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‘DISORDER’ AND ITS EVALUATIVE IMPLICATIONS FOR PSYCHIATRY

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Abstract

The proper definition of the concept of ‘disorder’ could resolve the existing issues in psychiatry today. Christopher Boorse and R.E. Kendell, as proponents of the medical model, aim at defining the concept in scientific and value-free terms. K.W.M. Fulford develops the fact-plus-value model which integrates the factual and evaluative elements. John Z. Sadler applies the Fulfordian account to diagnostic manuals to resolve their inconsistencies. I find Fulford’s initial and later arguments incongruent. His account is also too evaluative given the absence of any restrictions on the place and role of values. Furthermore, it is relatively easy to conclude that given the prominent position of values, facts need not exist as they are essentially evaluative terms with merely an overt factual connotation. Moreover, values provide the benchmark against which facts are assessed (for their degree of value-ladenness) and identified; and this makes facts dependent on and a subclass of values.

Dedication

To my parents, Abolghasem Ashouri and Nahid Sepehri.

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I have been very fortunate to meet and work under supervision of my outstanding advisors. They not only provided me with the much needed instruction and advice, but they also believed in my capacity and encouraged me from the beginning to the very end. They inspired me all along.

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Chapter 1: Introduction

One of the most fundamental questions in the domain of philosophy of psychiatry is concerning the definition of the concept of 'disorder' and its synonymously-used counterparts, 'dysfunction', 'disease', and 'illness'. What is a 'disorder' and what exactly distinguishes it from these other terms? The answer has been provided by an array of theories, the most notable of which are offered by the 'medical' and the 'fact-plus-value' models. In what follows, I will briefly introduce views of the two camps and then provide a short summary of my position on the topic. This chapter will end with an overview of the forthcoming chapters.

As a proponent of the medical model, Christopher Boorse defends the idea of defining 'disorder' in factual and value-free terms. To this end, he proposes distinguishing between the two senses of 'health', one in opposition to 'disease' and the other to 'illness'. For him, the former represents the 'theoretical' and the latter, the "practical or mixed ethical"[1] sense of the term in question. Boorse rejects the credibility of the concept of 'health' in practical terms since it depends upon the norms and moral evaluations at play in the contexts considered. The 'theoretical' concept, on the other hand, enjoys a scientific basis rooted in biology and is equally applicable to organisms of all species. In view of its solid basis and broader range of applicability, Boorse classifies 'illnesses' as a subclass of 'diseases'.[2]

He considers the state of normality as being assessable on the basis of its correspondence to the natural condition of an organism. Subsequently, 'health' can be determined in view of the degree of conformity of functioning to the 'species-specific natural

[1]Christopher Boorse, "On the Distinction between Disease and Illness," *Philosophy and Public Affairs* 5, no.1 (Autumn 1975): 56.
[2] Ibid., 57-58.

design'. Hence, the 'natural function' of a species is its "standard causal contribution"[3] to the pursuit of a goal by an organism. The ultimate goal of any given species is promotion of survival and reproduction. Physiological functions can subsequently be defined as specific factors that contribute to fulfillment of these goals.[4] Consequently, 'diseases' are defined as interruptions in and interferences with at least one particular function of a given species.[5]

Furthermore, he argues that 'health' is to be evaluated on the basis of proper functioning of an organism's parts. The function of a part is defined as its "causal contribution to empirically given goals"[6]. Given that the goals and their manner of pursuit can be identified independently of all value-considerations, he claims that a part's 'function' and 'goals' must be defined in 'value-free' terms.[7] Accordingly, Boorse proposes an 'evolutionary' account of 'disorder' by pointing to its role in reducing 'survival and reproductive' capacities. By referring to this reduction and through usage of the notion of 'evolutionary dysfunction', he offers a value-free definition of 'disorder' as 'functional incapacity' – or in his own words – as "deficiencies in the functional efficiency of the body"[8].[9]

For Boorse, 'illnesses' have a negative connotation built into them. Given the evaluative nature of 'illnesses', he specifies three conditions that must be fulfilled by 'diseases' in order to qualify as 'illnesses'. Generally, they must be incapacitating-enough to: first, be undesirable for the afflicted; second, entitle one to "special treatment"[10]; and third,

[3] Christopher Boorse, "On the Distinction between Disease and Illness," *Philosophy and Public Affairs* 5, no.1 (Autumn 1975): 57.
[4] Ibid.
[5] Ibid., 58.
[6] Ibid.
[7] Ibid.
[8] Ibid., 59.
[9] Ibid., 58-59.
[10] Ibid., 66.

provide the afflicted with a 'valid excuse' for their 'normally criticisable' behavior.[11] Boorse holds that while these conditions must be 'automatically' applied to "serious physical diseases" [12], they are especially inapplicable to 'serious mental diseases' (other than psychoses and neurosis).[13]

R.E. Kendell supports the authenticity of 'mental illnesses'. His model (which can be viewed as a modified version of Boorse's) argues against the possibility of developing a clear definition of the term.[14] Briefly put, he mentions several definitions, from 'a condition that requires treatment' to 'lesions with some structural damage'. He argues that each of these definitions is subject to inevitable and intolerable consequences and on that basis must be rejected. For the sake of brevity, I will only focus on the more relevant argument, that of the statistical concept of disease.[15]

Cohen initially defined the concept of disease in statistical (but vague) terms as "deviations from the normal ... by way of excess or defect"[16]. Scadding narrowed it down to exclude non-medically significant deviations from the normal. The distinction, he argued, could be made once the question about whether the particular abnormality has or has not placed the afflicted at a 'biological disadvantage' is settled. If it has, then it qualifies as a form of disease; otherwise, it does not. Kendell takes on the idea of 'biological disadvantage' and translates it as the sum of 'increased mortality' and 'reduced fertility'.[17]

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[11] Christopher Boorse, "On the Distinction between Disease and Illness," *Philosophy and Public Affairs* 5, no.1 (Autumn 1975): 66.
[12] Ibid.
[13] Ibid.
[14] R.E. Kendell, "The Concept of Disease and its Implications for Psychiatry," *The British Journal of Psychiatry* 127, (October 1975): 305-6.
[15] Ibid., 307-8.
[16] Ibid., 309.
[17] Ibid., 310.

K. W. M. (Bill) Fulford refers to Boorse's use of evaluative terms in defining 'disease' as "*deficiencies* in the functional *efficiency*"[18] and its causes being mainly due to a "*hostile* environment"[19] and argues that his inability at defining the concept in entirely value-free terms signals existence of an essential and undeniable element in the connotation of 'disease'. Therefore, irrespective of their place of use, whether in 'medical theory' or 'medical practice', the concept is in effect, value-laden.[20]

Fulford holds that value-terms can be replaced by descriptive notions in three different senses: first, descriptions of values may be replaced by values; second, value-terms could be replaced by equivocal terms; and third, they could be defined by "reference to the descriptive criteria for the value judgments they express"[21]. The first describes the Humean non-descriptivist's position which assumes that no value-laden terms could be analyzed into or defined in terms of factual statements alone.[22] The third reflects 'descriptivism' which permits re-defining value-terms through factual descriptions.[23] This is essentially Boorse's position when he claims that value-laden terms such as 'disease' can be defined in purely factual terms but ends up with an evaluative definition.[24]

Despite the fact that descriptivism can rid the Boorsian account of its inconsistencies in analysis, he denies being a descriptivist on 'disease'. The inconsistencies are evident in his movements back and forth between 'factual' and 'evaluative' connotations, failure to account for cases of illness when one cannot be said to be diseased (the case of a hangover), and lack of a proper distinction between illness and disturbance in functioning (by labelling

[18] K.W.M. (Bill) Fulford, "What is (Mental) Disease? An Open Letter to Christopher Boorse," *Journal of Medical Ethics* 27, no. 2 (April 2001): 81.
[19] Ibid.
[20] Ibid.
[21] Ibid.
[22] K.W.M. (Bill) Fulford, *Moral Theory and Medical Practice* (Cambridge: Cambridge University Press, 1989), 36.
[23] Ibid.
[24] Ibid., 37.

individuals who are ill as not being 'functioning' properly).[25] However, descriptivism is a problematic position given that its openness in regards to redefining values in 'factual' terms is not available in psychiatry in light of the diversity in human values (in the sense of beliefs, desires, emotions and etcetera).[26]

Consequently, Boorse aims at defining 'function' in value-free terms. Fulford rejects the credibility of this stance since the teleological (i.e. goal-oriented) nature of 'function' links it with 'purposes and values'.[27] Therefore, while it is reasonable for naturalists (such as Boorse) to take 'value-free' as 'teleology-free', naturalists aim at reducing the 'teleological' explanation to a 'causal' one.[28] Boorse maintains the 'teleological' aspect of 'goal' and offers a value and 'teleology-free' definition for 'function' as the "standard causal contribution to a goal actually pursued by the organism"[29].[30] Fulford identifies two problems with this definition: the *general difficulty* is concerning the concept of goal being inherently evaluative in meaning given that a goal is "good to hit and bad to miss"[31] and the *specific difficulty* is regarding the inapplicability of 'function' (as part-function) to 'mental disorders' since these involve the person as a whole and not individual organs and systems.[32]

Fulford, as a proponent of the fact-plus-value model proposes inclusion of values in the definition of the concept of 'disorder'. To distinguish between 'mental' and 'physical' disorders, he adopts Richard Hare's point that 'any *value* term' can under certain conditions

[25] K.W.M. (Bill) Fulford, *Moral Theory and Medical Practice* (Cambridge: Cambridge University Press, 1989, 31-32.
[26] K.W.M. (Bill) Fulford, "What is (Mental) Disease? An Open Letter to Christopher Boorse," *Journal of Medical Ethics* 27, no. 2 (April 2001): 82.
[27] Ibid., 83.
[28] Ibid.
[29] Ibid.
[30] Ibid.
[31] Ibid.
[32] Ibid.

have a '*factual* meaning'.[33] In fact, he thinks that there is no reason why 'disease' and 'bodily disorder' despite being used with largely factual connotations should not be value terms. Therefore, if 'disorder' is taken as a value-term, the difference in the case of 'physical' and 'mental' disorders would lie in their respective connotations. While the former enjoys a 'factual' connotation, the latter is assigned an 'evaluative' meaning. 'Mental disorders', by the same token, can be said to be more value-laden than 'physical disorders'.[34]

Subsequently, he provides an analogy for the case of mental and physical disorders. He explains that just as there is a consensus on what features a 'good' strawberry must have, there is a common understanding of the 'factual' elements of 'bodily disorders'. 'Mental disorders', on the other hand, can be compared to the concept of a 'good' picture in the sense that there is no general agreement on the characteristics a picture must possess to qualify as a 'good' picture. Granted that 'bodily disorders' are better explained by 'factual' connotations, it is undeniable that 'mental disorders' (given the existing diversity in individual values (i.e. experiences and behaviour)) are more sufficiently explained by value-laden connotations.[35]

Sadler adopts the Fulfordian 'fact-plus-value' model of 'disease'. He, too, insists that 'disorder' could not be defined in purely 'factual' or value-free terms. He describes 'values' as being 'part of an assumed (sub)-culture in the sense that they vary on a continuum, could be the inherent or intrinsic property of entities, and are essentially diverse and influential'. Thus, Sadler describes values as 'concepts' that "guide our actions, lead us to be deserving of praise or blame, and are assumed, to greater and lesser degree, in just about any everyday activity"[36].[37] Sadler focuses on the use of values as descriptions and argues that in 'the apple

[33] K.W.M. (Bill) Fulford, "Values, Science, and Psychiatry" in *Psychiatric Ethics*, ed. Sidney Bloch and Stephen A. Green (New York: Oxford University Press, 2009) , 69.
[34] Ibid.
[35] Ibid., 69-71.
[36] John Z. Sadler, *Values and Psychiatric Diagnosis* (New York: Oxford University Press, 2005), 9.
[37] Ibid.

is red and good', 'red' and 'good' are both predicates, and while the former is a 'factual' and 'objective' predicate about the apple, the latter is a 'subjective' 'value-predicate' which reflects a value-judgement.[38]

Sadler believes that the DSM (i.e. Diagnostic and Statistical Manual of Mental Disorders) is a good means of providing clinicians with 'denotations' or a catalogue of categories while essentially lacking a viable method or technique to characterize and promote an appropriate diagnostic practice.[39] Furthermore, he finds DSM to be a user-friendly document which gives the reader the wrong impression of being usable just by anyone.[40] Sadler states that apart from being a diagnostic manual, DSMs must be capable of providing practitioners with knowledge of how to be clinicians and how to employ the tools available at their disposal. This entails that DSMs must be more than a diagnostic catalogue by including the crucial evaluative factors that shape and modify treatment modalities. Put differently, DSMs must not only be concerned with the theoretical aspect of diagnosis but they must also bring in and employ the practical values-based considerations in making a diagnosis.[41]

Fulford does not seem able to put a cap on values (as used in regards to concepts) or explain where they tend to be dominant and where they cease to be. This is a problem in the sense that we would end up in a situation where we would have to label every term a value term (including those we previously deemed factual) and instead consider these as being value-laden in nature with less evaluative content and force and with merely overt factual connotations. A possible consequence of his view is that although there would be terms that are entirely value-laden, none can be entirely factual. Furthermore, he argues that VBM (i.e. Values-Based Medicine) complements and in no way replaces EBM (or Evidence-Based

[38] John Z. Sadler, *Values and Psychiatric Diagnosis* (New York: Oxford University Press, 2005), 9.
[39] Ibid., 418.
[40] Ibid., 418-419.
[41] Ibid., 419.

Medicine); under his model, however, this view becomes suspect. In fact, if values enjoy the dominance that he assigns to them, that is, in every concept, every diagnosis, and every decision-making process, then he must be, at minimum, willing to assign a sort of priority to VBM if not completely place EBM under the heading of VBM. After all, VBM includes matters related to both the theory and practice and its comprehensiveness necessitates a modification in the significance assigned to EBM.

Therefore, I think that keeping EBM and VBM as parallels underestimates the dominance of values that Fulford himself wishes to raise awareness of. To ensure consistency, I am of the opinion that, he must specify a hierarchical relationship where EBM would merely occupy a limited space within the boundaries of a general heading of VBM. Then, it does not seem unforeseeable that his model would implicitly place psychiatry at the tip of the medical profession's pyramid with all other specialties of medicine beneath it. He could then argue for the 'practical' priority of psychiatry since it can better accommodate VBM and also since inclusion of VBM does not automatically exclude or eliminate the space for inclusion of EBM (this enables psychiatry to act like a module under which other areas of medicine could be classified in accordance with their degree of dependence on values). Irrespective of where the actual place of psychiatry in the medical domain is, I reject the credibility of the hierarchical model of medicine and plan to argue that the Fulfordian fact-plus-value model of 'disorder' must be, at best, modified to fit his later views on VBM and EBM. Such a change would be a major shift and I am uncertain as to whether the revised account would qualify as a viable response to the Kendellian sort of worries.

Therefore, the two segments of his theory, that is, his book on the model of 'disorder' and his later articles on VBM, can be viewed as offering conflicting views of the author. However, one might argue that the term 'values' (as used in the two sections) differs for Fulford in his theoretical and practical arguments; while the former kind is subjective in

relation to the world, the latter is subjective in relation to the subjects themselves and the confusion arises due to non-recognition of this difference. I will argue for this interpretation and further claim that making such a distinction would only create a phenomenological gap between the two kinds of 'values' which would subsequently lead to further complexities in clinical practice and in particular in respect to patients suffering from anosognosia.

Sadler's account is similarly too dependent on values. He believes that the key to a proper understanding of mental disorders is consideration of values and their inclusion in nosology, diagnosis and decision making processes. Although it is undeniable that values form an integral part of clinical practice, I wonder whether we would be leaving them too much room by allowing them to play a part in both the theory and practice. I am of the opinion that we need to adopt a more neutral stance towards values and that despite their minimal role in the current nosology, we must try to restrict their usage to the limits of ethical clinical practice. Of course, there will never be any clear-cut boundaries but I tend to think that granting values the authority to influence the nosology brings about a sort of relativity in the classification of mental disorders that cannot be remedied. Although the nosology would then cover the region-specific disorders, accepting such relativity could potentially open the door to abuse and history has proven that psychiatry can be used as a political weapon against the dissidents.

As a final remark, this thesis will unfold as follows:

- Chapter 2 will introduce the 'medical' models of Boorse and Kendell. It will also be dedicated to pinpointing the similarities between the two views and highlighting the controversial key points later rejected by others.

- Chapter 3 will consider the ‘fact-plus-value’ model of Fulford and Sadler’s application of the model to the practical side of psychiatry. Furthermore, Fulford’s criticism of Boorse will be briefly looked at.
- Chapter 4 will comprise of my commentary and an in-depth critical evaluation of the ‘fact-plus-value’ model. It will include a discussion of worries and possible solutions and will end with my concluding remarks.

Chapter 2: The Medical Model

In an article called "On the Distinction between Disease and Illness", Christopher Boorse advocates the possibility of having a value-free and purely-factual account of 'health'. He believes that our present difficulty with properly defining the concept in question stems from our failure to distinguish between the two senses in which this concept can be understood. While 'health' can be defined as in opposition to 'disease', it could also be defined as in opposition to 'illness'. 'Disease' and 'illness' are distinct in that the former makes reference to the scientific, value-free, factual, and theoretical basis of a given malady and the latter involves the normative, value-laden, and practical side.[42]

He argues that defining 'health' in the second sense and as a state of 'normality' is problematic since the definition would be variable and dependent upon context-specific description of norms and moral evaluations. This standpoint is commonly referred to as 'normativism'. Boorse distinguishes between two forms of normativism (i.e. strong and weak) and claims that neither position can be maintained. Under the strong version, judgments of health are considered to be purely evaluative and devoid of any descriptive content. In other words, strong normativism claims that for a condition to be unhealthy it is both necessary and sufficient that it be bad. Boorse rejects this position by mentioning some undesirable conditions that are not diseases, such as having a Jewish nose or being moderately ugly.[43]

However, under the weak account, judgments of health are evaluative by virtue of satisfying some further descriptive criteria (in addition to the normative ones). Put differently, 'healthy' is a concept comprised of normative and descriptive components. To rebut, Boorse

[42] Christopher Boorse, "On the Distinction between Disease and Illness," *Philosophy and Public Affairs* 5, no.1 (Autumn 1975): 49-50.
[43] Ibid., 50-52.

refers to some counterexamples within physical medicine, such as the desirable mild infection contracted post-immunization. Even if the undesirability of conditions is deemed a necessary precursor for being labelled as diseases, he contends that the criterion to fulfill remains ambiguous. He mentions infertility as an example and argues that in the absence of considerations about its reproductive effects on humans over generations, it is not clear whether the condition is desirable or undesirable.[44]

Subsequently, Boorse points to biologists' use of 'disease' in reference to plants and animals. Just as they employ the term without bringing in any normative assessments of its desirability, he thinks that 'health' in regards to persons must equally be defined in value-free terms. Furthermore, given that the theoretical sense of 'health' is based upon biological facts (in contrast to practical norms) and since the term so defined has a broader spectrum of applicability (in view of its equal application to members of all species), Boorse argues that 'illnesses' are essentially a 'subclass' of 'diseases'. From the above, he concludes that 'health' can only be properly defined in terms of the sciences, theories, and facts.[45]

To define the theoretical sense of 'health', he introduces C. Daly King's definition of 'clinical normality'. King asserts that "the normal ... is objectively, and properly, to be defined as that which functions in accordance with its design"[46]. Accordingly, Boorse states that "the normal is the natural"[47] and that to be theoretically-healthy, an organism's level of *functioning* must conform to its species-specific *natural design*. To identify and determine the natural biological design of an organism, one needs knowledge of the organism's *natural function* which in biological terms is "the standard causal contribution to a goal actually

[44] Christopher Boorse, "On the Distinction between Disease and Illness," *Philosophy and Public Affairs* 5, no.1 (Autumn 1975): 53.
[45] Ibid., 56.
[46] Ibid., 57.
[47] Ibid.

pursued by the organism"[48]. As I will later discuss in detail, it is important to note that Boorse believes in the existence of natural mental function and that he deems any deviation from such functioning as a form of a 'disorder'.[49] He quickly notes the two universal physiological goals of all species, namely survival and reproduction. Taken together, he argues that to be considered 'healthy', an organism's mode of functioning must accord to its particular natural biological functions which consistently promote these goals.[50]

Consequently, 'disease' can be defined as a state in which an organism experiences a disruption in or interference with one or more natural functions typical of its own species. Given that to be 'healthy' each and every part of an organism must be functioning properly, he argues that functionality of an organism must be assessed at the level of its parts and not the individual as a whole. The function of a part can then be defined as its causal role in pursuit of the empirically-set goals of survival and reproduction. Since these goals and functions can be determined in isolation and without incorporating any value-laden considerations of their pursuit, the concept of 'health' in its theoretical sense must also be defined as an equally value-free notion.[51]

Subsequently, Boorse endorses this statistical account of King and to avoid the earlier objections made to normativism, he re-introduces the idea of 'natural design'. To this point, 'disease', in his own words, is defined as some form of deviation from the 'natural functional organization of a given species'. It is worthwhile to note that he defines 'deviation' as any form of disorganization that is not part of the natural design of the species in question. This means that for him any incongruity between the species-specific natural design and the particular condition which results in a variation of (and reduction in) functioning of the

[48] Christopher Boorse, "On the Distinction between Disease and Illness," *Philosophy and Public Affairs* 5, no.1 (Autumn 1975): 57.
[49] Ibid., 63.
[50] Ibid., 56-57.
[51] Ibid., 58.

particular species qualifies as a deviation. As a result, conditions we are inclined to call 'diseases' but not 'illnesses', such as tooth decay, constitute 'diseases' by virtue of the fact that they are not part of the natural organization of a species and are rather caused by environmental factors. This leads him to define 'disease' as unnatural or atypical "deficiencies in the functional efficiency of the body"[52] that can also be the result of a 'hostile' environment. Therefore, a 'disorder' can be viewed as a condition that results in a reduction in one's capacity to attain the two ultimate evolutionary goals of survival and reproduction. Therefore, in value-free terms, a 'disorder' is equated with a form of 'functional incapacity'.[53]

He provides two reasons for the desirability of functional normality in physical medicine. First, people do find it worthwhile to pursue the goals that physiological functions promote, and second, such functions attend to all types of activities indifferently. As a result, the desirability of particular physiological functions would not be variable or undergo changes on the basis of one's chosen ends. Hence, the desirability of 'health' would merely have an instrumental (and not intrinsic) value. As such, the value of 'health' would be proportional to the degree it can secure and further those goals.[54]

Contrary to the theoretical sense of 'health', the practical sense of the term is embedded with value-driven considerations. Boorse argues that there is a negative connotation built into the term 'illness'. He compares 'disease' and 'illness' with 'low intelligence' and 'stupidity' and explains that there are instances in which intelligence loses its commonly-assigned desirability such as when an employer hires someone for a basic job such as washing the dishes. In this scenario, a person of low intelligence can be equally

[52] Christopher Boorse, "On the Distinction between Disease and Illness," *Philosophy and Public Affairs* 5, no.1 (Autumn 1975): 59.
[53] Ibid.
[54] Ibid., 60-61.

qualified as one of high intelligence and the virtue of 'intelligence' loses its assigned value. Within this context, the less intelligent person cannot be deemed 'stupid'. There are also cases where 'disease' is desirable, such as alcohol intoxication or post-immunization infection. The persons experiencing these conditions are not 'ill' even though they have a form of 'disease'.[55]

Therefore, Boorse argues that to qualify as an 'illness', a 'disease' must be serious enough to result in some form of incapacity and additionally, it must be:

i. "undesirable for its bearer;
ii. a title to special treatment; and
iii. a valid excuse for normally criticisable behavior"[56].[57]

As the above conditions clarify, Boorse does not deem the term 'illness' as being applicable to plants and animals. After all, he explains that biologists do not evaluate the diseases in plants and animals as undesirable particularly since they have no personal interests in their health. Just as there is no sense in arguing for the interests of a 'begonia', he thinks that we must avoid using 'illness' in regards to plants and animals.[58]

Subsequently, he assumes that there are 'natural mental functions' and that psychopathology is an 'unnatural interference with these functions'. He explains that, contrary to physiological states, mental states are not 'neutral' in respect to the choice of actions.[59] He thinks that desires are to serve a motivational function in promoting action-taking and as a result, they may or may not accord to the species' design. Lacking a suitable

[55] Christopher Boorse, "On the Distinction between Disease and Illness," *Philosophy and Public Affairs* 5, no.1 (Autumn 1975): 61.
[56] Ibid.
[57] Ibid.
[58] Ibid., 53.
[59] Ibid., 62.

reason for demanding such conformity, he is left with what he regards as a form of 'disease' which is not an 'illness'. He takes the example of homosexuality and argues that given its deviance from normal sexual function (which is reproduction), it meets the criterion of being a 'disease'.[60]

In respect to the second condition and given the fact that illnesses are serious diseases that reduce functioning at the level of 'gross behavior', it is possible for everyone to be diseased without being ill. Under Boorse's account, statistically normal conditions could be diseases only if they are caused by the environment. Some may argue that cultural environments can negatively affect children and cause 'diseases'. However, he thinks that empirical support for this hypothesis is needed and further argues that even if proven true, one can still maintain the idea that 'only serious diseases can be illnesses' by abandoning the presupposition that 'not everyone can be ill'.[61]

The third condition for a 'disease' to be an 'illness' poses a difficulty, namely that while excusing conduct on the basis of 'disease' in physical ailments depends upon the relation of patients to their own bodies, in case of mental conditions such a relationship must be maintained with one's psychology which involves an activity with the "very seat of responsibility – the mind and character"[62]. The problem with mental disorders lies in the fact that it is persons that are held legally liable and not their personalities or character traits. In holding one responsible, the person must be conscious of their actions and their implications. In some mental disorders, such as neurosis and psychoses, the afflicted lacks a conscious awareness of the consequences of their actions. Although excusing conduct of such persons seems justified, Boorse thinks that the test of consciousness is inadequate since the actions

[60] Christopher Boorse, "On the Distinction between Disease and Illness," *Philosophy and Public Affairs* 5, no.1 (Autumn 1975): 63.
[61] Ibid., 65.
[62] Ibid., 66.

are still *our* actions. This issue is better demonstrated in the case of character disorders since the unhealthy condition is embedded within the realm of their consciousness and as such, their conducts cannot be justifiably excused.[63] From this he concludes that actions and behaviors when produced under the influence of mental diseases are totally inexcusable.[64] Furthermore, he claims that while the three aforementioned conditions are to be routinely applied to serious physical diseases, none should be assumed as being routinely applicable to serious mental diseases. In fact, he argues that the term 'mental illness' must only be used in reference to psychoses and neurosis.[65]

He explains that the implications of the above argument support two conclusions. Of these, only the second is of significance to our purposes here and will be discussed in detail. The second implication is 'twofold':

> a) The claim that health professionals disapprove of what is 'ipso facto unhealthy' is unfounded. The society cannot arrange and modify the functional settings of members of a given species and as a result can never have an absolute authority on either 'disease' or 'illness'[66] and,
>
> b) Unless the argument for desirability of 'health' is questioned, its force undergoes 'inflation'. After all, the value of 'health' is to be set in accordance with the 'value of conformity' to the species-specific design.[67]

R.E. Kendell is a proponent of the existence of 'mental illnesses'. His model, as a variant of the Boorsian account, rejects the existence of a clear definition of the term.[68] He

[63] Christopher Boorse, "On the Distinction between Disease and Illness," *Philosophy and Public Affairs* 5, no.1 (Autumn 1975): 66.
[64] Ibid., 65-66.
[65] Ibid., 66.
[66] Ibid.
[67] Ibid., 68.

acknowledges that no clear-cut definition of 'illness' with the capacity of marking out non-pathological conditions, such as 'delivery of babies or circumcision of infants', exists. The problem can be traced back to medicine's reverse identification and classification of diseases. As a practical discipline, medicine began by identifying individual diseases and then working its way up to grouping clusters of disorders and in the end seeking to develop a proper definition of the term in question. The overlap in the boundaries of diseases and the variability in definition of constituents of 'disease' and 'health' by context are the reasons that make arrival at a unified definition all too difficult.[69]

Furthermore, he explains that our ignorance of the 'essential functions' of organisms in general and human beings in particular (which is rooted in their not being man-made entities) contributes a great deal to our inability to define 'disease'. He argues that plants and animals (as species that we are not typically biased about, either emotionally or economically) can provide the best means of understanding our very own functions. He thinks that we can simply agree that their basic biological functions are to promote survival and reproduction. As such, any condition that results in a reduction of a species' chances of meeting these goals could be justifiably called a 'disease'. He admits of the significant role that environmental factors play in producing diseases by pointing to the fact that no species could exist in absolute isolation from these elements and that their functioning could not be assessed *in vacuo*.[70]

Subsequently, he examines a number of historical accounts of 'disease', from the 'cause of suffering and injury' to 'incapacity to perform' and the 'cause of a complaint'.

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[68] R.E. Kendell, "The Concept of Disease and its Implications for Psychiatry," *The British Journal of Psychiatry* 127, (October 1975): 305-306.
[69] Ibid., 307-308.
[70] R.E. Kendell, "What are Mental Disorders?" in *Issues in Psychiatric Classification, Science, Practice, and Social Policy*, ed. Alfred M. Freedman, Richard Brotman, Irving Silverman, and David Hutson (New York: Human Sciences Press, 1986) 32.

Given the difficulties associated with these viewpoints (one of which, as Kendell explains, is the fact that there are some illnesses, the carriers of which neither make a complaint nor suffer, such as the case of a man with an undiagnosed and symptomless form of cancer developing in his lungs), Kendell denies the credibility of such accounts. For the sake of brevity, I will only attend to the more relevant argument, that of the statistical concept of disease.[71]

Cohen initially defined the concept of disease in statistical (but vague) terms as "deviations from the normal ... by way of excess or defect"[72]. This definition is inadequate given that it fails to distinguish between the kinds of deviations; that is, between those that are harmful (such as hypertension), neutral (such as 'great height'), and 'positively beneficial' (such as high intelligence). Scadding tried to narrow the definition down to exclude non-medically significant deviations from the normal. To qualify as a disease, the deviation must place the afflicted at a 'biological disadvantage' by either reducing their chances of survival or reproduction. To be precise, he defines a disease as "the sum of the abnormal phenomena displayed by a group of living organisms in association with a specified common characteristic or set of characteristics by which they differ from the norm for their species in such a way as to place them at a biological disadvantage"[73].[74]

Kendell identifies multiple implications of this definition. First, it clarifies that a deviation in either direction – in excess or defect – can produce disease. Second, it demonstrates that the boundary between diseases and health is 'arbitrary' just as it is in the case of mental subnormality and normality in reference to intelligence. Third, it implies that

[71] R.E. Kendell, "The Concept of Disease and its Implications for Psychiatry," *The British Journal of Psychiatry* 127, (October 1975): 307-308.
[72] Ibid., 309.
[73] R.E. Kendell, *The Role of Diagnosis in Psychiatry* (Oxford: Blackwell Scientific Publications, 1975), 14.
[74] Ibid.

the majority of people are exempted from being labelled as 'ill'.[75] Nonetheless, he believes that Scadding's definition of 'disease' is ambiguous. To demonstrate his point, he mentions psoriasis as a condition that (given the suffering it causes and the fact about its being treatable by the available medical means), we would want to label as a disease even though it does not involve any noticeable 'biological disadvantages' or impairments of functioning.[76]

In accordance with Boorse, Kendell deems it unnecessary to consider 'disease' as a value-laden term (or 'disease judgments' as 'value judgments'). He offers an analogy in which he compares the assertion: 'a particular organism is not functioning properly' with the statement: 'a lawn mower is not functioning properly' (given that it no longer cuts the grass). He claims that so long as the functions of the organ (or organism) under consideration are adequately understood, the impairment or failure of function could be easily and confidently identified and moreover, the impact of such changes on survival and reproductive capacities of the organism could be assessed.[77]

Furthermore, he rejects the possibility of 'disease' being a value term by claiming that if it were so, the question of 'whether X is a disease' would be dependent on the way the respective culture or those involved in the process viewed it. In that event, a condition would qualify as a disease only if it were judged to be undesirable. The concept so defined would be unstable in regards to the treatment methods it supports or produces, possibly resulting in using a combination of physicians and medical technologies in one society and utilizing institutions and medical technologies in another society for an identical form of disease.[78]

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[75] R.E. Kendell, *The Role of Diagnosis in Psychiatry* (Oxford: Blackwell Scientific Publications, 1975), 14-15.
[76] R.E. Kendell, "What are Mental Disorders?" in *Issues in Psychiatric Classification, Science, Practice, and Social Policy*, ed. Alfred M. Freedman, Richard Brotman, Irving Silverman, and David Hutson (New York: Human Sciences Press, 1986) 35.
[77] Ibid., 39.
[78] Ibid.

Interestingly, Kendell is well-aware of the limitations of his theory, particularly in respect to its exclusion of cases one would reasonably wish to include, such as 'post herpetic neuralgia and psoriasis'. These conditions cause considerable suffering, are accompanied by lesions, and are treatable by medical means.[79] While acknowledging these points, he still argues for his own interpretation of the term. He worries that broadening the definition any further opens the door to all sorts of misperceptions and that the theory would, as a result, lose its credibility and must be rejected. Therefore, when presented with the option of defining the concept in narrow or broad terms, he opts for the stricter of the two.[80]

At this point it may not be very difficult to see the similarities between the Boorsian and Kendellian views. For instance, both theories are scientifically-oriented, with a biological undertone and an evolutionary look. Furthermore, both models reject the value-ladenness of 'disease' and also attempt at producing a value-free definition of the concept based on the reduction such conditions bring about in the survival and reproductive capacities of organisms. Environmental factors are considered as influential elements affecting the production of such conditions under both theories. Moreover, under both accounts, homosexuality is a 'disease'. However, while Boorse tries to link it to a form of deviation from normal human functioning and natural design in the evolutionary path, Kendell associates it to its counter-effects to fertility and reproduction and hence to the biological disadvantage that it subjects the individual to.

In the next chapter, I will look at arguments posited by the second camp, or the proponents of the fact-plus-value model. For the time being, I will list the key points of the Boorsian account that Fulford is going to challenge. These are:

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[79] R.E. Kendell, "The Concept of Disease and its Implications for Psychiatry," *The British Journal of Psychiatry* 127, (October 1975): 310.
[80] Ibid.

1. Inconsistency in its application when ‘disease’ is defined as some form of ‘disturbance of bodily functioning’.
2. Its failure to recognize conditions whose ‘particular disturbance of function’ is still unknown, as diseases.
3. Its faulty assumption regarding our ordinary use of ‘disease’ (and not ‘illness’) of plants and animals as the terms are used in respect to persons.
4. Its failure in specifying a satisfactory logical relationship between ‘disease’ and ‘illness’ by requiring that all diseases be disturbances of function.
5. Its misguided classification of ‘illness’ as a subcategory of ‘disease’ and the resulting confusion in defining ‘illness’.
6. Its failure to properly address non-empirical problems that arise in analytical research.
7. Its reference to the teleological aspect of goal and its use in developing a teleology and value-free definition of function which subjects the definition to two problems, namely general and specific.

Chapter 3: The Fact Plus Value Model

Fulford refers to the difficulties associated with the concept of ‘illness’ and their implications for physical and psychological medicine. While both areas of medicine have encountered concept-related problems, psychological medicine has faced a greater many issues. Historically, ‘mental illness’ was deemed an ambiguous concept (given its value-ladenness, variability with context, and normative basis) whereas, ‘physical illness’ was considered a clear concept (due to its objectivity, solidity, and factual basis). Naturally, the problem to be addressed was identified as ‘mental illness’. In order to evaluate the genuineness of mental illnesses as real illnesses, the concept of ‘mental illness’ was compared to the supposedly-transparent notion of ‘physical illness’ (which was thought to represent the ‘genuine’ form of illnesses). Upon close examination and once it was discovered that no single, acceptable definition of the ‘mental illness’ could be arrived at, this concept was rendered defective.

In contrast to the classical view, Fulford holds that the ambiguity in meaning and the disparity in views that inevitably result from employing the old strategy (namely, some arguing for ‘mental illness’ while others oppose it) can be avoided if we come to realize that the contradictory positions are directly due to misidentification of the target problem. He argues that if the validity of an ambiguous concept, say X, is to be decided by making a detailed comparison with a concept that is deemed clear and valid, say Y, and upon making the comparison, one ends up deducing radically different and even contradictory conclusions about the nature of X, then the problem must lie in the concept used as the benchmark, or Y, given that Y is proven to have several possible interpretations and this renders Y unclear. Similarly, when proponents of the pro- and anti-psychiatry camps compare ‘mental illness’ to the supposedly-clear and valid concept of ‘physical illness’ and end up confirming and

rejecting the reality of ‘mental illnesses’ respectively, the problem to be addressed must be revised to ‘physical illness’ or that to which the comparison is made.

Despite this, some might insist that ‘mental illness’ is nonetheless conceptually more problematic than ‘physical illness’. To coherently connect these disparate ideas (that is, the view that ‘physical illness’ is the problem to be resolved and also that ‘mental illness’ is conceptually more troublesome), it may be suggested that we distinguish between difficulties in ‘use’ of a concept and difficulties of ‘definition’. Just as we would be mistaken to assume that our common use of the concept of ‘time’ is proof of its transparency, we would be wrong to conclude that given the absence of conceptual problems in ‘physical illness’, this concept is transparent in definition.[81]

In the first sense of this argument (that is, in the sense that ‘physical illness’ is clinically unproblematic in ‘use’), the second assumption (namely that ‘physical illness’ by virtue of being clinically unproblematic is indeed an unproblematic concept) would be fully justified.[82] However, in the second sense (that is, the sense in which ‘physical illness’ is deemed an obscure concept), this notion, contrary to the second assumption, is clinically problematic. It is worthy of attention that in both these senses, the concept of ‘mental illness’ is clinically problematic. Although making a distinction between difficulties in ‘use’ and of ‘definition’ allows us to redefine the ‘target problem’ to better cohere to the first assumption (or the idea that ‘mental illness’ is the ‘target problem’), it introduces a difficulty related to identifying an explanation of the clinically unproblematic use of ‘physical illness’ that is based upon a criterion other than the perspicuousness of the concept.[83]

[81] K.W.M. (Bill) Fulford, *Moral Theory and Medical Practice* (Cambridge: Cambridge University Press, 1989), 6.
[82] Ibid., 6-7.
[83] Ibid., 8.

It might be suggested (as a variant of the second assumption) that the unproblematic use of 'physical illness' is due to the notion's conceptual soundness notwithstanding its possible obscurity. The problem with this third sense is that the conceptual soundness of the term cannot just be assumed and furthermore, its clinically unproblematic use cannot be presupposed in providing proof for its soundness.[84] For example, in the case of a patient suffering from classical migraine, the patient's physical illness is taken for granted while in regards to someone with depression, the question of whether the patient is ill remains open to debate.[85] The fact that illness of patients with migraine is routinely taken for granted suggests that physical illnesses are the 'genuine' kind of illnesses. If true, they can help us resolve the difficulties associated with mental illnesses.[86]

On the other hand, Fulford contends that better routes than conventionalism exist that do not require the 'conceptual slide' from the specific concept of 'physical illness' to the more general notion of 'illness'.[87] The significance of this proposition is related to a serious difficulty with the conventional viewpoint that arises when examples of 'mental illness' are compared to those of 'physical illness'. Such a comparison essentially asks whether 'mental illnesses' are in effect 'physical illnesses' and this is directly in tension with the conventionalists' tendency to question if 'mental illnesses' are genuine *illnesses*. The fourth sense (as another variant of the second assumption) comes about once 'physical illnesses' are imagined to constitute 'real illnesses' and when one thinks of them as providing the 'more authentic' examples of 'illnesses'. It assumes that the clinically unproblematic use of the

[84] K.W.M. (Bill) Fulford, *Moral Theory and Medical Practice* (Cambridge: Cambridge University Press, 1989), 9.
[85] Ibid.
[86] Ibid., 11.
[87] Ibid. I will get into details of his so-called 'reverse position' later on. For now, it suffices to clarify that he opposes the conventional viewpoint.

concept of 'physical illness' is owing to the fact that only illnesses of this kind provide 'authentic examples' of 'illnesses'.[88]

While 'illness' and 'physical illness' are 'coextensive' in regards to the maladies that they properly apply to,[89] Fulford explains that this position is problematic since making a distinction between 'physical' and 'mental' illnesses imply the existence of the more general concept of 'illness'.[90] Fulford supports the existence of this general concept and argues that 'mental illness' must only be compared to that and not to 'physical illness'. In fact, 'mental illness' must only be directly compared to 'physical illness' if the existence of the general notion of 'illness' is refuted and no argument to this effect has ever been provided by the conventionalists. He concludes that there have to be instances of *authentic* mental illnesses (in other words, he claims that the notion of 'mental illness' must represent a genuine and real form of 'illness' in general); otherwise, the concept would be meaningless.[91]

Overall, he identifies three difficulties with the two stated assumptions:

1. Irrespective of how clear the definition of the possible senses of 'illness' (i.e. 'mental illness' and 'physical illness') are, difficulties in use of these notions could still arise.[92]
2. If each term has several distinct senses, an 'illness-diagnosis' of a given malady could be made by reference to any possible combination of these with the consequence that a patient suffering from a particular condition could be deemed both mentally-ill and not mentally-ill (or physically-ill and not physically-ill).

[88]K.W.M. (Bill) Fulford, *Moral Theory and Medical Practice* (Cambridge: Cambridge University Press, 1989), 12.
[89] Ibid., 12-13.
[90] Ibid., 13-14.
[91] Ibid., 14.
[92] Ibid., 15-16.

This issue results in a lesser degree of clarity in making a distinction between the concepts of 'mental illness' and 'physical illness'.[93]

3. If the legitimacy of a patient's illness is decided based on considerations other than the particular features of their condition, the 'illness-diagnosis' criteria would be even more diverse than the 'condition-diagnostic opinion'.[94]

Consequently, Fulford rejects the validity of the second assumption by arguing against consideration of 'physical illness' as an unproblematic concept given that it is subject to problems in clinical practice when 'illness-diagnosis' matters are under consideration.[95] Furthermore, the first assumption must be given up since it assumes that 'mental illness' is problematic in the three senses in which 'physical illness' is unproblematic. These include clarity of definition, soundness of the concept, and authenticity of conditions. These are supported by the second assumption and their refutation amounts to rejection of the first assumption.[96]

It is important to note that although clinical difficulties of 'mental illness' could lead to contradictory 'illness-diagnosis opinions', the 'illness-diagnosis' problem does not support the first assumption since it could be reflecting some feature of the general concept of 'illness' (under which 'mental illness', like 'physical illness', would provide authentic examples of 'illness').[97] Furthermore, Fulford believes that the value-ladenness, subjectivity, vagueness of connotations, and variability of denotations alone do not render 'mental illness' a defective concept as these may also be features of the notion of 'illness'.[98] He contends that by employing the method of linguistic analysis, distortions in our view of each concept

[93] K.W.M. (Bill) Fulford, *Moral Theory and Medical Practice* (Cambridge: Cambridge University Press, 1989), 16.
[94] Ibid., 18.
[95] Ibid.
[96] Ibid., 19.
[97] Ibid.
[98] Ibid., 20.

considered can be corrected since the method seeks to thoroughly examine the implications of the term in question.[99]

He begins by distinguishing between 'illness', 'disease', and 'dysfunction'. Although the first two terms are commonly linked together, only 'disease' is typically defined in dysfunctional terms and as a condition in which a body or a part of it is not functioning properly. Conventionalists treat 'illness' and 'disease' as synonyms and use a combination of the two to refer to 'disturbance in functioning'. However, despite being 'closely related' in definition, the three terms are not always logically interchangeable.[100] For instance, while "He has some awful illness"[101] has the same meaning as "He has some awful disease"[102], there are cases when a patient can be said to have a disease and yet not be ill. For example, a diabetic whose condition is well-controlled suffers from the disease diabetes but is not ill.[103]

Furthermore, 'disease' is sometimes interchangeable with 'dysfunction'. For instance, someone with 'obstructive airway disease' basically suffers from a disturbance in their lung functioning. In spite of these examples, there are many conditions (such as migraines) that cannot be defined in terms of dysfunction of bodily parts. Although this kind of headache may have been caused by a disturbance in functioning of a bodily function and it may reduce sufferers' level of functioning, migraine itself cannot be defined in functional terms. Therefore, Fulford argues that the proper theory must be able to explain both the synonymous and non-synonymous uses of these concepts.[104]

[99] K.W.M. (Bill) Fulford, *Moral Theory and Medical Practice* (Cambridge: Cambridge University Press, 1989), 22-23.
[100] Ibid., 27.
[101] Ibid., 28.
[102] Ibid.
[103] Ibid.
[104] Ibid.

Subsequently, he refers to the shared property of 'disease', 'dysfunction', and 'illness' – namely that despite being 'etymologically' evaluative, they can be used with 'mainly factual connotations' in technical contexts.[105] Fulford observes that in the analytic philosophy of R.M. Hare (among others), there exists an argument in favor of the view that "*all* value terms may under certain circumstances, be used with clear factual meaning"[106]. This is in fact a property of *all* value terms and is not a unique feature of medical terms. He proceeds with an analogy. While we commonly treat terms such as 'good' and 'bad' as having an evaluative meaning when used of, say 'pictures', they entail a rather descriptive or factual connotation once their referent is, say 'apples'.[107]

To be precise, the case of apples is different in that one can point to an objective and pre-determined guideline that everyone can agree on for distinguishing 'good apples' from 'bad' ones. In the case of pictures, however, no such shared consensus can exist as each person has a unique psychological makeup which consists of variations in constituents of what they deem to be 'good' or 'bad'. As a result, 'good' and 'bad' can have differing connotations in different contexts. From this, Fulford concludes that since *all* value terms can under certain conditions have descriptive meanings, the terms in question (i.e. 'disease' and 'physical illness'), despite being dominantly used with factual meaning, can in fact be value terms.[108]

[105] K.W.M. (Bill) Fulford, *Moral Theory and Medical Practice* (Cambridge: Cambridge University Press, 1989), 35.
[106] K.W.M. (Bill) Fulford, "Analytic Philosophy, Brain Science, and The Concept of Disorder" in *Psychiatric Ethics*, ed. Sidney Bloch, Stephen A. Green, and Paul Chodoff (New York: Oxford University Press, 1999), 173.
[107] Ibid.
[108] Ibid., 173-174.

Subsequently, Fulford considers the "variations with context in the factual and evaluative connotations of value terms" [109] a significant property of value-laden terms 'illness', 'disease', and 'dysfunction'. More importantly, he argues that variations in the *criteria* of value terms are representative of a psychological fact. That is, the criteria of the value term 'good', as used of apples, are (despite the possible variations) more settled than that of the same term as used of pictures. Therefore, given their clarity, the descriptive meanings expressed by some value terms are more 'prominent' than others. Consequently, the strength of the descriptive meanings of value terms will be contextually variable.[110]

Subsequently, Fulford asserts that 'mental illness' and 'physical illness' are conceptually similar in that they are 'subspecies' of the general concept of 'illness'. Once 'illness' is viewed as their constant and shared feature, the difference between the two concepts would lie in the "properties of their respective constituents"[111] – that is, emotions, beliefs, and the like in regards to 'mental illness' and feelings and sensations in the case of 'physical illness'. By considering the two kinds of properties of such constituents – namely, 'empirical and evaluative' – he then argues that differences between the empirical properties of physical and mental illnesses lead to differences in the 'disease categories' of physical and psychological medicine.[112]

In comparison to 'physical illness', constituents of 'mental illness' lack the empirical properties for the development of disease categories, are clinically used with less reliability, and are identified in terms of symptoms or cluster of symptoms (rather than being organized on the basis of underlying causes). He notes an exception to this rule, namely, 'cognitive

[109] K.W.M. (Bill) Fulford, *Moral Theory and Medical Practice* (Cambridge: Cambridge University Press, 1989), 54.
[110] Ibid.
[111] Ibid., 79.
[112] Ibid.

phenomena', (such as "defects in memory, attention and intellect"[113]) which provide an example of the variety of 'mental illness constituents' with empirical properties quite similar to those of 'physical illness constituents'. Consequently, 'mental illnesses' that are constituted by cognitive phenomena (such as amnesias and dementias) are conceptually closer to 'physical illnesses' (than 'mental illnesses') and are accordingly easier to reliably diagnose, categorize, and understand causes of.[114]

Despite our ignorance of the precise changes that are made in brain functions, cognitive disorders are caused by known aetiological agents such as toxins, chemicals, and traumas. This feature makes their categorization into more specific disease categories possible.[115] Since these categories are routinely used in clinical settings and in regards to physical medicine, the concept of 'disease' is almost as prominently used to refer to cognitive disorders as it is employed in physical medicine. Hence, the empirical properties of illness constituents are roughly correlated with the conceptual properties of their constituted illnesses implying that the latter is affected by the former, although there must be other sources affecting the latter as well.[116]

He offers three reasons for this claim:

1. The extent of the differences between constituents of 'mental illness' and those of 'physical illness' (in view of their empirical properties) is not adequately large to account for the degree of the conceptual differences that exist between 'mental illness' and 'physical illness'. That is, although the constituents of 'mental illness' are hard to identify, they may nonetheless be reliably identified. Additionally, the

[113] K.W.M. (Bill) Fulford, *Moral Theory and Medical Practice* (Cambridge: Cambridge University Press, 1989), 80.
[114] Ibid.
[115] Ibid.
[116] Ibid., 81.

reliability of the constituents of 'physical illness' and the 'bodily signs' and 'radiological' and 'biochemical' test results are often on a par with that reported for constituents of 'mental illness'. Moreover, symptom-based categories are a 'necessary precursor' to causal disease categories and in psychological medicine, they have significant implications for 'prognosis and treatment'; it is also possible that progress made in the area of brain science could potentially provide for the shift from 'symptomatic to causal disease categories' in psychological medicine in the future (similar to the one made in 'physical medicine').[117]

2. The rough correlation just noted holds in cases of 'large clinical groups' and falls apart upon detailed analysis. The conceptual difficulties that arise in clinical settings appear to be prominently in the area of psychological medicine where evidence-related empirical issues are better addressed. That is, in psychological medicine, the patient's overall condition is not relevant and it is the subject's response to certain impulses and their beliefs (which lead to anxiety or depression of the individual) that must be used to determine the conceptual status of their condition as an 'illness'.[118]
3. The last reason is related to 'variability of' and 'difference in' strength of the evaluative connotations whose relevance to the empirical properties of the illness constituted might seem obscure. This is mainly due to the more value-laden questions that tend to arise in cases of 'mental illness' and is also a result of the particular and distinct way that values enter the picture of a mental illness diagnosis in contrast to that of physical illness.[119]

[117] K.W.M. (Bill) Fulford, *Moral Theory and Medical Practice* (Cambridge: Cambridge University Press, 1989), 81.
[118] Ibid., 82.
[119] Ibid.

To demonstrate the point, he compares 'anxiety' as a common constituent of 'mental illness' with 'pain' as a typical constituent of 'physical illness'. Just as the criteria of evaluation differ in cases of 'anxiety' and 'pain', the kinds of such evaluations and their extent vary for each condition. For instance, while 'anxiety' can be evaluated both negatively and positively (an example of the latter is the thrill experienced while participating in dangerous sports), 'pain' can only be weighed negatively. It is important to emphasize that variation of 'pain' and 'anxiety' differ in proportion to their intensity for the experiencing subject and it is wider in the case of 'anxiety' as its criteria of evaluation are less settled than those of 'pain'. The example clarifies that if 'illness' is considered as an evaluative notion, it will be more marked evaluatively when employed for 'anxiety' rather than 'pain'.[120]

Furthermore, if 'illness' confers a negative value judgment and if the criteria for expressing 'anxiety' are less settled, then it becomes clear that judgments of 'illness' in regards to cases of 'anxiety' would be more value-laden than instances of 'pain'. He argues that, by extension, similarity of 'mental illness constituents' to 'anxiety' and 'physical illness constituents' to 'pain' entails that judgments about constituents of the former (or judgments that determine 'mental illness' of subjects) will more likely result in questions of value than judgments of 'physical illness'. Likewise, the diagnosis of 'mental illness' will be more evaluative and its evaluative connotations will be more marked in clinical practice in comparison to those of 'physical illness'.[121]

It is evident that in view of the points examined, differences between the evaluative properties of mental illness constituents and those of physical illness influence the conceptual differences between psychological and physical kinds of medicine and are *prima facie* 'directly relevant' to the problematic nature of 'mental illness' in clinical settings. The

[120] K.W.M. (Bill) Fulford, *Moral Theory and Medical Practice* (Cambridge: Cambridge University Press, 1989), 83.
[121] Ibid., 84.

aforementioned properties also affect the variability factor of 'mental' and 'physical' illnesses. The two types of 'illness' are variable in respect to their connotations both 'cross-culturally and historically'. The greater variability of 'mental illness' in such cases demonstrates the wider variation in the criteria against which 'mental illness constituents' are evaluated.[122] Nonetheless, 'mental illness', as a *more* value-laden concept and 'physical illness', as a *less* value-laden notion, are both conceptually sound in spite of the fact that 'mental illness' is more difficult to work with clinically.[123]

Fulford further argues that the greater value-ladenness of the concept of 'mental illness' can be tracked down to the existing diversity in 'human values' in regards to 'experience and behavior'. Given that he deems values an integral component to understanding the definition of 'disorders', his proposed model (which promotes the idea that 'values' be considered alongside the 'facts') is called the 'fact-plus-value' model. To put this model into practice, he introduces values-based practice (now on referred to as VBP) as a complement to the routinely utilized scientific-driven notion of evidence-based practice (now on, EBP).[124]

While EBP is based upon the evidence-based medicine (now on EBM), VBP is founded upon values-based medicine (or VBM). According to Fulford, when correctly implemented, the two, EBM and VBM, will complement one another in that the former deals with complexity of facts in healthcare decision-making processes and the latter concerns complexity of values in such processes. Fulford clarifies the distinction between the evidence- and values-based forms of practice (EBP and VBP respectively) and the evidence- and values-based forms of medicine (EBM and VBM respectively) by explaining that while

[122] K.W.M. (Bill) Fulford, *Moral Theory and Medical Practice* (Cambridge: Cambridge University Press, 1989), 84.
[123] Ibid., 85.
[124] K.W.M. (Bill) Fulford, "Values, Science, and Psychiatry" in *Psychiatric Ethics*, ed. Sidney Bloch and Stephen A. Green (New York: Oxford University Press, 2009), 71.

the former refer to practical considerations in healthcare settings, the latter are more comprehensive and entail both the theoretical and practical considerations in clinical decision-making.[125]

Subsequently, Fulford cites ten principles of VBM which emphasize the significance of values to the theory and practice. The first five are indicative of the theoretical principles of VBM and state that:

1. All decisions (including clinical ones) are based upon facts and values [the 'two-feet principle'].
2. Only conflicting values tend to get noticed [the 'squeaky-wheel principle'].
3. Advances in science support inclusion of human values in medicine [the 'science-driven principle'].
4. VBM first considers the values of patients or patient groups affected by the decisions made [the 'patient-perspective principle'].
5. VBM supports resolution of conflicts in values through balancing legitimately diverse views [the 'multi-perspective principle'].[126]

Of the above, the first three principles demonstrate similarities between VBM and EBM whereas the latter two, reflect the differences between VBM and EBM. Fulford argues that the two kinds of medicines (i.e. VBM and EBM) are nonetheless complementary. The reason is that while the fourth principle states that at the top of the "values hierarchy"[127] are the individual values of patients, at the top of the "evidence hierarchy"[128], there are independent and non-relative facts. The fifth principle states that although conflicts in values

[125] K.W.M. (Bill) Fulford, Facts/Values: Ten Principles of Values-Based Medicine," in *The Philosophy of Psychiatry*, ed. Jennifer Radden (New York: Oxford University Press, 2004), 205.
[126] Ibid., 206.
[127] Ibid., 208.
[128] Ibid.

can be resolved by balancing out relevant views, conflicts in evidence are primarily settled by research methods designed to produce value-free facts.[129] Furthermore, Fulford clarifies that contrary to EBM, there is no *right outcome* when conflicts in values are under consideration and as such, the goal must be set to identifying *processes* that generate effective action. It might be asked how the values of parties involved can be balanced out when the conflicts are over fundamental values. He thinks that although the values of service providers might differ from individual to individual and from caregivers to patients, it is through the process of evaluating these values and looking for the best outcome for the patients (which is made possible by engaging the patients and their families in the decision-making processes as much as possible and incorporating the 'quasi-legal model of bioethics' which offers a resolution by making reference to a preapproved and shared rule) that we can arrive at a resolution. It is worth mentioning that 'quasi-legal model of bioethics' closely resembles EBM in the sense that both are outcome-oriented.[130]

Returning to the second set of principles or 'key pointers', they state the following:

6. Values are evident in language pending our awareness of their usage in particular contexts [the 'values-blindness principle'].
7. Empirical and philosophical methods can help ameliorate understanding of others' values [the 'values-myopia principle'].
8. Ethical reasoning in VBM merely looks at differences of values and is not the determinant of the 'right' [the 'space of values principle'].
9. Communication skills play a substantive (and not executive) role in VBM [the 'how it's done principle'].

[129] K.W.M. (Bill) Fulford, Facts/Values: Ten Principles of Values-Based Medicine," in *The Philosophy of Psychiatry*, ed. Jennifer Radden (New York: Oxford University Press, 2004), 208.
[130] Ibid., 216.

10. Decision-making in VBM is placed with users and service providers in clinical settings [the 'who decides principle'].[131]

The first principle makes note of a feature of VBM which deems values in healthcare as those that evaluate good and bad judgments. In Hare's words, values are "prescriptive or *action-guiding*"[132]. [133] Fulford, in accordance with the second principle, states that the tendency of values to vary on a spectrum, from the visible and explicit to the invisible and implicit, has made the parties involved seek a double standard in their considerations of values. That is, as Hare puts it, it is the degree to which values are shared that determines their visibility. Stated differently, where the values in question are commonly shared, they tend to be implicit and only where the opinions diverge, they tend to get noticed and become explicit. For instance, while decisions made in an emergency are thought of as being essentially scientific (given the implicit essence of the values involved), they are deemed to be of an ethical nature once the question is one of the soundness of providing developing countries with cheap anti-AIDS drugs (due to the explicitness of values).[134]

The third principle points to the shift in values from being widely-shared to being overtly diverse in medicine. Such diversity could be traced back to five sources and factors. First, their inherent diversity; second, their diverse origins (including individual, cultural, and professional); and third, their diversity given the fact of individualism; that is, there is a variety of values for each person within different contexts or at different times and within different cultures and at different historical intervals. The final two factors can be grouped into external and internal elements. Of the former, Fulford cites 'increasing individualism', 'rejection of authority', 'global travel and communication', and 'an increasingly

[131] K.W.M. (Bill) Fulford, Facts/Values: Ten Principles of Values-Based Medicine," in *The Philosophy of Psychiatry*, ed. Jennifer Radden (New York: Oxford University Press, 2004), 206.
[132] Ibid., 208.
[133] Ibid.
[134] Ibid., 210.

cosmopolitan society'. The internal factor involves scientific progress. That is, advancements in science continuously '*opens up choices*' and the availability of choices inevitably brings about '*values*'.[135]

The fourth principle reinforces the idea that the diversity in views is 'legitimate'. The legitimacy, in turn entails that within clinical settings, knowledge of key operative values (despite being necessary as the seventh principle states) is inadequate due to absence of the '*actual* values of the *particular*' parties affected.[136] While this principle's patient-centred nature allows us to assign priority to individual values, the fifth principle cites the inevitable disagreements that arise as a result of such assignment. These could be resolved not by a consensus of facts (as in the EBM), but by a 'dissensus' or the "*processes that support action through a balance of legitimately different value perspectives*".[137] It is crucial to note that 'dissensus' has a particular meaning for Fulford. He states:

> *"Despite its name, "dissensus" ... is not about disagreement in the sense of dissent (falling out). Dissensus can be thought of rather as a particular values-based take on "agreeing to disagree." In the more familiar consensus, those concerned come to an agreement on whose values are right. In dissensus, differences of values, instead of being resolved, remain in play to be balanced according to the circumstances presented by particular decisions".*[138]

Fulford next focuses on four key areas of clinical skills which help VBM in providing what he refers to as 'good process' (in contrast to 'good outcome') and on '*how* it is done' (versus on '*what* is done'). To this end, he proceeds by examining the sixth principle which specifies the first skills area or 'awareness of values'. It points to the value-related problems in clinical settings that can be traced back to 'values blindness' or the failure to recognize values in practice. Of its many sources, Fulford mentions three: 1) invisibility of shared

[135] K.W.M. (Bill) Fulford, Facts/Values: Ten Principles of Values-Based Medicine," in *The Philosophy of Psychiatry*, ed. Jennifer Radden (New York: Oxford University Press, 2004), 213.
[136] Ibid., 215.
[137] Ibid., 216.
[138] K.W.M. (Bill) Fulford, Edward Peile, and Heidi Carroll, *Essential Values-Based Practice : Clinical Stories Linking Science with People* (New York: Cambridge University Press, 2012), 32.

values; 2) ascription to a system of shared values by endorsing a 'professional identity'; and 3) shifting the attention away from values by new scientific discoveries.[139] However, Fulford thinks that an awareness of values could be gained once knowledge of their existence is complemented by an understanding of their usage in language. To support this idea, he refers to J. L. Austin's assertion that a proper understanding of the connotation of values in particular contexts can be gained by examining the laypeople's language. This approach is particularly important in VBP as there can be a wide range of differences in the values of individual service providers involved in care of a given patient and also in the values of providers and users of services.[140]

The seventh principle is concerned with the second skills area or knowledge of values. Values-myopia is the idea that other people's values resemble one's very own. Therefore, the second crucial skill to VBM specifies the significance of having knowledge of the values involved or at play in particular decision-making contexts. To gain this knowledge, one could make use of the empirical and philosophical resources of other people's values. Of the first, he notes: 1) 'firsthand narratives; 2) use of literary sources like poetry; 3) anthropological methods; 4) psychological techniques; and 5) surveys'. The philosophical method he has in mind is continental with its phenomenology and hermeneutics.[141]

While he assumes that the previous principle could reconcile many conflicting and divergent views of values, he explains that for the difficult-to-resolve cases, one must resort to the eighth principle of VBM which specifies the third skills area, or that of reasoning about values.[142] In healthcare, two methods of reasoning are routinely applied – consequentialism and deontology. In clinical settings, on the other hand, the two dominant methods are: 1)

[139] K.W.M. (Bill) Fulford, Facts/Values: Ten Principles of Values-Based Medicine," in *The Philosophy of Psychiatry*, ed. Jennifer Radden (New York: Oxford University Press, 2004), 218.
[140] Ibid., 219.
[141] Ibid., 220.
[142] Ibid., 221.

"principles: [or the] "top-down" reasoning from general principles"[143], and 2) "casuistry: [or the] "bottom-up" reasoning, direct from cases"[144]. Fulford contends that although the differences in values may at times require resolution in VBM, such differences often provide a rich resource for clinical decision making. He likens these divergent values perspectives to 'lenses or filters' which often accord to and bring to light values of individual patients. In this sense, not only are the conflicting values conducive to effective clinical decision making but they are also a rich resource for making decisions that closely conform to the values of individuals concerned.[145]

Where the three mentioned skills fail to resolve conflicts, the ninth principle (which expresses the fourth skills area – the communication skills) comes into play.[146] He clarifies that there are two essential communication skills in VBM, namely: 1) 'patient-perspective skills' or the skills that are incremental to understanding patient values. These form the basis of the fourth, sixth, seventh, and eighth principles despite the fact that values of individual patients are 'irreducible';[147] and 2) 'multi-perspective skills' which assist us in arriving at a balance of values. These form the basis of the fifth principle which aims at replacing consensus with dissensus. Overall, communication skills play a crucial role in 1) identification and recognition of the different values involved in a particular case (which is complementary to principles 6-8), and 2) resolving conflicts in values where the views are in serious conflict. The second role clarifies the reason for the argument (in principle 5) to the effect that VBM not only involves the '*what*' is done, but also the '*how*' it is done.[148] Finally, the tenth principle of VBM removes the authority to decide from the hands of doctors and

[143] K.W.M. (Bill) Fulford, Facts/Values: Ten Principles of Values-Based Medicine," in *The Philosophy of Psychiatry*, ed. Jennifer Radden (New York: Oxford University Press, 2004), 222.
[144] Ibid.
[145] Ibid.
[146] Ibid., 223.
[147] Ibid., 223-224.
[148] Ibid., 224.

ethicists and places it back 'where it belongs' – that is, at the discretion of those involved in the process or the users and providers of services.[149]

Subsequently, Fulford considers the problems in the Diagnostic and Statistical Manual of Mental Disorders or the DSM and explains that the issues in the various versions of these manuals originate from inconsistencies in their treatment of values. According to him, the upward inconsistencies become evident in the shift from the definition of disorder to its scientific description. The downward inconsistencies, on the other hand, reflect the divergence when we move from the definition of disorder to the specific diagnostic categories.[150] The upward inconsistencies become apparent on the first reading of the definition of 'disorder' in the DSMs and once particular attention is paid to sections which emphasize that mental disorder must not be diagnosed "... on the basis of social values alone, [and as such] it 'must not be *merely* an expectable and culturally sanctioned response'"[151]. The implication of this caveat is that social values play a dominant role in defining both the concept of 'mental disorder' and the particular mental disorders.[152]

The downward inconsistencies are recognized once the second and third readings are considered. On the second reading, it clarifies that the "...impairment in social, occupational or other important area of functioning ... may not be considered problematic by the individual ..."[153]. The third reading lays out the fact that "these individuals are rarely self-referred and usually come to the attention of mental health professionals only when their behaviour has brought them into conflict with sexual partners or society"[154]. Therefore, notwithstanding the

[149] K.W.M. (Bill) Fulford, Facts/Values: Ten Principles of Values-Based Medicine," in *The Philosophy of Psychiatry*, ed. Jennifer Radden (New York: Oxford University Press, 2004), 224-226.
[150] K.W.M. (Bill) Fulford, Tim Thornton, and George Graham, "Values in Psychiatric Diagnosis," in *Oxford Textbook of Philosophy and Psychiatry* (New York: Oxford University Press, 2006), 572.
[151] Ibid. Brackets and emphasis are mine.
[152] Ibid.
[153] Ibid., 573.
[154] Ibid.

caveat, the DSMs allow for diagnosis of mental disorders on the basis of social values alone. Fulford argues that the implication of such diversity in value considerations in the DSMs is that clinical judgments are at minimum, partly value-laden. As this example demonstrates, by these inconsistencies, the DSMs fail to acknowledge the dominance of values in psychiatric diagnosis.[155]

I will now shift the attention to the argument posited by John Z. Sadler. Sadler endorses the 'fact-plus-value' model by Fulford and argues against the possibility of defining 'disorders' in value-free terms. He initiates his discussion by defining values as "... concepts we use to guide our actions, lead us to be deserving of praise or blame, and are assumed, to greater or lesser degree, in just about any everyday activity"[156]. As such, values play a descriptive role in that they can thoroughly evaluate the quality of things (e.g. they can determine whether a particular entity or quality has intrinsic value) and can affect individuals' choices and actions by providing a benchmark against which value judgments could be made. Consequently, values form an integral part of a '*(sub)culture'*, vary on a '*continuum*', entail the '*inherent (intrinsic) property*' of entities, and demonstrate the many *particular* ways in which they could be diverse.[157]

He explains that in philosophy, qualities used to describe entities are called 'predicates'. To make a distinction between the two types of predicates, he asserts that in the statement 'the apple is red and good', 'red' and 'good' are distinct in that the former refers to an objective, factual, and empirically-verifiable quality of the apple and the latter merely represents a subjective, non-factual, and variable value judgment about it. He contends that subjective value judgments can be easily identified by an awareness of the significant amount

[155]K.W.M. (Bill) Fulford, Tim Thornton, and George Graham, "Values in Psychiatric Diagnosis," in *Oxford Textbook of Philosophy and Psychiatry* (New York: Oxford University Press, 2006), 573.
[156] John Z. Sadler, *Values and Psychiatric Diagnosis* (New York: Oxford University Press: 2005), 9.
[157] Ibid., 8-9.

of disagreements that they result in.[158] He argues that in the statement 'James Carter is the greatest living jazz saxophonist', while his being the best is open to debate and a matter of opinion, his being a saxophonist is a universally-endorsed fact.[159]

Subsequently, Sadler refers to the role of values in the DSM. Classification of disorders inevitably requires the ability to distinguish one form of disease from another and consequently, it is largely dependent on proper diagnosis. He points to a standard dictionary definition of 'diagnosis' as 1) "the art of distinguishing one disease from another"[160] and 2) "the determination of the nature of a case of disease"[161]. The use of 'determination' implies that something beyond making a distinction is involved in diagnosis which can be summed up as a holistic understanding of the clinical situation.[162] He concludes that diagnosis must be evaluated in light of its two components; that is, in terms of 'diagnosis-as-denotation' and 'diagnosis-as-process'. While the former represents classification and naming disorders, the latter entails the 'approach' (or the procedure) to diagnosis. Diagnosis-as-process implies a more general understanding of clinical contexts and it is only through its incorporation alongside diagnosis-as-denotation that can result in a proper diagnosis.[163]

Having provided the standard definition of diagnosis, he proceeds to evaluate the DSM's current status. He contends that despite its prominent position in categorization of mental disorders, the DSM is quite incomplete as a handbook of proper diagnostic and clinical practice.[164] The DSM also fails at another level; although there is value in its employment of ordinary language and its being a user-friendly piece, it gives the reader the wrong impression that it is usable by anyone. In other words, it does not have the appearance

[158] John Z. Sadler, *Values and Psychiatric Diagnosis* (New York: Oxford University Press: 2005), 9.
[159] Ibid., 9-10.
[160] Ibid., 416.
[161] Ibid.
[162] Ibid.
[163] Ibid., 417.
[164] Ibid., 418.

of a technical document.[165] Furthermore, he argues that to be engaged in proper diagnostic practice, diagnosticians must have knowledge of the system of classification and categories and additionally, be aware of 'how' to utilize the tools at their disposal (or 'how' to *be* clinicians). He believes that this awareness can only be attained once the common features of what he broadly calls 'healing practices', are identified. Stated rather briefly, the seven features are: '*characterization, disclosure, embedded observation, relevance, privilege, rationality, and ritual*'.[166]

1. Diagnosis-as-characterization: the diagnostician views the malady as an exemplar of a condition that is shared with or was experienced by some other individuals and results in similar symptoms.[167]
2. Diagnosis-as-disclosure: the diagnostician's role is to recognize and reveal that which is unavailable to the patient and is crucial to effective clinical intervention.[168]
3. Diagnosis-as-embedded observation: moving between patient complaint and the related context, the diagnostician must search for clues irrespective of where and in which domain it might be embedded in.[169]
4. Diagnosis-as-relevance: the diagnostician is guided by the practical value of the information obtained in helping or treating a patient. Therefore, diagnosis is shaped by its degree of relevance to therapeutic intervention.[170]
5. Diagnosis-as-privilege: the diagnostician, by virtue of having access to private information of a patient and employing their knowledge and expertise in the field,

[165] John Z. Sadler, *Values and Psychiatric Diagnosis* (New York: Oxford University Press, 2005), 418-419.
[166] Ibid., 419.
[167] Ibid., 419-420.
[168] Ibid., 420.
[169] Ibid., 421.
[170] Ibid.

is given considerable power. The clinician also has a moral duty to serve, care, and cure. Fusing these factors together, diagnosis can be seen as a privilege.[171]

6. Diagnosis-as-rationality: in addition to observation, the diagnostician must interpret findings. Therefore, diagnosis is, in Sadler's words, a 'deliberative and rational' act. In view of the dual definition of the term, diagnosis-as-denotation pinpoints the presence of *theoretical* reason, whereas diagnosis-as-process entails the necessity of *practical* reason. This duality of reason leads to problems particularly in use of diagnostic classifications in clinical practice.[172]
7. Diagnosis-as-ritual: this refers to the standards that are followed in making a diagnosis. In the West, these include: "diagnostic descriptions, diagnostic criteria, structured interviews, mental status examination, and DSM diagnostic decision trees"[173].[174]

Sadler argues that the aforementioned features do not explicitly describe the characteristics of proper clinical practice. However, the values that are implied by these features can mark out proper from improper practices. The following five conditions – which Sadler calls diagnostic aesthetics – define the limits of good clinical practice.[175]

1. 'Diagnosis should provide a simple characterization'; that is, it should simplify a complex phenomenon into a manageable and comprehensible entity. The way a good diagnosis fulfills this goal is via naming the condition itself or naming a collection of particular phenomena. The latter reflects characterization of conditions by defining them in terms of 'syndrome', 'ideal type', 'dimension', and

[171] John Z. Sadler, *Values and Psychiatric Diagnosis* (New York: Oxford University Press, 2005), 421.
[172] Ibid., 422.
[173] Ibid., 422-423.
[174] Ibid.
[175] Ibid., 423.

'diagnostic category'. [176] He clearly warns against oversimplification of characterization which in his opinion can be prevented by pairing and balancing out the inherent reductionism with other considerations.[177]

2. 'Diagnosis should involve ongoing reinterpretation'. This clause could be traced back to the second common feature of diagnosis namely, 'disclosure'. Reinterpretation occurs when clinicians employ their expert knowledge to reinterpret the phenomena in consideration of patients' information and reach an understanding that was previously absent and then disclosure is made. He emphasizes that reinterpretation is an ongoing task for the whole duration of the clinical relationship. As an example, it contributes to assessments of the patient's response to treatment, modification of the treatment focus, and determination of the end to treatment, among others. It is also beneficial in that it prevents 'premature diagnostic closure' and restricts the tendency to oversimplify the diagnosis.[178]

Given the possibility of having conflicting interpretations, Sadler recommends adding 'embedded observation' to the bundle since it can guide and direct reinterpretation.[179] For instance, consideration of the context of diagnosis can eliminate pragmatically false interpretations.[180] He notes that placing too much value into diagnostic reinterpretation could result in what he labels 'diagnostic indecisiveness'. Furthermore, he acknowledges that requiring diagnostic simplicity and reinterpretation is difficult to meet.[181]

[176] John Z. Sadler, *Values and Psychiatric Diagnosis* (New York: Oxford University Press, 2005), 423.
[177] Ibid., 423-424.
[178] Ibid.
[179] Ibid., 424.
[180] Ibid., 424-425.
[181] Ibid., 425.

3. ‘Diagnosis should forge clinical understanding and moral purpose into therapeutic action’. This condition provides for the feasibility of balancing diagnostic simplicity with diagnostic reinterpretation. It does so by pointing to the diagnostic characteristic of ‘relevance’ which itself is founded upon the moral-pragmatic features of clinical contexts. It is the action-forging of clinical understanding and moral purpose that directs us in resolving the tension between simplicity and reinterpretation. Taking the effective course of action in clinical intervention is the key to arriving at a resolution.[182]

Sadler is clear that even if a given case does not fit the specifications of the classification categories, the more the clinician can forge effective action, the greater the diagnosis finesse.[183] This entails that clinicians must not get entangled in particular DSM or ICD categories for making a proper diagnosis and that pragmatism requires incorporation of all the different factors in making a psychiatric diagnosis. These involve understanding and explanation of the disorder which are restricted by the therapeutic tools available to the clinician. Therefore, the clinicians’ accuracy in making a diagnosis inevitably depends on the degree that they can “forge effective action from characterization and reinterpretation”[184].[185] There are dangers associated with an unbalanced forging action. Firstly, it may result in ‘premature closure’ or imposition of a false understanding upon a patient and secondly, it may result in unnecessary therapeutic interventions lacking any discretion. The remedy can be found in the incorporation of diagnostic characterization and reinterpretation.[186]

[182] John Z. Sadler, *Values and Psychiatric Diagnosis* (New York: Oxford University Press, 2005), 425.
[183] Ibid., 425-426.
[184] Ibid., 426.
[185] Ibid.
[186] Ibid.

4. ‘Diagnosis should respect the patient’. Diagnostic respect has four characteristics. First, it is both a moral action and a means to advancing therapeutic goals. Second, it allows clinicians to enter patients’ phenomenal world and characterize and reinterpret anew. [187] Third, a clinician’s diagnostic understanding is incomplete without an appraisal of what the patient is willing and able to do in treatment.[188] Finally, it entails finesse in dealing with ‘practical limitations’ in addition to ‘moral dignity’. Unbalanced diagnostic respect may result in overtly slow assessment and intervention which may lead to a worsening of the patient’s condition, for example. Therefore, diagnostic respect when left unchecked could cause a *reductio ad absurdum* or in Sadler’s own words, “an unjustified deferment of action-taking”[189].[190]
5. ‘Diagnosis should be faithful’. This requirement has a regulatory role as it is applicable to the previous four conditions. Furthermore, it engages several diagnostic values which demand diagnosis to be “rigorous, accountable, thorough, and consistent”[191]. These values entail faithfulness to “data, patient, context, and procedure” [192] respectively. Therefore, faithfulness by mediating interactions between diagnostic values, balances them out. For instance, when applied to diagnostic simplification, faithfulness ensures that the values at play restrict and prevent over- and under-simplification by attending to the complex phenomenon under consideration and simplifying it. The multitude of values involved in this

[187] John Z. Sadler, *Values and Psychiatric Diagnosis* (New York: Oxford University Press, 2005), 426.
[188] Ibid., 426-427.
[189] Ibid., 427.
[190] Ibid.
[191] Ibid.
[192] Ibid.

case includes "diagnostic accuracy, precision, coherence, [and] correspondence"[193], among others.[194]

Once applied to reinterpretation, faithfulness involves assessments of actions based on 'closeness of fit'. Fitness is to be evaluated not only in regards to 'the phenomenon and diagnosis', but also in respect to 'the phenomenon and therapeutic potential' and 'the diagnosis and patient respect', for instance. The aim would be to unify the patient's views with the diagnostician's reinterpretation, to conform diagnostic characterization with the availability of therapeutic means, to make changes in treatment methods based upon the patient's response to treatment, and the like.[195] In other words, in reinterpretation, faithfulness implies awareness of the many ways that phenomenon, diagnosis, and intervention affect one another. In its application to diagnostic respect, faithfulness pushes for following professional ethics in providing services to the diagnosed, particularly since accuracy of diagnosis is not the only consideration in ensuring faithfulness to diagnostic respect as the patient may be offended by the label and cease treatment.[196]

Sadler states that the diagnostic features and requirements that were thoroughly discussed up to this point bring to light considerations that are beyond those addressed by the DSMs (or the ICDs in Europe) as these manuals focus on raising an awareness of the distinction between diagnostic concepts and diagnostic practice.[197] Having noted the two definitions of 'diagnosis' (as a noun and a verb – where the former reflects the classification or categorization of disorders and the latter refers to the process or procedure of making a

[193] John Z. Sadler, *Values and Psychiatric Diagnosis* (New York: Oxford University Press, 2005), 427. Brackets are mine.
[194] Ibid.
[195] Ibid.
[196] Ibid., 428.
[197] Ibid.

diagnosis), Sadler argues that many of the issues often cited with psychiatric diagnosis and the DSMs are due to our ignorance of this duality in definition of the term.

For example, the two senses of 'diagnosis' are often unwittingly used interchangeably resulting in a confusion of the flaws in diagnostic taxonomy with those in diagnostic practice. Furthermore, given the associated difficulty with specification of features of proper clinical practice, this crucial task is often neglected. Moreover, he contends that values play a substantial role in psychiatric diagnosis especially since diagnostic procedure (and the values involved in the process) triumphs over diagnostic classification. He also thinks that an under-appreciation of psychiatric values has contributed to the development of many of the existing problems in psychiatry.[198]

[198] John Z. Sadler, *Values and Psychiatric Diagnosis* (New York: Oxford University Press, 2005), 429.

§ Fulford's Critique of Boorse's Medical Model

I will now shift the attention to Fulford's critique of the Boorsian model. Fulford agrees with Boorse on the value-ladenness of the concept of 'illness' and on the fact that this concept (contrary to 'disease') is more often used in non-technical contexts.[199] While 'illness' is used to convey that "something is *wrong*"[200], 'disease' is used to express "*what* is wrong"[201]. He states that most causes of illness are 'protean' and have 'disturbance of functioning' as a shared common element. From this Boorse concludes that 'diseases' must be defined in terms of 'disturbances of bodily functions'.[202] Fulford, however, finds the Boorsian view inconsistent given that despite being capable of explaining cases where one is diseased without being ill, it cannot provide a meaningful explanation of the opposite cases (that is, it fails to explain instances when one is ill without being diseased such as the case of someone experiencing a hangover).[203]

It is important to note that Boorse aims at defining 'function' in value-free terms. Fulford rejects the credibility of this stance since the teleological (i.e. goal-oriented) nature of 'function' links it with 'purposes and values'.[204] Therefore, while it is reasonable for naturalists (such as Boorse) to take 'value-free' as 'teleology-free', they generally tend to aim at reducing the 'teleological' explanation to a 'causal' one.[205] Boorse maintains the 'teleological' aspect of 'goal' and offers a value and 'teleology-free' definition for 'function' as the "standard causal contribution to a goal actually pursued by the organism"[206].[207] Fulford

[199] K.W.M. (Bill) Fulford, *Moral Theory and Medical Practice* (Cambridge: Cambridge University Press, 1989), 29.
[200] Ibid., 30.
[201] Ibid.
[202] Ibid., 30-31.
[203] Ibid., 31.
[204] Ibid., 83.
[205] Ibid.
[206] Ibid.
[207] Ibid.

identifies two problems with this definition: the *general difficulty* is concerning the concept of goal being inherently evaluative in meaning given that a goal is "good to hit and bad to miss"[208] and the *specific difficulty* is regarding the inapplicability of 'function' (as part-function) to 'mental disorders' since these involve the person as a whole and not individual organs and systems.[209]

The second difficulty becomes evident when the case of individuals feeling ill (whose conditions have not been either identified or diagnosed, yet) is considered. These patients cannot be said to suffer from diseases of the Boorsian kind which require knowledge of the occurrence of a 'particular disturbance of function'. The third problem with Boorse's model is related to our ordinary use of 'disease' (and not 'illness') of plants and animals as we employ the term about people. Boorse thinks that the difference reflects a variety in forms of value judgments that we commonly make of people and other living beings.[210] In spite of this difference, it would be a mistake to think of illnesses as serious diseases which incapacitate the afflicted party because if this were true, we would have to label a disease-incapacitated plant or animal 'ill' and this, we clearly do not do.[211]

The fourth issue is in respect to the 'logical relationship' between 'disease' and 'illness'. The Boorsian model demands that all diseases be disturbances of function. However, neither are all diseases disturbances of function nor are such disturbances always diseases. For instance, one may be wounded but cannot be called 'diseased'. Therefore, the above distinction is 'too broad'. The fifth objection to Boorse concerns treating 'illness' as a subcategory of 'disease' which is equivalent to a 'disturbance in functioning'; this implies that when someone is said to be ill, it is meant that they are not functioning properly. Fulford

[208] K.W.M. (Bill) Fulford, *Moral Theory and Medical Practice* (Cambridge: Cambridge University Press, 1989), 83.
[209] Ibid.
[210] Ibid., 31.
[211] Ibid., 31-32.

explains that when 'ill' is substituted with 'not functioning properly' in a statement like 'he is ill', the meaning thus arrived at is distinct from the original connotation of the sentence since it could be understood as stating that the person is not functioning properly in 'some social role'.[212]

Fulford contends that Boorse's account can survive if his model is deemed as offering the crucial definitions for the purposes of 'medical theory'. In fact, his assumption of the possibility of defining 'disease' in value-free terms is prominent in the technical contexts of medicine. However, his theory is subject to shortcomings when the objective is to explain ordinary usage. Despite these, it can still be a helpful model once it is assessed from the perspective of its practical utility.[213] Given that the medical model is only successful in respect to '*empirical* clinical problems', it fails to successfully address the '*non*-empirical' problems arising in analytical research. Therefore, adoption of the medical model for analytical research purposes merely complicates the problems that research must address.[214]A clear example of this problem is Boorse's example of 'homosexuality'. In order to resolve the dispute about its disease-status, he redefines the 'scope of medical theory' to exclude the debate altogether.[215] The failure of Boorse's model to account for the logical characteristics of the medical concepts is, in Fulford's opinion, related to the fact that the three terms (namely, 'illness', 'disease', and 'dysfunction') are inherently value-laden.[216]

Furthermore, upon defining 'dysfunction' and 'disease' in factual, descriptive terms, Boorse slips into evaluative definitions. For instance, despite initially defining 'disease' in descriptive terms and as "...a deviation from the natural (= statistically typical) functional

[212] K.W.M. (Bill) Fulford, *Moral Theory and Medical Practice* (Cambridge: Cambridge University Press, 1989), 32.
[213] Ibid., 33.
[214] Ibid.
[215] Ibid., 33-34.
[216] Ibid., 34.

organisation of the species ..."[217], he offers another definition two lines later in evaluative terms and this time 'disease' is viewed as "a deficiency in the functional efficiency of the body"[218]. While 'deviation' of the functional organization of a member of a given species might be better, worse, or of equal worth in comparison to that typical of a species, the claim to its functional inefficiency clearly involves value-judgments since it could be assessed as not functioning well, or *properly* or successfully or as it ought to do.[219]

Boorse attempts to broaden his definition of 'deviation from the natural' to include both 'statistically atypical conditions and those brought about by 'environmental causes'. Shortly after, he uses the evaluative "hostile environment"[220] in place of 'environmental causes'. Another slippage occurs when he defines 'mental illness' as an '*interference* with a mental function'. Given that distinguishing interference requires a value-judgment and since he could have used a neutral term (for instance, 'effect') such slippage significantly undermines his theory.[221] Boorse allows value-judgments by 'ordinary implication' – that is, he allows for consideration of disease as a condition that is generally evaluated negatively but argues against the idea of a negative value-judgment being a part of the '*meaning*' of 'disease'.[222] Nonetheless, he allows evaluations to take part in the meaning of the terms as his example of 'intelligent' demonstrates. In non-technical contexts, the term 'intelligent' has a positive value-judgment built into its meaning and is clearly evaluative; despite this, Boorse deems it purely descriptive in technical contexts.[223]

[217] K.W.M. (Bill) Fulford, *Moral Theory and Medical Practice* (Cambridge: Cambridge University Press, 1989), 37.
[218] Ibid.
[219] Ibid.
[220] Ibid., 38.
[221] Ibid.
[222] Ibid., 38-39.
[223] Ibid., 39.

'Disease' and 'dysfunction' are similar to the term 'intelligent' in that they are evaluated (albeit negatively); in addition, the terms contain 'descriptive information' as a part of their meaning similar to that of 'intelligent'.[224] The difference between the two sets of terms is that while 'intelligent' can be used with a descriptive connotation, the other two terms cannot be defined in purely descriptive terms (as Boorse's slippage made it clear).[225] Indeed it is '*strictly* impossible' to use 'disease' and 'dysfunction' in purely descriptive terms. Descriptivists might suggest reinterpreting Boorsian theory as one holding that value-judgments expressed by value-terms 'disease' and 'dysfunction' are entailed by certain descriptions. Therefore, to have a 'disease' or 'dysfunction' is equivalent to being in a functional state which results in a reduction in life expectancy and reproductive capacity. Hence, the value-judgments entailed by the two terms are offered by the same description.[226]

In the subsequent chapter, I will thoroughly discuss my views on the 'fact-plus-value' model and by pointing to the inconsistencies and deficiencies of the views of Fulford and Sadler, I will raise my concerns. The forthcoming chapter will end with an overview of a possible solution to reducing or possibly eliminating the problems by recommending that certain changes be made to ensure coherence of the accounts under consideration.

[224]K.W.M. (Bill) Fulford, *Moral Theory and Medical Practice* (Cambridge: Cambridge University Press, 1989), 39.
[225] Ibid., 39-40.
[226] Ibid., 40.

Chapter 4: Critique of The Fact Plus Value Model, Possible Solutions & Concluding Remarks

A clear indication of the fact-plus-value model is that despite medicine's historical inclination towards incorporation of a fact-only approach, psychiatry is, at its core, value-laden. Whether this drives psychiatry away from the medical orientation that its practitioners wish to have is a question that Fulford rejects. For him, values play an integral role alongside facts in developing a *proper* understanding of the concept of 'disorder' and particularly of 'mental disorder'. He seeks the assistance of philosophy by employing linguistic analysis in distinguishing between factual and value-laden statements and arguing for R. M. Hare's view that "*all* value terms may under certain circumstances, be used with clear factual meaning" [227]. However, this position is, in my opinion, problematic with respect to psychiatry.

For instance, Fulford's failure to provide a methodical guideline for identifying factual concepts in their own terms results in an ambiguity that cannot be resolved easily. Put differently, it is relatively simple for one to slide from the assertion that 'all value terms can sometimes have factual connotations' to the argument that no factual term can essentially exist since what appears to be factual may turn out to be a value term concealed under a factual cover. This is worrisome in that Fulford does not proceed to define the particular circumstances or instances where values can have factual meanings, resulting in an increased complexity in application. Subsequently, it would be very convenient for the reader to assume that no boundaries need to be set and this, lands us in a slippery slope in that the absence of pre-defined boundaries would make one assume that it is safe to apply the notion

[227] K.W.M. (Bill) Fulford, "Analytic Philosophy, Brain Science, and The Concept of Disorder" in *Psychiatric Ethics*, ed. Sidney Bloch, Stephen A. Green, and Paul Chodoff (New York: Oxford University Press, 1999), 173.

of terms being value-terms with merely factual appearances in all circumstances or conditions.

Furthermore, I am concerned that rejection of the existence of factual terms can only make them second-class, arbitrary terms that are unverifiable, unless values are blended into their consideration. That is, factual terms can only be deemed *essentially* factual by virtue of their lack of evaluative qualities. This means that it is only through making a direct comparison with values that factual terms can represent distinct entities. In other words, unless values are present as the benchmark for identification of factual terms, they could not be recognized as distinct entities. This renders their existence largely dependent on values which would subsequently make them a sub-category of values. As a result, facts lose the very solid essence that they have been long assumed to have and by questioning their inherent quality, we are merely placing the solidity of our knowledge foundation under fire. Moreover, it is clearly against the spirit of the Fulfordian argument to award such precedence to values by implicitly reducing facts to sub-entities within the evaluative sphere and under the influence of values.

A possible consequence of this position is that all terms in general would have to be deemed as value terms and the possibility of having independently identifiable facts becomes suspect. The question is, if all terms are indeed value terms and no external factual term exists, why are we to even bother trying to make a distinction? Clearly, facts play an undeniable and crucial role in our understanding of psychopathology, which is evidently demonstrated in the case of neurocognitive disorders (such as dementia or in terminology of DSM 5 – major or mild neurocognitive disorders). As mentioned in Chapter One, this Fulfordian conjecture seems to equate factual terms with ‘terms with less evaluative content and force and with merely an overt factual connotation’. Consequently, I fail to see how this position could successfully explain the factual content or causes of such disorders. I do not

believe that he intends to define major neurocognitive disorders merely in terms of the afflicted person's failure at fulfilling a certain function (irrespective of whether it is in the form of a reduction of function or absence of it) and by doing so, deny the role of factual data underlying the disorder in the whole diagnostic enterprise.

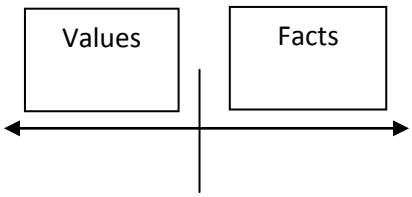
In fact, radical social constructivists may argue that the distinction he makes (between 'use' and 'nature' or 'essence' of factual and value terms) is capable of resolving the issue; that is, it should be sufficient that terms be factual only in 'use' and not in 'nature'. They might reason that as long as values precede facts, in connotation and applicability, having the purely factual terms is not necessary. In other words, they tend to think that since values have a broader range of applicability in psychiatry, the few facts that we know about this field of medicine can be blended into value terms, making the factual terms' distinct existence unnecessary. This implies that they are predominantly placing an overt authority in the hands of values while facts are almost entirely absent.

I do not share this view. No matter how clear a distinction we could make, factual terms need to be factual in both their 'use' and 'nature'. A term that is factual in *use* alone cannot be deemed inherently factual. Imagine being on the road where you encounter a yellow traffic light. Yellow is a factual predicate of the traffic light. Since it is a concept that is verifiable and shared with others, the proposition that 'the traffic light is yellow' states a fact. Nowhere within the sphere of our thoughts may we allow someone to say otherwise. The discrepancy in Fulford's account becomes obvious when his former and latter views are compared. On the one hand, he supports the factual nature of the above statement. He agrees that facts do exist independently of values and this is clear where he implicitly acknowledges that empirically-verifiable, objectively-true, and commonly-endorsed scientific ideas describe facts that are in essence factual. On the other hand, based on R.M. Hare's assertion (about the possibility of having value terms that are factual in appearance) he argues for the evaluative

essence of '*physical* disorders'. If facts can indeed be independently identified in view of their commonly-shared qualities (which I deem both possible and desirable), then Fulford should not need to argue for the evaluative nature of a historically-known factual term. Doing so would only make values very influential in his account and given the lack of a proper description of boundaries, his account turns out to be too evaluative.

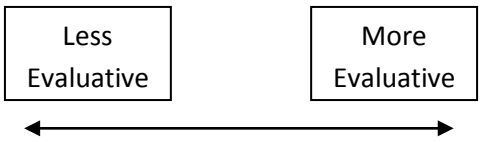
Furthermore, Fulford claims that VBM complements EBM and that the two are to be used as parallels. This view, as he notes, takes away the possibility of VBM replacing EBM. The conflict arising in this case is related to the priority and dominance he implicitly assigns to values. It is not clear to me why we are to accept the argument he posits in defence of the role that values play (by allowing them to take part in every concept, diagnosis, and decision-making processes) and not be convinced that in light of their comprehensiveness and broad spectrum of applicability (that is, in both theory and practice), values can eliminate the need for facts. It is worthwhile to note that he does not argue for the elimination of facts; however, in my opinion, this is a possible consequence of the arguments he makes. Furthermore, this would entail that his argument in regards to the place of factual inputs on the continuum of definition is, contrary to his view, a matter of the degree of value-ladenness. Therefore, while Fulford aims at clarifying the distinction between facts and values, I think that he is only adding to the difficulty.

Moreover, while he proposes a model under which facts and values occupy distinct positions within the theory, the model that he ends up developing is one in which the boundaries between facts and values are blurred. In addition, within his new continuum, facts are not explicitly observable since the spectrum of constituents of 'disorder' revolves around an evaluation of the degrees of values involved. Indeed, the role of facts is so minimal that they cannot possibly provide a benchmark for the assessments of terms. Below, I have provided a graph of the two positions Fulford takes on.



Fulford's Claimed Position

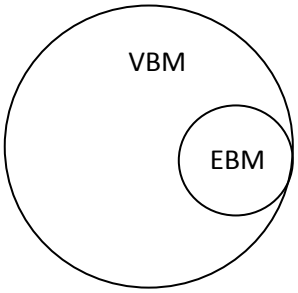
VBM and EBM as Parallels



Fulford's Actual Position

EBM as a subcategory of VBM

As the diagrams demonstrate, Fulford has assumed that VBM plus EBM would result in what can be optimistically called *proper* medicine. However, he fails to maintain this position by granting values more room to influence our knowledge of psychopathology. Therefore, arguing for the equality and parallelism of VBM and EBM underestimates his main objective (that is, increasing the awareness of values). In order to ensure consistency in his arguments, Fulford must either try to resolve the matter by specifying the boundaries of values or alternatively, revise his current position in regards to the significance of facts and the crucial role that EBM plays. However, in order to make the most minimal effort in revising his argument, I suggest that he should re-position the facts and place them within the boundaries of values. The diagram below clarifies my point.



Although this modification can potentially help Fulford's theory, I do not support its validity. I think that once we adopt this new model, we will be locked in a position that considers 'disorder' in general and 'mental disorder' in particular as social constructs. The danger of assuming this position becomes evident once we realize that our means of identifying psychopathology is limited to values alone particularly since facts are merely a subcategory of values and they themselves are recognized in light of existent values. It is

clear that once we are left with only values as our guide to identification of ‘disorders’, containing or restricting the influence of socially-accepted norms and culturally-specific customs becomes impossible. The society in that event would define and determine the constituents of maladies and would further describe and develop proper treatment modalities. This means that the catalogue of unhealthy conditions would vary widely from one society to the next. It also opens the door for the state’s imposition of paternalistic policies and their inevitable coercion. However, this cannot truly hold since there are disorders that have empirically-verifiable and largely-shared factual causes, such as CAD (or Coronary Artery Disease). We know that a diet comprised of fatty foods and lack of physical activity can cause CAD. Moreover, we have a solid medical means to treat the condition (whether with medications or surgery). While values can help us get acquainted with the lifestyle of people around the world, they cannot point to a particular social construct that is responsible for the development of CAD or alternatively provide us with a solid means of treating CAD. It is important to emphasize that in my opinion, facts are our best means of restricting values. Once our scientific understanding of the factual causes of mental disorders advances, we would be in a much better position to utilize facts in limiting the role that values play in our current nosology simply by incorporating them more in defining psychopathological conditions. In that case, facts would provide us with a solid and objective benchmark against which particular conditions can be assessed in order to determine whether they can qualify as instances of mental disorders.

His placement of EBM under the supposedly more general heading of VBM can potentially lead to another kind of difficulty as well. One could overextend his argument and claim that given the dominance of values in psychiatry and their more comprehensive nature in comparison to facts, psychiatry has precedence over all other medical specialties. In that case, psychiatry would be an all-encompassing field that acts as the guide and benchmark

against which efficiency and appropriateness of treatment modalities and medical practice are evaluated. To realize this potential, Fulford must demonstrate that other specialties are in effect dependent upon the values that psychiatry addresses. Although he does not explicitly provide an argument in support of this view, I believe that he could back up this hypothesis in a different way; that is, on the basis of the *practical* priority of psychiatry since it is capable of incorporating or including both VBM and EBM. In view of the fact that even despite the superiority of VBM, EBM could still survive (as a sub-category) under psychiatry whereas under other specialties values are not considered or incorporated into EBM, psychiatry could act as a module under which other medical specialties would be placed in respect to their degree of dependence upon values.

However, taking this route is not problem-free either. Psychiatry stands at one extreme end of the values spectrum while other specialties rest on the other end. The question is, 'why are we to prefer one extreme position to the other?' While values are under-balanced on the EBM side, they are overrated on the VBM side. I am hesitant to accept either view since they are both out of balance. I think the solution could be found in a medical orientation that is the result of a combination of psychiatry and an EBM-based specialty. In my opinion, the issue could be resolved if we merge psychiatry and neurology. The new field that emerges (which we may for the ease of reference call neuropsychiatry) is a much better balanced view and can address both EBM and VBM sorts of concerns. It could then provide us with a more comprehensive and practical approach to define or assess and diagnose 'disorders'. I think that neurology is our best available option particularly since all mental disorders appear to originate in the brain. My belief is partially supported by the recent advancements in developing the next generation of psychopharmacological agents that tend to be effective in reducing or eliminating symptoms of an array of mental disorders (and these have been particularly helpful in cases of schizophrenia and psychotic disorders). These agents are

known to affect the balance of neurotransmitters in the brain in one way or another. My view is further supported by improvements in our understanding of the role that talk-therapies play in controlling or reducing symptoms of psychopathology. Talk-therapies have been proven effective by virtue of the changes that they make in the brain functions of patients and their subsequent modification of behavior.

It is important to note that neuropsychiatry does not automatically dismiss psychiatry or place the future of the field into jeopardy. It is rather a matter of balancing out conflicting views. Granted that psychiatry (as we know it today) will not remain the same, the changes made are crucial to the development of an acceptable definition of 'disorder'. I think that neurology could also help psychiatry in regards to the DSMs by balancing out and supplementing the values that are embedded within the diagnostic categories with facts. Moreover, neuropsychiatry could also shift the attention away from the shortcomings of psychiatry in explaining causes of psychopathology by complementing the field with its scientific and factual data on the brain. Whether this dualistic view of the mind and brain is justified, is a question that is out of the scope of this paper.

Returning to Fulford, he seems to have provided conflicting arguments in favor of values and psychiatry in general. Irrespective of what the actual proper model of medicine should look like, I am of the opinion that he must make several significant revisions in his theory to coherently connect the ideas he offers in his book with those in his later works. For instance, he must try to balance out his views on the parallelism of facts and values with the arguments he makes in support of values complementing facts given his belief that values have an inherent capacity at resolving irreconcilable conflicts. In other words, the role of values seems to be disproportionately weighed when their interaction with facts is under consideration. Fulford must either announce that values have a greater role in medicine than that normally assigned to them or come to the realization that they occupy a similar space as

facts in our definition of ‘disorder’ and consequently in our understanding and developing strategies in diagnosing and treating ‘mental disorders’.

I tend to agree with Fulford that the significance of values has been historically underestimated in medicine but that alone does not make them the ideal candidate for reducing the questionable strategies that facts offer in the identification and treatment of ‘mental disorders’ in general. I also sympathize with him where he tries to contain the range of applicability of facts in psychiatry and announces that psychiatry is distinct from the other fields of medicine by virtue of its more significant reliance on value considerations; but I do not think that that alone should grant him the authority to effectively argue in favor of the current understanding of medicine in general. Put differently, I worry that in his account there is not a lot of room left for scientific advancements and that to ensure coherence, he must take the status quo as what will inevitably persist into the future. This implies that although he appears to argue for the possibility of future scientific advancements, his account pushes him into restricting the influential range of EBM and consequently, closing avenues that allow us to debate whether our understanding of causes of mental disorders should remain the same or change over time.

Furthermore, the superiority of VBM to EBM (although implicit) must either be outright rejected or justifiably assumed. I am in favor of a state of equilibrium between facts and values and for this reason, I think that he must promote the idea of parallelism between EBM and VBM. The feasibility of holding this stance in light of his other arguments is slim. However, if he truly plans on defending this view, he must be willing to discuss the differences between psychiatry and other fields of medicine in regards to their incorporation of VBM and EBM in even further details and also identify and explain what precisely acts as the medium of change that makes the divergence between the two forms of medicine possible without overturning their credibility. The medium in my opinion is neither a fact nor a value;

instead, I think it is the widely-shared norms that exist within all societies. It is important to emphasize that by 'norms' I have two distinct definitions in mind. Eric Matthews, in his book called *Body-Subjects and Disordered Minds*, defines 'mental disorders' as deviations from 'human norms' that are unintelligible to the common human reason; 'bodily disorders', on the other hand, are equated with deviations from pre-defined 'biological norms'.[228] On the same basis, I believe that psychiatry largely depends upon VBM as it must identify and evaluate conditions on the basis of the 'common human norms' that are at play in any particular society. It is not so reliant on EBM given that its objective is to distinguish deviations from intelligible reasoning. Other fields of medicine, however, aim at discovering deviations from the commonly-shared biological norms or standards which are defined and specified on the basis of empirical findings and as such, they are mainly reliant on EBM.

Nonetheless, it is important to acknowledge that a society's developmental status (in regards to scientific and technological advancements) has a significant role in determining whether EBM or a mixture of EBM and VBM is to be used in practice. If we imagine an underdeveloped society where the resources are scarce, many modes of treatment for, say schizophrenia are unavailable. If a schizophrenic patient acts out, he or she will be devalued as a person within the society by being deemed criminal, and will be shunned upon by everyone including their own family. The same story holds true within the physical realm. In the case of someone suffering from infertility, the society may be reluctant to view the person as being afflicted with a physical disorder and in the absence of solid scientific knowledge, it may consider the person as being sinful and/or not having 'proper' faith in God. Given the unavailability of treatment and the fact that patients could not be magically cured of their illness, the society views the sufferer as an unwanted part of the community since they do not fit within their particular socio-cultural understanding of personhood. Not surprisingly, to

[228] Eric Matthews, *Body-Subjects and Disordered Minds* (New York: Oxford University Press, 2007), 99-103.

avoid ending up with more and more of such persons, the society might end up trying to deter the afflicted with other means of control such as imposing criminal convictions or religious accusations on the basis of their deviant actions (that defy social norms) and the role of the afflicted persons within such environments changes from a patient to a criminal or an accused. Clearly things would have been different for the above persons had they been living in a modernized society like ours.

As such, VBM could only be 'properly' enacted where the society enjoys at least a moderate understanding of pathology or psychopathology and to get there, EBM must be in existence prior to such enactment. Therefore, if any of the two is to be prioritized, it is the EBM and not the VBM that must have precedence. For this reason, EBM must be in operation before psychiatry could argue for the discipline's more evaluative basis. It is interesting to ask where this understanding takes us in regards to the field of psychiatry particularly since it is heavily reliant on VBM. Far from being at the tip of the medical pyramid, psychiatry is so dependent on the very little knowledge it has gained through EBM that it cannot be sustained on its own as a purely VBM-based enterprise. Simply put, without EBM psychiatry has no future. Therefore, it is crucial that EBM and VBM be used as joint partners.

One of the issues that may arise at this point is regarding the manner in which incompatible values are balanced out. Fulford writes extensively on reaching a balance when values of patients and service providers are in conflict. Despite this, he does not offer a model example in which he puts the idea into practice. Granting that the practice of psychiatry is significantly values-based, how could opposing views be coherently understood and practiced? There is again the gap resulting from lack of specification of the limits of value considerations that is at play. Although Fulford thinks that VBM puts patient-considerations first, I am not clear how this could pragmatically be done particularly since there are many

patients who lack either an insight into their conditions or the ability to communicate their needs. How are we to address such needs while keeping in mind that they *supposedly* have to want the specific need we are about to address, fulfilled? In psychotic disorders, especially those with hallucinations, the patients often think that the service providers are not acting in their best interests and instead, they frequently believe that clinicians are part of a plot against them. In the absence of family members, how can we reasonably assume that what we think is right, is indeed the best course of action for such patients? Fulford does not say and I think that unless we are willing to introduce and engage an external source of assistance (such as the law and legal proceedings) to his account, the subjectively-variable 'best' course of action for the individuals afflicted cannot be easily determined and even then, there will be no guarantees that the chosen option would accord to individuals' own sense of well-being.

One might argue that consideration of patients' values need not accord with pragmatic and viable solutions to their problems. If the healthy mind and body is what everyone aims at having, then anything that promotes these would implicitly or explicitly accord with patients' goals. I strongly disagree. The therapeutic boundaries are not so clear-cut that we could calculate the outcomes beforehand and aim at what is commonly considered as the best option. Those views fit within the utilitarian viewpoints and utilitarianism is subject to its very own shortcomings and problems. Furthermore, the best course of action for patient A might not be identical to that for patient B even if both patients are suffering from the same disorder.

To be clear, I am hesitant to argue for the viability of such arguments and instead think that there ought to be a way of evaluating the past decisions of the afflicted persons in order to find similar or sufficiently similar (in the sense of being reasonably the same) courses of actions and the particular values that the patient in question has previously assigned to them. In this sense, I believe that facts come into play. The reason is that the

phenomena and the processes that led to particular decisions could only be assessed in light of the underlying facts that were significant at that point in time. For instance, if the patient has decided to take medications as opposed to ECT (i.e. Electro-Convulsive Therapy) in the past when both options were made available to them, then by virtue of similarity of this episode of depression to those that occurred in the past, medications are to be used even if the patient has lost the ability to communicate their choices and needs to the caregivers.

It is important to clarify that this method of identifying patients' needs is by no means a problem-free option. While it may rid us of the dilemmas that we would have to face if we opt in for the other options, it is nonetheless challenging. The reason is that we must be careful enough to avoid placing too much authority (in the decision-making processes) into the hands of service providers given that history has proven the susceptibility of this path to the promotion of paternalistic forms of therapies and even worse, misuse of power. This is where EBM could help. If we decide to accord our values-based considerations to the scientifically-proven treatment methods of EBM, then the likelihood of psychiatric misuse drops significantly. It is a fact that psychiatry is nowhere near the level of advances made in the other medical fields but that should not deter us from engaging as much scientific knowledge as is possible and available to us into our diagnosis and treatment modalities. Patient advocacy is another means of restricting the opportunity for therapeutic misuse. By having an independent advocacy group that functions in the interests of individual patients and possibly keeping a track record of their choices and preferences, we might be able to incorporate patient needs into decision making processes more fully and completely. The decision making power is then divided between two independent sources, one which offers treatment and one which proposes the much desired treatment.

In regards to Fulford's position on the model of 'disorder' and his later references to VBM, I think that an inconsistency exists between his original and later views on the concept

of ‘values’. One may only coherently understand the difference by distinguishing between the two possible senses of the term in question. While in his definition of ‘disorder’ (and on the theoretical side of matter), ‘value’ refers to a subjective relationship that one may have in relation to the external world, his later works (on the practical side) suggest a differing understanding of the concept as the subjective relationship of one to their very own subjective and internal sense of existence.[229] It may be argued that the non-recognition of this difference is the reason behind possible objections. In my opinion, one may rationally find coherence in the totality of his works by endorsing this view even though it is subject to its own shortcomings. It is worthwhile to note that Fulford does not explicitly or implicitly speak of the distinction in the meaning of ‘value’ and one may only assume that he wants the reader to come to this conclusion by themselves.

On the theoretical side, ‘disorder’ is defined as a combination of facts and values where the two elements differ in regards to their application to physical and mental disorders. While the case of ‘physical disorders’ is more factual and scientific, ‘mental disorders’ are more value-laden and normative. The normativity found in the definition of these terms corresponds to the external views of society in regards to particular cases of disorders. Therefore, while the values shared by both kinds of disorders differ in quantity, they share the quality of being normatively defined by the norms of the society at large. As a result, ‘disorder’ can be defined as the sum of some factual evidence and socio-culturally-defined normative values that determine the relation of subjects to their external environment. The practical side, on the other hand, considers the values of individual patients and evaluates them on the basis of their endorsement by the afflicted persons within VBM and VBP. The

[229] K.W.M. (Bill) Fulford, “Values, Science, and Psychiatry” in *Psychiatric Ethics*, ed. Sidney Bloch and Stephen A. Green (New York: Oxford University Press, 2009), 71.

practical sense of values, then, considers the relationship of subjects to their own existence as experiencing subjects.

While the two senses of values seem to be jointly forming a comprehensive understanding of values in general, they are deeply problematic. The reason is that they cause a phenomenological gap in one's understanding of values when both the theoretical and practical senses of values are under consideration. Put differently, it is not obvious how we are to shift our attention and make a leap from the socially-defined sense of values to the individual's consideration of them when the aim is to effectively define, diagnose and treat 'disorders'. Imagine a person who is diagnosed as having clinical depression. It is not clear why we must assume that if their external environment views them as being in need of treatment, then the patient must adhere to the social views and reject their subjective experiences and values which may be suggestive of a progress made in, say their spiritual awareness. This is where the phenomenological gap becomes evident. One may be aware of their subjective experiences of their external environment but in the absence of conformity between that and their own private and inner subjective experiences it is not obvious which must outweigh the other or even how a balanced position, if at all possible, can be reached.

The problem is particularly acute for those suffering from disorders that have anosognosia as their core feature. How are we to convince those persons that the treatment offered is their best available option to regain their sense of clarity and to fully enjoy their capacity as experiencing subjects? It is far from clear that we could provide them with any solid reasons. Another difficulty that may arise is related to the issue of forced treatment. It is undeniable that the values and views of patients differ greatly from those of their societies and while we reject holding such patients criminally responsible, we routinely subject them to forced therapeutic intervention. How can we objectively judge them to be ill when psychiatry is so significantly reliant on consideration of values (particularly since we lack any solid

evidence that social values are, by virtue of being more commonly shared, more correct value-wise)? I do not suppose that there can be a simple answer to this but to avoid difficulties in evaluating the role that values play (both at the level of subjective experience of the external world and the subjective experience of self) we must define a benchmark against which validity of possible views are to be assessed. In other words, in view of the complexity of values and the need to objectively assess them and also given that facts constitute an inseparable element in the ideology of mental disorders, we must develop a benchmark which, in my opinion, is best provided by facts. This is the view that Dominic Murphy supports; he contends that neuropsychiatry can provide us with all the necessary facts for identifying conditions that are instances of mental disorders. While he recognizes the significance of values to the development of mental disorders, he emphasizes that the changes that lead to such maladies all arise as a result of the changes that occur in the brain. Simply put, the socio-cultural values and forces affect and make changes to the brain and these changes in turn modify the patients' behavior.[230] This is a crucial point; given the current status of facts (i.e. we do not know what they are in psychiatry), we can perhaps understand the predominant position of values in Fulford's account. However, in conformity with Murphy's 'biopsychosocial' approach, I think that facts are the driving force that will help us understand and identify instances of mental disorders. I believe that as neuropsychiatry advances, we will be better equipped to explain psychopathology and once we learn the facts, Fulford would have to revise his account.

Another related issue is in regards to homosexuality. Fulford rejects the validity of arguments in favor of its having a disease status but fails to explain how, under his fact-plus-value model, we are to treat it as a normal human condition or even a rational choice. The

[230] Dominic Murphy, "Social Construction and Sociological Causation" in *Psychiatry in the Scientific Image* (Cambridge: Massachusetts Institute of Technology, 2006), 263.

case of homosexuality is distinct in that the values that are involved in its understanding are at best not uniform. That is, the disease status of the condition varies from one society to another and this is strengthened by Fulford's account. If the society views it as a form of illness, deviant behavior, or even sinful act, the label of the condition varies accordingly. I worry that there are too many variables that can affect and promote non-acceptance of the condition and the variables constitute differing conceptions of values within societies. This essentially reflects the fact that the disease-status of the condition is verified in view of external value forces and that the person, their personhood, and particular values play no role. The distinction between the two forms of values tends to get exaggerated in the case of homosexuality and Fulford's account seems unable to effectively resolve the issue.

Sadler's account is also overtly value-laden. I do feel a need for imposing limitations on the influence of values when he allows them to be present in both theory and practice. My reservation may become more obvious when inclusion of values as a significant source of contribution to theory is considered. Simply put, I am hesitant to accept the idea that given our lack of scientific knowledge of the factual causes of psychopathology, we must use values in our identification of their causes. Values are not by any means interchangeable with facts and where facts are absent we must aim at discovering facts rather than looking for a proper substitute. One might claim that psychiatry is in its infancy and that this requirement could not be possibly met. I tend to think that just as medical knowledge was expanded through time by observation and empirical verification, psychiatry, too, could form hypotheses and try to empirically test them. In my opinion, values are best suited to the domain of medical practice where decisions have to be made and the values of all parties involved must be considered and implemented to the greatest degree possible.

Regarding the role of values in theory, I assume that these must be limited to inclusion of social norms and externally influential phenomena that happen to be restricted to

a particular geographic area. An example of such usage is offered by Ian Hacking, who notes the numerous cases of the French Fugue which demonstrated a sort of disorder that was restricted to France only.[231] Values in this sense could be viewed as complementary forces that make the factual assumptions comprehensible in particular contexts. Consequently, it would be a deeply-rooted confusion to permit values to replace facts where the latter seem to be either missing or inadequate.

Furthermore, Sadler thinks that values are to be allowed to not only participate in, but also to influence and modify the nosology.[232] This position inevitably introduces a sort of relativity in classification and subsequently, diagnosis of mental disorders that cannot be eliminated easily. On the positive side, a relativistic nosology can allow us to account for region-specific disorders without having to modify the nosology in use. Such relativity, however, does not come for free. For one thing, we must be willing to employ a different set of classifications in each region and mental disorders would no longer have to be classified on the basis of their common symptoms or courses of diseases. Instead, it would be the limits of the political boundaries that are used to specify and classify mental disorders. Consequently, any changes in the limits of boundaries constitute a reason to develop a new nosology that could include the specific maladies of that particular region. While this is the least cost we must be willing to pay, there are more costly changes that need to be accounted for. For instance, the relativity of diagnoses makes them changeable upon migration of individuals from one geographic region to another. Moreover, there will never be a universal manual for identification of these disorders which entails that the social forces are the

[231] Dominic Murphy, "Social Construction and Sociological Causation" in *Psychiatry in the Scientific Image* (Cambridge: Massachusetts Institute of Technology, 2006), 265-266.
[232] John Z. Sadler, "Values and Psychiatric Diagnosis," in *Values and Psychiatric Diagnosis* (New York: Oxford University Press, 2005), 10, 437-444.

decisive factors that can label conditions normal or deviant. Determination of deviance by the society makes mental disorders a means of political control and the fact about them constituting deviance from socially-accepted norms makes the afflicted a deviant party and not a patient. Depending on the society, one can foresee that the deviant population tends to get a different sort of treatment than those who are deemed to be ill.

An example can better demonstrate my point. Under Islamic regimes, homosexuality is viewed in two different ways. First, the person is often viewed as suffering from a sort of disorder (be it genetic, hormonal, or psychological) or they are seen as being rebellious and defiant of the norms already in place. While in the first case, persons are referred to receive the relevant treatment (whatever might be deemed relevant in the context of the particular society), in the latter case, they are penalized by being detained, imprisoned, or even killed. The point is, if we leave enough room for societies to make their own decisions regarding the status of what may be broadly called ‘mental disorders’, the ensuing outcome for the individuals affected will vary widely. In a society like Canada where homosexuals do not fit within either category, the experiencing subjects are viewed as individuals who have differing views and as such, they are free to make their own choices and live life according to their utmost desires.

Although homosexuality is an extreme and controversial example, I believe that it can teach us a number of things. First, we must avoid leaving decisions in the hands of authoritarian regimes. Second, we must aim at limiting the decisions to the boundaries of medicine and not allowing social norms to dictate the status of conditions. Third, we must aim at taking relativistic considerations out of our nosology in order to move towards a more universal catalogue of psychopathology. Fourth, mental disorders might be better identified in the nosology by virtue of the facts already available and values must exist in the background as factors that can effectively complement facts. Finally, values must be present

in the context of medical practice where the individual values differ and must act as a means of reaching a balanced consideration of values of all affected by the decisions.

Overall, in accordance with both Fulford and Sadler, I believe that values have a crucial role in developing a proper understanding of psychopathology but that does not entail their inclusion at the expense of excluding facts. Fulford has a very promising account for the enactment of values in psychiatry but his account is also in need of some serious modifications in order to coherently fit and accord with the rest of his arguments. It is undeniable that at our current place, facts have a very minimal role in explaining mental disorders but their inadequacy must not be translated into the impossibility of ever attaining more solid knowledge. Psychiatry may not reach the level of scientific advancement that we will be witness to in other fields of medicine in general in the next twenty years but the likelihood of making progress is still great. Furthermore, Fulford proposes the idea of incorporating values alongside facts in what he labels as VBM and EBM. I think that the interaction between the two areas can take us much further than ever, particularly since up until recent years values have been likened to the practical norms of societies and for that reason, we have neglected their crucial role in the practical realm. Once we agree that they form a crucial part in developing a definition and incorporating the causation, identification, and treatment of mental disorders, we would be in a better position to argue for their inclusion beyond psychiatry and in other medical disciplines.

It is important to emphasize that I am not proposing a model under which values would play the main role and facts are sparingly spread to complement them. Given the fact that mental disorders must originate in the brain (I cannot imagine any other human organ to have a role in our development of mind and mental disorders), facts inevitably must lead the way both in our nosology and diagnosis. Values, by the same token, become influential in selection and application of treatment methods and are determinate factors in evaluating the

appropriateness of clinical practice and in distinguishing ethical from non-ethical practices. This entails that while facts and values are inseparable elements in understanding ‘disorders’ in general and ‘mental disorders’ in particular, each nonetheless provides the benchmark against which assessments of efficiency are made. Facts are determinant in theory and values are the dominant force behind practical considerations. This division can be properly made once we neutralize our tendency to engage values (more than facts) within the totality of the medical sphere.

Sadler has argued that ‘values’, as the key to a proper understanding of mental disorders, must be included in the nosology, diagnosis, and decision making processes. I hold the same viewpoint except that their application in the differing areas must be closely monitored. Where factual data are dominant, values must play a small role, if any. Even in cases where values seem to precede, I believe that their imposition must be in consideration of the role that facts play. Whether I am imposing a too narrow approach is something I am willing to defend. My reason is that by allowing values to take part in all the areas without defining pre-set limits, we are leaving the door open for the possibility of values overtaking facts even where the latter seem to be dominant. My worry is in this sense similar to that of Kendell where he held that broadening the definition any further would provide the necessary space for implementing abuse in psychiatry. I am reluctant to accept that without any set boundaries values would be contained if not by facts then by external socio-cultural forces. For one thing, facts currently occupy quite a small space in psychiatry and values, given their free reign and their variable nature in accordance to the context considered, could be disguised as an independent entity capable of causing alterations in our understanding. As a result, granting values a loosely-restricted sphere of influence automatically introduces abuse (whether in regards to the stigma present in the clinical settings of psychiatry or in respect to the political dissidents refusing to adhere to injustice). Therefore, it is rationally-sound to be

hesitant to grant values the opportunity to be involved in and influence the many aspects of psychiatry.

In the end, I am uncertain as to whether we would be able to come up with a more pragmatic model for understanding psychopathology than the one Fulford and Sadler have offered. While we must not close our options by limiting our choices to the models that they have developed, I think that we must aim at incorporating them in the clinical contexts and it is only then that matters related to better and more ethical clinical practice could be effectively addressed. Therefore, even though their models are flawed unless changes are made to them, I contend that they provide us with the most feasible and best available option yet. Once the fact-plus-value model is introduced into clinics, the other potential problems that it may implicitly have (which could not be identified in isolation from the context) would become visible. Hence, on the whole, I defend the introduction and incorporation of this model into the medical practice of psychiatry.

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