Chapter 9

Psychiatry, objectivity, and realism about value

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9.1 Introductory Remarks

When the editors of this volume asked us to supply a chapter outlining a "perspective" on psychiatric validation, they invited us to consider two questions:

1. How does your perspective compare and contrast with the other existing views/models of validation?
2. What are the prospects that your model can contribute to a single model of validation adopted by the whole field?

While the argument we go on to develop provides an answer, of sorts, to these questions, it is probably not the answer the editors were wanting or expecting. Indeed, it is an answer that might initially strike readers as bizarre, as it challenges certain pervasive background assumptions that, we argue, need to be revised before we can begin to make progress in this area. It is, if you like, the "groundwork" that needs to be done before we can attempt to give a sensible answer to the question of what is the right "model" of psychiatric validation.

We sketch the outline of an approach to validation, but it is one that converts questions about psychiatric validation into questions of a primarily moral nature, and our concluding comments make reference to the sort of epistemic and ethical virtues we need to develop via the education of practitioners, rather than suggestions for the development of formal guidelines, criteria, and unified processes. This is because we think that, before psychiatry can progress, we need to understand fully the underlying conceptual problems that led to what is sometimes termed the "crisis" in psychiatry (Loughlin et al. 2013b). Underlying assumptions, by no means exclusive to psychiatry, about the relationship between science and value generated quite specific problems for this area of practice. For psychiatry to defend and develop its intellectual framework we need to bring these assumptions out in the open, subject them to critical scrutiny, and, we argue, reject them.

So, in answer to question 2, we are precisely as far away from having a "single model" as we are from having a broad consensus on the nature of the human

good. But we can begin to defend different conceptions of the human good and use them as the basis for diagnosis—a diagnosis will be valid *contingent upon* the assumption of a normative framework, which will require defense in terms of moral arguments. In reply to question 1, what we offer here is more of a meta-perspective, a view on what is necessary for any model if it is to have a hope of being valid. We are not in a position to deliver the final word on any of the important practical issues other contributors to this volume discuss, but hope more modestly to "contribute" to the debate by providing a method for examining assumptions, reframing problems where necessary in an area that is going to remain extremely controversial for the foreseeable future.

9.2 **Don't Start Here**

There is a joke English tourists sometimes tell about asking directions in certain parts of Ireland. Supposedly, when you ask how to get from some remote place to a local landmark or vantage point, people will tell you, "Well, you don't start from here." Now, if that really is all the locals are prepared to say, then it is, arguably, a little unhelpful, but if followed by instructions on how to retrace one's steps, to get back to a place where it will be easier to get clear directions, then it may be the best, most practical advice it is reasonable to expect in the context.

Certainly, when it comes to matters more complex than the quest to find and photograph the Holy Stone of Clonrichert, there are questions to which the warning not to start from here is the best response that one can give (Loughlin 2007). In this chapter, we will argue that a cluster of questions surrounding the issue of psychiatric validation fall into this category, including how to classify mental disorders, and how to explain the relationship between mental and physical health and illness so as to be able to diagnose and care for the mental health needs of one's fellow human beings. Before we can give a full, satisfying, and truthful answer to these questions, we need to retrace the intellectual steps that led some astute contemporary thinkers to regard the very idea of "mental illness" with suspicion.

Questions about the scientific validity of psychiatric diagnosis derive their meaning and impetus from specific conceptions of science, value, and reality. It is possible to identify these conceptions and their origins in our intellectual history, and to examine the intellectual framework of which they form component parts. We propose that, instead of working within that framework, in this case what is needed is a revision of the framework itself—a redrawing of the conceptual map to describe different relationships between value, reality, and science. Sometimes, to solve particular problems, or even (more modestly) to discover a perspective upon the problems which enables us to view their solution as attainable, we need to accept that some fundamental feature of the way we see the world is wrong. In such cases, we do not need to gather further empirical

evidence, nor do we need a more astute analysis of that evidence, but rather we need a *philosophical* shift: a revision in the way the evidence is conceptualized or "framed" (Loughlin et al. 2010). Such a shift can change our views regarding what counts as evidence in the first place, and what methods of analyzing that evidence are appropriate. It will require us to step back from the current debate, to remind ourselves how we got to where we are now, and how certain dichotomies became part of our standard academic lexicon.

The feature of our contemporary world-view that stands in the way of progress, in the discussion of health care generally but most significantly in the discussion of mental health and illness, is a presupposition we will express as subjectivism with respect to value, or simply value-subjectivism. This presupposition is implicit in popular accounts of the key features distinguishing scientific analysis on the one hand, from moral judgment on the other (Loughlin 2013a), and it gives rise to what some authors characterize as "the myth of moral neutrality" in psychiatric diagnosis (Hamilton 2013) and in science in general (Loughlin 1998). Though it by no means originates in the modern era, today's pervasive subjectivism about value owes a good deal of its intuitive plausibility to the currently dominant and (in a sense we'll explain) characteristically "modern" view of the world and our place within it. Before we can arrive at a proper methodology in psychiatry, we must jettison those features of our conceptual framework that require authors either to deny the irreducibly moral nature of psychiatric diagnosis or to reject psychiatry as scientifically unsound.

Thus, we submit this chapter as a contribution to the philosophy of psychiatry, in that it does not represent a proof that subjectivism with respect to value is false (although, for independent reasons we think it is false), but it does tell us that we must believe this philosophical position to be false if we believe that psychiatric diagnosis can, in principle, be valid.

9.3 How We Got Here

Powerful criticisms articulated by exponents of the anti-psychiatry movement in the latter half of the twentieth century (Szasz 1960; Cooper 1967; Foucault 1987) led to what some authors have described as a "crisis" in psychiatry, one "sufficiently serious to jeopardize the constitution of psychiatry as a medical discipline" (Loughlin et al. 2013b: 418). While these arguments are well known, it is worth reminding ourselves that the key problem for characterizing psychiatric diagnosis as a valid branch of medicine was, for Szasz, the specific relationship between "the context of value" and the diagnosis of "mental illness":

> The concept of illness, whether bodily or mental, implies *deviation from some clearly defined norm*. In the case of physical illness, the norm is the structural and functional

> integrity of the human body . . . The norm from which deviation is measured whenever one speaks of a mental illness is a *psycho-social and ethical one*." (Szasz 1960: 114, emphasis in original)

While Szasz clearly recognizes that "the practice of medicine is intimately tied to ethics" (1960: 115), he maintains that psychiatry is "very much more intimately tied to problems of ethics than is medicine" (1960: 116) and attempts to capture the essential difference between each discipline's relationship with value by noting that, "although the *desirability* of physical health, as such, is an ethical value, what health *is* can be stated in anatomical and physiological terms" (1960: 114).

The point seems to be that while we cannot practice medicine in a way that is "free of ethical value" (and interestingly, we cannot do medical research without similarly becoming embroiled in "many ethical considerations and judgments" (Szasz 1960: 115)), we can at least explain the ontology of physical health in value-neutral terms, because "what health *is*" can be stated in terms of the language of anatomy and physiology. So, Szasz says:

> The notion of mental symptom is therefore inextricably tied to the *social* (including *ethical*) *context* in which it is made in much the same way as the notion of bodily symptom is tied to an *anatomical* and *genetic context* (1960: 114), [and] whereas bodily disease refers to public, physicochemical occurrences, the notion of mental illness is used to codify relatively more private, sociopsychological happenings of which the observer (diagnostician) forms a part. (1960: 116)

How is it that the observer "forms a part" when mental illness is being diagnosed, but not so when the illness being diagnosed is physical? There is an implied ontological distinction here: "bodily disease" is a "public" entity. The language of "public occurrences" suggests things that can be observed from any perspective, whatever the observer's private beliefs and values. In contrast, the identification of a mental illness requires engaging with norms of an "ethical" nature, which are, by implication, subject-dependent, being social constructs or subjective reactions to the reality observed. Having characterized the relevant norms as "ethical," Szasz feels this leads directly to the question (1960: 115): "Who defines the norms . . .?" swiftly giving rise to the follow-up question: "Whose agent is the psychiatrist?" Questions of agency and subjectivity are raised by the presence of ethical norms in a way that they are not immediately raised by diagnosis in (genuine) medical science, where what the thing observed "is" can be classified as a "bodily disease".

According to Szasz, the realization that the psychiatrist "does not stand *apart* from what he observes" but is already committed to a picture of the world that includes ethical norms "stands in opposition to a currently prevalent claim, according to which mental illness is just as 'real' and 'objective' as bodily illness"

(1960: 116). Szasz instantly qualifies this point by admitting some confusion as to exactly what is meant by such words as "real" and "objective," but he says he suspects "that what is intended by the proponents of this view is to create the idea in the popular mind that mental illness is some sort of disease entity, like an infection or a malignancy" (1960: 116).

We have quoted Szasz at some length here because it is important to establish that, for this leading figure in the anti-psychiatry movement, problems for the "objectivity" and "reality" of mental illness are closely related to the requirement for value-judgments (where the values in question are moral, or as Szasz prefers, "ethical"[1]) in the process of their diagnosis. While it is assumed that the "desirability" of physical health is an ethical matter, the ontology of disease is not: diseases are real "entities," and this means they can be identified without recourse to value-judgment. It would seem, then, that only that which is "objective" in this sense can be "real," though because Szasz expresses himself via speculation on what those he is criticizing might mean, we must be cautious about ascribing a clear thesis to him on this point. However, the idea that there is a close conceptual connection between objectivity and reality, and that both of them lie on the other side of a conceptual divide from "ethical value," does at least seem to be in influence.

So the extensive disputes in the contemporary philosophy of mind, about the relationship between specific mental states and brain states, while of great importance in their own right, do not in any immediate or obvious way impact on this particular problem. Even if we accept a strict identity theory, reducing any given mental state to some particular brain state, it will not follow that mental disorders are reducible to brain disorders, as what is at issue is the type of "norm" relevant to the diagnosis of the disorder—and as Szasz noted, that norm remains a moral one (Banner 2013).

The area in which to seek a solution, then, would appear to be ethics, or what is sometimes categorized as "meta-ethics," as it concerns the status of moral thinking and its relationship with other species of human thought. Human beings make value-judgments all the time, but is the making of a value-judgment a rational activity or some sort of alternative to rational thinking? Are "values" subjective reactions to the world, or is the making of certain value-commitments (or "evaluative perception") a prerequisite for understanding aspects of the world we encounter as they really are? (McDowell 1998; Dancy 2004).

In the decades following the publication of Szasz's arguments, authors such as Fulford (1989) convincingly argued that, even if we accept that psychiatric diagnosis is value-laden, this does not imply that the process is invalid, because there are reasons to believe that *all* medical diagnosis is value-laden. Fulford

(amongst many others) has been accused of employing something called "the likeness argument" (Pickering 2003, 2006) in inferring that because mental illness is relevantly similar to physical illness, and because we cannot plausibly give up on the concept of physical illness, we must conclude that mental illness is at least as "real" as physical illness. While the "likeness argument" is not, in our view, a fallacy (Loughlin 2003), we maintain that we need to go further than Fulford seems prepared to go. Giving a full defense of the intellectual legitimacy of diagnosis in both medicine and psychiatry entails adopting a view we will express as *realism with respect to value*.

This should not, we must note, be read as implying that by adopting this view we somehow render disputes about value less controversial, but simply that where there are controversies they are *bona fide* controversies, not expressions of "subjective opinion" disguised as substantive claims. Claims about value are contentious but *truth-apt*: the aim of such debates is to discover the truth. Value-judgments, we contend, can be genuinely true, or genuinely false. When a practitioner is making up her mind about whether a person has, or does not have, condition X, she is making a judgment that is value-laden. But she is also making up her mind about a real question, not simply bringing to bear her own "subjective feelings" on the matter. The ability of diagnosis in medicine and psychiatry to be genuinely correct or incorrect is conceptually tied to the status of the value-judgments underlying diagnosis: only if those judgments are truth-apt can it even be possible, in principle, for a diagnosis to be correct (or indeed, incorrect). Value-realism is a necessary presupposition of valid medical and psychiatric practice.

9.4 Science, Value, and Scientism

It follows that, to vindicate the necessary presuppositions of psychiatric diagnosis, we must believe two claims which, to many modern readers, may appear in tension if not outright contradiction. The first claim is that psychiatric diagnosis is inherently value-laden. The attempt to categorize a person's mental state as more or less healthy, or to consider a person as suffering from a mental illness or indeed as mentally healthy, logically presupposes taking up an evaluative stance, asserting certain normative statements to be the case, and this presupposes some normative framework. That is to say, when we describe someone as in good or poor mental health, or as suffering from a mental illness, we commit ourselves logically to a value-laden position, to the view that there are ways that people *should be* and ways that they *should not be*. Any attempt to reduce or eliminate the evaluative aspect of diagnosis must, therefore, fail. Diagnosis of mental health, and indeed diagnosis of health in general, is not a value-neutral

project. The normative judgments or claims involved are not reducible to statistical or other empirical claims.[2]

The second claim is that psychiatric diagnosis is an objective process in the specific sense that a diagnosis can be correct or incorrect. Claims about the mental health of persons are truth-apt: they can be true or false in the same way the claims about a person's weight can be true or false. Those who claim that *because* psychiatric diagnosis is a value-laden process it is therefore "subjective" or "relative" (such as those critics of psychiatry who claim that it is the unscientific imposition of arbitrary value-judgments upon human behavior) are mistaken. Psychiatric diagnosis can indeed be wrong, but this is because it can also be right. Wrong diagnoses can be extremely harmful, but even this judgment presupposes that claims about what is good or bad for persons are objective, in the sense that they are truth-apt.

Each of these claims might strike many readers as plausible in its own right. As Thornton (2011: 989) notes, "[t]o an unprejudiced eye, both the general concept of illness and specific instances of illnesses simply look to be evaluative," and claims that the "norms" in health are merely empirical and statistical just seem wrong because

> there is more to pathology in general than what is unusual . . . . Illness is *bad* for us. So unless there is a way to explain away that apparently evaluative or normative aspect of illness, there is good reason to believe appearances . . . . Merely statistical analyses of what is usual and unusual do not seem to capture the fact that high intelligence is in itself a good thing and low intelligence is a bad thing.

Trying to make something like the badness of borderline intellectual functioning objective by hand-waving in the direction of "value-free" evolutionary advantage doesn't help here. For instance, the relationship between having above average intelligence (by definition deviating from the statistical norm) and having more descendants than those with merely average intelligence, or indeed the just plain stupid, is by no means factually established.[3] However, citing Wakefield (1999), Thornton concedes that "[m]ore sophisticated attempts to use the notion of biological function have had the more modest aim of explaining away evaluative notions from the concept of *disorder*, rather than illness or disease, conceding that the latter notions also contain the ineliminable notion of harm"; but he notes that even with regard to that modest aim, "it is far from clear that the notion of failure of function presupposed explains away, rather than smuggling in, normative notions."

Although the attempt to make the badness of maladaptive behaviors value-free fails, such badness is not therefore merely a matter of opinion, if that means we cannot be right or wrong about what is bad or harmful to us. We aim to bring up our children to make sound judgments about what is and is not harmful, and to avoid harm because we want them to live well. Outside the

context of academic debate no serious person disputes the claim that it is possible to make correct and incorrect judgments about what is harmful to oneself (Loughlin 2002: 226–8).

Why, then, do we claim that many modern readers might find a tension or even contradiction between these two, independently plausible claims regarding the value-laden nature of diagnosis and its objectivity? Both the first and second claims can be true if, and only if, a specific philosophical view about the nature of value is correct. This is the view that normative claims, about what should be the case, can be true or false, just as empirical claims, about what is or is not the case, can be true or false. The process of diagnosis, to be possible and valid, presupposes a specific position in philosophical ethics, which we characterize as realism with respect to value.

The problem is that our uses of language, including the terms "objectivity," "subjectivity," "rationality," "science," and "value," are heavily influenced by a specific picture of the world and our place within it, which we have elsewhere characterized as "scientism" (Miles 2009; Miles and Loughlin 2011; Loughlin et al. 2013a). Scientism is sometimes equated with science, but this is a mistake. Scientism is not a scientific thesis but a philosophical thesis about the nature of science and "the relationship between science and either the truth, knowledge or reality" (Loughlin et al. 2013a: 131). So scientism can be understood as the view that science, *and only science*, "reveals the truth, such that all true claims are part of a true scientific theory, or are reducible to claims of this sort" (Loughlin et al. 2013a: 132). Scientism is distinguished from an alternative philosophical position called "scientific realism," which is the more modest view that the posits of true scientific theories are real. While the scientific realist believes that science reveals genuine aspects of reality, the believer in scientism goes further, asserting that science reveals the *essence* of reality, such that only the posits of true scientific theories are real, and all else must either be reducible to the posits of true scientific theories or consigned to the realm of fiction (Loughlin et al. 2013a: 135).

The influence of scientism explains why the quest to distinguish science from non-science became a major preoccupation of twentieth-century philosophy (Loughlin et al. 2013a: 132). If science, and only science, can reveal the nature of reality, then it becomes imperative to discover criteria distinguishing genuine science from non-science. According to the assumptions of scientism, disciplines that wish to be taken seriously as vehicles for the discovery of truth about the world are required to establish their scientific credentials or to be dismissed.

We have given numerous examples elsewhere of the pervasive influence of this particular world-view on popular debate and practice within a range of academic and professional areas (Miles 2009; Loughlin et al. 2013a). For our present purposes, the most significant implication concerns the relationship between

"objectivity" and "value." Scientism espouses what Nagel (1986: 91) called "an epistemological criterion of reality," defining what is real as that which is discoverable by science. The combination of this philosophical view with its account of the nature of science renders the idea of "objective value" a contradiction in terms:

> Descartes is often credited as one of the finest exponents of the "modern" world view. Writing at the dawn of the scientific age, he famously divided reality into two realms, the "inner" or "subjective" and the "outer" or "objective" realms. The external world was characterised in terms of the language of the emerging, physical sciences. The importance of quantification to the emerging sciences is fundamental to understanding Descartes' conception of the "external world". External reality is, by definition, something we can measure. In contrast, "phenomena" are internal, subjective properties dependent for existence on a perceiving subject. (Loughlin et al. 2013a: 137)

Thus modern thinkers see an absolute dichotomy between the subjective and the objective, with all properties assigned to one side of this divide or the other. Later versions of scientism turned on the "subjective" side, insisting on its denial or reduction to the objective side—hence the increasing tendency to equate the "objective" with (a) the properties of the "external world" (taken to be, exclusively, the measurable entities or properties posited by mechanistic science) and (b) claims that can be true or false (truth-apt).

By repeated association under the same term, based on the *assumption* that they are co-extensive, these two (logically distinct) senses of "objective" (publically observable and truth-apt) are effectively treated as equivalent. Eventually, the idea that all value-judgments are "subjective" acquires an almost self-evident status, as though it "just follows" from the meanings of "ordinary language" terms like "objective" and "true" (Loughlin et al. 2013a: 140). While the claim that Harry is 6ft tall refers to properties we can measure, the claim that Harry is a good person does not, so only the former claim is treated as truth-apt. If my criteria for calling someone a good person differ radically from yours, all that can be said is that we use the term in different ways, and there is no question that either usage (or associated criteria) can really be right or wrong: hence the modern dogma that all value-judgments are "mere expressions of opinion or preference."

Once this particular division between the subjective and the objective has been posited, a number of philosophical problems come into being. "Human beings are rendered inherently problematic entities as they seem to straddle both realms and have properties (such as cognition and choice) that are not easily assigned to either one realm or the other" (Loughlin et al. 2013a: 137).

Medicine is thereby rendered problematic, psychiatry even more so. Both concern the human good, so are deemed subjective. A natural inclination is to

rescue these disciplines by showing that the value-judgments they embody can be reduced to properly "scientific"—meaning value-neutral—properties and concepts. But this is a mistake. Scientism allowed human beings to focus on the measurable aspects of the world and this focus undoubtedly gave rise to massive intellectual and social progress as a direct consequence. But it would be hasty to conclude that, because a particular way of viewing the world gave rise to intellectual progress, it is therefore the conclusion of the intellectual evolution of the species: "We should be sceptical of the idea that intellectual history came to an end, that the definitive and final world view was discovered at just about the point that we arrived on the scene" (Loughlin et al. 2013a: 136).

The time to revise an underlying philosophy or conceptual framework is, precisely, when it ceases to facilitate progress and seems instead to be standing in its way.[4] Scientism's failure to accommodate the value-laden and "humanistic" aspects of clinical practice (Miles 2009) is a reason to revise this conceptual framework.

As we noted earlier, the employment by Fulford and others of what Pickering (2003) termed "the likeness argument" in support of the reality of mental illness need not be viewed as a fallacy, even though we concede that it does not, in itself, logically establish the conclusion that mental illnesses are real. The analogy with medicine serves to illustrate an important point. We would indeed have to give up far too much to maintain the absolute dichotomy between science and value presupposed by the framework of scientism. To maintain an absolute divide between our evaluative and "human" capacities on the one hand, and "objectivity" on the other, would make practice not only in psychiatry but in general medicine impossible. However extensive its empirical knowledge base, a robot could not be a good medical practitioner, unless we found a way to program it in addition with a sound normative framework, giving it the ability to make human value judgments (Gelhaus 2011).

It follows that, if "objectivity" means "value-neutrality," then it is a capacity of no use to, and in fact destructive of, good practice. To know the world it is necessary to be *engaged* with it, such that if "objectivity" excluded engagement it would have little or no epistemic value (McDowell 1998; Loughlin 1998). When we use "objectivity" to denote something positive, something worth having, we mean something like, the ability to see the world from perspectives other than one's own, or the ability to weigh arguments and reach a balanced conclusion. An objective person is not someone bereft of emotion, detached from and indifferent to the suffering of others (again, if it is a capacity we want practitioners of any sort to have), but rather it is someone with the mental discipline to find the level and manner of emotional engagement appropriate to respond compassionately and helpfully to the problem at hand (Marcum 2011).

Of course, such accounts of objectivity are value-laden, but to *complain* that such an account is evaluative is still to be caught up in the dichotomous framework which, we suggest, needs revising at this stage in our intellectual history, if debates about good practice are to move forward.

9.5 **Reclassifying Psychiatry**

Having retraced the intellectual steps that led to what some called the "crisis" in psychiatry, we have arrived at the conclusion that the discipline must abandon all pretentions to value-neutrality, and reject value-subjectivism in favor of value-realism. Psychiatry is a discipline whose essential purpose is concerned with promoting the human good. The fact that this project is value-laden is not the problem. What we need in order to explain the reality of mental health and illness is a less restrictive conception of reality.

The problem is philosophical: the influence of scientism and the idea that "objective reality" consists only of that which is detectable and measurable according to certain methods. Only when we make that idea explicit, identify it as the problem, and reject it, can we move forward and start to talk about the sort of value-judgments that unavoidably inform diagnosis, and discuss their rationale with reference to a defensible conception of the human good. That's the point to which we must return, before we can recommence our journey to validate our notions of mental health and illness. The debate we need to have is within the field of ethics. Ethics is not a side issue but conceptually central to psychiatry.

This does not mean that we must abandon science, but instead we must move beyond the idea that there is an absolute dichotomy or incompatibility between science and morality. Scientific thinking, like all human thinking, takes place in the context of living a human life, and engaging with the world in ways that require the making of value-judgments. Psychiatry and other disciplines devoted to improving people's mental health are moral disciplines, and it is the modern misunderstanding of that truth—the sense that it is worrying or problematic—that calls out for explanation.

We noted earlier that Fulford would not join us in defending value-realism, and his own thoughts on the issue nicely illustrate this modern reaction. Commenting on three responses to his own work on "Values-based practice" (Brecher 2011, Hutchinson 2011, and Thornton 2011), he asserts that:

> there are clear hints of totalitarian leanings (understood as commitment to pre-set "good outcomes") in all three commentators' positions: Brecher's apparent endorsement of "moral objectivism", . . . Hutchinson's advocacy of *Eudemonia* as "*the* Good Life" (p. 1001, emphasis added but Hutchinson's capitalization), and Thornton's moral particularism . . . all suggest authoritarianism. (Fulford 2013: 539)

According to Fulford, the problem with Brecher's moral objectivism (he is a Kantian), Hutchinson's commitment to Aristotelian ethics (as evidenced by his usage of "the Good Life"), and Thornton's moral particularism would seem to be, simply, that they are all versions of what we have called realism with respect to value. The very fact that these authors, in their very different ways, think that moral judgments are truth-apt, is a sign, for Fulford, that they are "authoritarians" with "totalitarian leanings." How does this follow?

Fulford notes that "authoritarianism in the guise of totalitarian psychiatry" was "the basis of some of the worst abuses of medical practice in the twentieth century" (2013: 539). Referencing the treatment of political dissidents in the Soviet Union, he adds that: "Similar though less endemic forms of abuse have been driven in all areas of psychiatry by this or that authority imposing its own particular vision of what is right" (2013: 539).

To be accurate, he should also note that the views about "what is right" here have by no means been restricted to views about what is *morally* right or wrong. Nor have the oppressors consistently used psychiatry as their rationale or mechanism of imposition. People have been deprived of their autonomy and dignity for disagreeing with the approved viewpoint on almost any matter, by those wielding political power, throughout recorded history. Religion and genetics have similarly been abused to vindicate violence, persecution, and even the attempted eradication of whole castes deemed decadent or inferior.

Those of us who espouse the value-realism Fulford apparently deems symptomatic of "authoritarianism" are in a position to regard these abuses as genuinely *wrong*—in contrast to the value-subjectivist, who must regard these things as wrong only from a given perspective, such that "the holocaust was just the Nazi's way of doing things" (Clark 1988). We can only have a rational basis for condemning totalitarianism if value-subjectivism is false, so any argument moving from the evident wickedness of totalitarianism to a rejection of value-realism looks at risk of pulling the inferential rug from under itself (Loughlin 2002: 206–21).

So what is Fulford's argument here? He does seem to move from the observation that these authors hold the view that moral judgments are truth-apt, to the implication that they are somehow (logically?) committed to approving of practices that he rightly regards as reprehensible. Because Brecher, Hutchinson, and Thornton think that evaluative questions can have right answers, can we infer that they are more likely to imprison you for disagreeing with them than someone who thinks that all moral questions are fundamentally arbitrary? Is someone heavily influenced by Nietzsche's work on moral nihilism (for instance, a 1930s fascist) far less likely to imprison those who oppose his political agendas than a Kantian moral objectivist like Brecher? We assume this is not what Fulford is saying, as it is clearly false.

People have been imprisoned and tortured for believing that the Earth orbits the sun, rather than vice versa. Is the conclusion to be inferred from this abuse of power that the issue in question cannot be an objective one, that the question of which object orbits which is just a matter of opinion? Instead of rejecting the idea that the question has a right answer, we should instead conclude that the use of violence, repression, and torture is not the correct way to settle controversial questions, because that way of settling such questions is rationally invalid and morally wrong. I do not prove that you are wrong about any matter, scientific or moral, by locking you up. Indeed, the desire to lock up dissidents may betray a lack of rational arguments on the matter at hand.

Fulford's equation of "totalitarian leanings" with "a commitment to pre-set 'good outcomes' "[5] (in psychiatry and in medical practice more generally) suggests a different reading of his argument. We take it as read that he is not claiming that his opponents are committed to a view about which outcomes are good, prior to considering the arguments and evidence relevant to any specific case. If so, then he would surely be knocking down a straw man, and doing a great disservice to his three correspondents. If he is simply saying that totalitarians claim, incorrectly, that by repression they will improve the lives of the people they repress, then surely the problem is that this claim is typically *false*. Self-determination is a component of the human good. While we cannot rule out in principle the possibility that some psychiatric patients, given their specific problems and circumstances, will need to be restrained for their own good, the burden of proof should always be on those advocating such extreme measures to argue that, in this specific instance, such an extraordinary decision is the right one. The fact that totalitarians have claimed, falsely, to be restraining people for their own good when, in fact, the restraint simply served the totalitarian's own political agenda, does mean we should look at all such arguments with a *particularly* skeptical eye.

Despite struggling to find a valid reading of his argument, we think that Fulford's worries (about treating psychiatry as fundamentally a discipline dedicated to promoting the good) will be shared by many modern readers, and not because either Fulford or those readers are misguided. One clear intellectual advance brought about by the attack on the objectivity of value-judgments was a greater skepticism, a greater caution regarding pronouncing on matters of right and wrong.

Taken to the logical extreme of value-subjectivism, such an attitude becomes self-defeating, as if there really is no right answer to a question, then it strictly doesn't matter which answer you give, as none is better than any other. In that case, the caution inspired by a degree of skepticism disappears. Caution (as a mean between the extremes of unreflective certainty and paralyzing self-doubt) is the

virtue that makes us aware of our own fallibility. So the skepticism about making value-judgments regarding the lives and behavior of others, evident in the work of thinkers including both Szasz and Fulford, expresses a healthy attitude, and one that needs to be cultivated in the education of practitioners in many fields, including psychiatry. That said, contrary to the views of both of these authors, the correct theory explaining *why* this attitude is healthy is that the more practitioners possess the virtue of caution, the more likely we are to have genuinely good outcomes, and the less likely we are to have outcomes that are genuinely harmful.

The cautious attitude may be at work in Fulford's apparent (and mistaken) belief that Hutchinson's use of the definite article and capitalization in characterizing "the Good Life" is a "clear hint" of an "authoritarian" mind-set. Fulford is of course well aware that this use of terminology reflects Hutchinson's commitment to Aristotelian virtue ethics, but Fulford draws attention to Hutchinson's talk of "the" Good Life (as opposed, one assumes, to "a" range of possible good lives) because Fulford is also acutely aware that psychiatry has often helped repress difference, to regard diversion from the norms of belief and action in one's own society as a sign of "madness" (Fulford 2013: 539).

This is an easy mistake to make if one fails to make the distinctions noted in the passages cited in Thornton's article between statistical and normative conceptions of "the norm." The statistical norm—knowledge of "what people usually do around here"—is rarely a good indicator of what normative stance we ought to take up with regard to the behavior in question. There are notorious examples, such as the classification of homosexuality as a mental illness in our not too distant history, to demonstrate the fallacy of moving from empirical observations of the statistical norm to patently evaluative conclusions about the status of such "abnormal" behavior, in the absence of any independent moral argument that there is anything genuinely wrong or harmful about the behavior to be "corrected." A rudimentary education in meta-ethics should be sufficient to expose the fallacy here—the same one that would lead us to attempt to "correct" those with above average intelligence to make them more stupid, so as to "help" them achieve the statistical norm.

The correct point to conclude from this, we think, is not that psychiatrists and others should be taught to think of diagnosis as value-neutral (which it never is), but rather that they need the sort of education, in critical moral thinking, that will enable them to realize why such evaluations are fallacious, and more broadly will enable them to practice well in a professional context that requires them to confront irreducibly evaluative questions. A minimal requirement for an acceptable education of this sort would be that it should make them powerfully aware that the conventions in one's own society are not immune from criticism. Ryan (2011) has argued that the education of social workers should emphasize the critical skill

of knowing when they must challenge, rather than enforce, social norms. As there is no point denying that their behavior will have some value-base, it is worth enabling them to think rationally about that value-base, to become the autonomous and virtuous professionals that we need them to be. Similar arguments seem to us to apply to the education of psychiatrists.

To evoke Aristotelian virtue ethics in defense of the repression of diversity in society would, of course, be to employ a "bastardized" version of virtue ethics, and not one to which Hutchinson has ever subscribed. People have a wide range of different skills, interests, qualities, and preferences, and allowing a diversity of lifestyles is the best way to facilitate human flourishing—just as allowing diverse opinions to be openly debated facilitates social progress. Such diversity benefits, rather than harms, the community, allowing new ideas to be considered so that intellectual and social progress remain real possibilities, allowing diverse skills and insights to contribute to the meeting of the community's needs, and generally making life for its members a good deal more interesting. Thinking that talk of "the Good Life" implies believing in one, homogenous vision of how to live well, so ruling out diversity, is like thinking that because someone refers to "the Ocean" he can only see a flat surface, and is unaware of all of the different eddies, currents, and waves that the mass of water necessarily embodies. Virtue ethics as a commitment to promoting the human good (and the value-realism it presupposes) no more requires calling in the "totalitarian psychiatrist" to stamp out diversity of thought and action within society, than calling a mass of water "the Ocean" implies calling in King Canute to command it to be still. Similarly, the versions of value-realism presupposed by Brecher and Thornton provide no valid defense of the totalitarian psychiatry Fulford rightly abhors. Properly understood, they provide ways of validating Fulford's underlying intuition that this is the wrong way to practice psychiatry. [6]

9.6 **Conclusion**

The debate about the values that should inform psychiatric practice has always been a moral one, and if freed from the shackles of scientism it could be debated unapologetically in these terms. All judgments—in science, in morality, in any aspect of human life—are "subjective" in the trivial sense that they require a subject, but not in the sense that they are "merely" subjective reactions to the world, such that they cannot be truth-apt.

To fully validate our claims in psychiatric and indeed in general medical diagnosis, we need to discuss and defend our value-judgments about health and illness. We must reject scientism for an openly value-laden account of human functioning. Medical epistemology (including the epistemology

of mental illness) requires value-realism. The contentious nature of the value-judgments in the case of mental illness should not mislead us into concluding they are "subjective" or "relative."

Are some value-judgments better than others? We contend that this is manifestly the case, and that it is the modern skepticism of that assertion that represents the real intellectual puzzle. Such skepticism can be vindicated not as a thesis but (at least partially) as an attitude that informs the mind-set of a virtuous practitioner. We need an approach to the education of practitioners, in psychiatry and in other areas of medicine, that cultivates the crucial virtue of caution with respect to judgments that can have a profound effect on people's lives. This involves recognizing the diversity of lifestyles that can represent human flourishing, while being open to the possibility that some lifestyles are genuinely harmful.

Ethics is not a subsidiary component of psychiatry but is conceptually central to the subject. It is not as though one can study the epistemology of psychiatry and then, as a separate task, discuss its ethics, as the latter forms an inseparable part of the former: taking up an evaluative stance toward the nature of psychiatric disorders is an essential component of understanding what a psychiatric disorder *is*. Education in the mental health professions should encourage cautious, critical reflection on the value-judgments about health and illness that inform diagnosis, and discussion of their rationale with reference to their underlying conception of the human good. As we have by no means arrived at the end of intellectual history or moral evolution, discussion of the correct way to characterize the human good is ongoing. But any defensible conceptions of mental health, any efforts to categorize mental illness and to diagnose it in practice, must be framed with reference to a conception of the human good, so the more serious thought we put into this fundamental ethical project, the better for all of us—those who practice and those they treat.

Notes

1. Some authors may feel there is an important distinction between "moral" and "ethical," but we have never been able to work out what precisely it is (cf. Loughlin 2002: 27–31).
2. Given a sufficiently broad conception of "experience"—for instance that embraced by Husserl (1970)—we could arguably include the normative within the "empirical," treating evaluative perception as part of our experience. But we are using the term here in a sense more akin to that of the British empiricists: normative claims do not count as "empirical" in the sense intended by Ayer (1987).
3. Anyone who believes there to be a systematic, necessary link between high intelligence and having many children is invited to watch the American comedy *Idiocracy*.
4. Arguably, Aristotelian attacks on pre-Socratic atomism represented progress in their time, but they rightly did not preclude the reintroduction of atomistic thinking at a later stage in human history (Loughlin et al. 2013a: 142).

5. The insistence on putting terms like "good outcomes" in inverted commas, even when not directly quoting, may suggest the background belief that no outcomes are *really* good or bad—it's just that some people say/think of things as good and bad, as part of their subjective reaction to the world.
6. In fairness to Fulford, we should point out that we have only focused on his specific claims about the belief in "good outcomes" and "authoritarianism," and his use of the examples he cites from psychiatry. He makes these claims in the context of a discussion of Values-based Practice (VBP). While we do not think this invalidates anything we have said, he would no doubt want us to say a lot about his distinction between "good outcome" and "right process" to do justice to that broader debate. For a discussion of VBP's relationship to value-subjectivism, see Cassidy (2013).

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