice (see above, Chapter 4, R.M. Hare's work); and in psychiatry, at any rate, the greater danger is not relativism but absolutism (see above with regard to the USSR). So far as diagnostic agreement is concerned, bringing values explicitly into the frame could well increase the scope for agreement. At the very least, bringing the 'user's' values explicitly into the frame brings him or her back to centre stage in diagnosis as the defining step in the clinical encounter.

Having a say in how your problems are understood

Dr V.Y. Allison-Bolger, a consultant psychiatrist in England with wide experience of the psychopathology of psychotic conditions, has made this key point about user empowerment in values-based diagnosis by analogy with the move in traditional bioethics from paternalism to autonomy.

> 'In bioethics', she has pointed out, 'we have got used to the idea of users of services 'having a say' in how they are treated. We call this patient autonomy. Recognizing the importance of values in diagnosis means that, as professionals, we have got to get used to the idea of users of services 'having a say' also in how their problems are understood.'
>
> Allison-Bolger (personal communication)

Reading guide

Values in diagnosis: (2) The philosophy literature

A valuable edited collection covering most of the key conceptual issues in psychiatric diagnosis and classification is the American psychiatrist and philosopher, John Sadler et al's (1994) *Philosophical Perspectives on Psychiatric Diagnostic Classification*. Edited jointly with two leading figures in the early years of the new philosophy of psychiatry, the psychiatrist Michael Schwartz and the philosopher Osborne Wiggins, this book was published to coincide with the appearance of DSM-IV. It has a foreword by Allen Frances, the Chair of the DSM-IV task force. Sadler has subsequently published two major books specifically on values in psychiatric diagnosis: (1) an edited collection, including contributions from users of services and

carers as well as clinicians, philosophers and neuroscientists, *Descriptions and Prescriptions* (Sadler, 2002), and (2) an extended monograph with detailed studies of the values impacting on each of the main classes of psychiatric disorder *Values and Psychiatric Diagnosis* (Sadler, 2004).

The potential impact of Fulford's (1989 and 1994) analytic and Sadler's substantive work on the form and content of future editions of psychiatric classification such as the ICD and DSM is explored in Fulford's (2002a) futuristic *Report to the Chair of the DSM-VI Task Force*, and (2002b) *Executive Summary*. The role of users of services and families in the development of these classifications is argued for in Sadler and Fulford, 2004. A discussion of the issues from widely different viewpoints has been presented in *World Psychiatry*—see Fulford *et al.* (2005). 'Looking with both eyes open: fact *and* value in psychiatric diagnosis?' with commentaries by Sadler, First, Wakefield, Spitzer, Sartorius, Banzato and Pereira, Mezzich, Tan, Kitamura, Van Staden and King (all 2005).

As detailed in Part I, Fulford (1989), draws on linguistic-analytic philosophy to show how values help to define diagnostic concepts in all areas of medicine, but are especially important practically in psychiatry because of the diversity of human values in the areas of experience and behaviour with which psychiatry is concerned. The possible relevance of this diverity to the diagnosis of bipolar disorder is noted by Goodwin, 2002.

Articles on the importance of values in all areas of psychopathology appear regularly in the international journal, *Philosophy, Psychiatry, & Psychology*. Besides Jackson and Fulford (as above, chapter 20), examples include Kopelman (1994) 'Normal grief: Good or bad? Health or disease?'; Moore *et al.* (1994) 'Mild mania and well-being'; Sadler (1996) 'Epistemic value commitments in the debate over categorical vs. dimensional personality diagnosis'; Sadler and Agich (1995) on 'Diseases, Functions, Values, and Psychiatric Classifications', with a reply by Wakefield (1995).

Values-based practice: (2) Resources

Resources to support VBP are now well developed through a number of initiatives in the UK and internationally in policy, training and research.

Policy

The National Framework for Values-Based Practice (reproduced in 18.2, chapter 18) has been developed by the National Institute for Mental Health in England (NIMHE) to support policy, training, and research within the UK Government's policies for mental health as defined by the National Service Framework for Mental Health (Department of Health, 1999). As a policy implementation body, the NIMHE Values Framework reflects early recognition of the need for a new user-led approach to service development. It has implications for a number of workstreams, including 'experts by experience' (user-led service developments), recovery practice, spirituality, social inclusion, and black and minority ethnic initiatives. The NIMHE Values Framework is available at www.connects.org.uk/conferences. (See also, Woodbridge and Fulford, 2004a; and Department of Health, 2004).

A detailed discussion paper exploring some of the key issues about values for the Experts by Experience programme, one of the work programmes of the NIMHE, is Wallcraft (2003) *Values in Mental Health—the role of experts by experience* (available at www.connects.org.uk/conferences). Jan Wallcraft is the NIMHE's National Fellow for 'Experts by Experience'. The links between VBP and recovery are described in Allott *et al.* (2002) 'Discovering hope for recovery.' (Special issue of the *Canadian Journal of Community Mental Health*). The role of VBP in providing links between policy and user-led service developments are explored in Williamson (2004) 'Commentary "Can Two Wrongs Make a Right?" ' (*Philosophy, Psychiatry, & Psychology*).

Training

There are two sources of VBP training in the UK

- A training manual for Values-Based Practice, 'Whose values?', developed jointly by the Sainsbury Centre for Mental Health in London and the Department of Philosophy and the Medical School at Warwick University (Woodbridge and Fulford, 2004b). It was launched by Rosie Winterton, Minister of State in the Department of Health with responsibility for mental health, at a conference in London in July 2004.
- A detailed manual developed by the West Midlands Mental Health Partnership to support training in values for mental health and to provide an informal audit tool to monitor their implementation, is West Midlands Mental Health Partnership is *Values in Action: developing a values based practice in mental health* (West Midlands Mental Health Partnership, 2003.)

These resources will support a UK training initiative in the generic skills required for working in mental health, the Ten Essential Shared Capabilities (10 ESCs, see Department of Health (2004b). The 10 ESCs are built on values-based and evidence-based sources aimed at developing the skills-base for the new roles and ways of working for professionals (Department of Health, 2004c) that are required to support the National Workforce strategy (Department of Health, 2004a).

Papers describing early work on the development of training methods for VBP include:

1. Fulford *et al.* (2002) 'Values-Added Practice (a Values-Awareness Workshop)'. This paper describes the first of the series of training workshops that Kim Woodbridge, Toby Williamson, and Bill Fulford developed and on which the workbook is based.

2. Woodbridge and Fulford (2003) 'Good practice? Values-based practice in mental health'. This paper covers similar material to reading 5 but in the form of an interactive workshop suitable for self-study.
3. Woodbridge, and Fulford (2004) 'Right, wrong and respect.' (*Mental Health Today*).

There is a large social science literature on values and value diversity. A classic textbook exploring the impact of diversity in a wide variety of health-care settings, including cross-cultural perspectives on the human life cycle, the social effects of medical technology, and cultural aspects of pain, stress, physical disability, and impairment, is Helman (2000) *Culture, Health and Illness: an introduction for health professionals*, (4th edn). A resource of literature and patient narratives illustrating the importance of differences of values in all areas of health care, is Fulford et al., (2002) 'Introduction. Many voices: human values in health care ethics (in ed. Fulford, Dickenson, and Murray, *Healthcare Ethics and Human Values: an introductory text with readings and case studies*).

Sessions on VBP are included in a number of training programmes, for example those run by the Sainsbury Centre for Mental Health (see website below); in Piers Allott's Masters Programme in Recovery at Wolverhampton University in the UK; in the medical school programmes at Pretoria Medical School, South Africa and Warwick Medical School, UK; and at workshops organized by the philosophy and Humanities and Psychopathology Section of the WPA and AEP, and the Philosophy Special Interest Group in the Royal College of Psychiatrists.

Research

As described in the text, work in the analytic philosophical tradition on values in psychiatric diagnosis is relatively recent. There is, however, a rich tradition of phenomenological scholarship in this area. A recent exemplar, in English, is Giovanni Stanghellini's (2004) exploration, drawing on extensive clinical experience, of values in the experience of people with schizophrenia.

Recent empirical work on values and value diversity specifically in relation to classification and psychiatric diagnosis, includes the Oxford psychiatrist, Jacinta Tan's studies of the assessment of decision-making capacity in anorexia nervosa (Tan *et al.*, 2003) 'Anorexia nervosa and personal identity: The accounts of patients and their parents.' Juan Mezzich's proposals (Mezzich, 2002; and Mezzich *et al.*, 2003) for an idiographic classification, to stand alongside current symptom-based classification, noted in chapter 13, accommodates personal values as a key aspect of the individuality of responses to mental distress and disorder.

Colombo *et al.*'s (2003a) work on models of disorder, in 'Evaluating the influence of implicit models of mental disorder on processes of shared decision making within community-based multidisciplinary teams', gives the results of work combining philosophical-analytic and empirical social science methods to elicit implicit models (values and beliefs) of mental disorder. As described in Part I, the groups studied—psychiatrists, approved social workers, community psychiatric nurses, people who use services and informal carers—all had very different implicit models. Colombo *et al.*'s (2003b) 'Model behaviour' gives the main findings from the study and describes its importance for user-centred practice. (*Openmind* is the journal of one of the main voluntary sector mental health advocacy groups in the UK.) Fulford and Colombo (2004) 'Six models of mental disorder: a study combining linguistic-analytic and empirical methods' discuss the methodological implications of combining philosophical-analytic and empirical social science methods.

The NIMHE-funded conferences described in the text are available at the Mental Health Foundation website (see below). The proceedings from John Sadler's foundational conference in 1997 in Dallas are the basis of Sadler's (2002) (ed.) *Descriptions & Prescriptions: Values, Mental Disorders, and the DSMs*. Updates on developments in this area include Fulford's 2002a and b, 2005. The issues are discussed in a Forum Issue of *World Psychiatry* based around a target article by Fulford, Broome, Stanghellini, and Thornton (2005) on 'Looking with both eyes open' with responses from a range of perspectives expressing widely different views about the merits or otherwise of recognizing a role for values in psychiatric diagnosis.

Web-based resources

- A good starting point is the Mental Health Foundation Website, http://www.connects.org.uk. This website hosts two on-line standing conferences, including extensive discussions by users and carers, of values in psychiatric diagnosis and in the assessment of decision-making capacity.
- http://wwwnimhe.org.uk The National Institute for Mental Health England. As noted above, NIMHE is responsible for mental health policy implementation in the UK. The website includes information regarding implementation guides and mental health policy. Search on "values" for all relevant entries.
- http://www.doh.gov.uk/mentalhealth/implementationguide.htm gives an extract on the values underpinning the Mental Health National Service Framework.
- http://www.scmh.org.uk This website for the Sainsbury Centre for mental Health, which spearheaded with Warwick

University the development of VBP training materials, see above. This gives much useful information in general about practice and policy issues. The training workbook in Values-Based Practice, 'Whose Values?' (Woodbridge and Fulford, 2004b) can be ordered on-line from this site.

- http://www.warwick.ac.uk *and* http://www2.warwick.ac.uk/fac/med, are the websites, respectively, for The University of Warwick, with links to the Philosophy Department, and for the Warwick Medical School, SCMH's partners in the development of VBP training materials.
- http://www.skillsforhealth.org.uk The Health Functional Map and other curriculum support tools published by Skills for Health.

Other useful websites includes

- http://www.basw.co.uk/article.php?articleId = 2&page = 6 Sets out the values and principles of social work.
- http://www.nice.org.uk The National Institute for Clinical Excellence (NICE). Schizophrenia guidelines and other information.
- http://www.nmc-uk.org This gives the code of professional conduct for nursing and midwifery in the UK.
- http://www.rcpsych.ac.uk/publications/cr/council/cr83.pdf Sets out the duties of a doctor registered with the General Medical Council, the professional body responsible for the regulation of medical practice in the UK.
- http://www.scie.org.uk Social Care Institute for Excellence. SCIE is the equivalent for social care of the NICE for health care. The website includes information on social models of care and other general social care information.

International initiatives can be viewed through: (1) the World Psychiatric Association website: see especially, the Home Pages for the Philosophy and Humanities and the History sections, the *WPA Bulletin* for announcements, and the on-line version of the journal, *World Psychiatry*; and (2) the website for the International Network for Philosophy and Psychiatry (http://www.inpponline.org), for conferences, national, and subject-based groups, and information about publishing and training opportunities.

Information about relevant books in the Oxford University Press series, International Perspectives in the Philosophy of Psychiatry is available at http://www.oup.co.uk, and for articles in *Philosophy, Psychiatry, & Psychology* see the on-line resources at Project Muse in the Johns Hopkins University Press website at http://muse.jhu.edu.

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