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A modest proposal

(Commentary on "A role for philosophers, sociologists and bioethicists in revising the DSM")

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There are many points on which I agree with Kayali Browne. I agree that value-judgments necessarily play a role in constructing a classification such as the DSM. I agree that people with different backgrounds and interests are likely to assess problems differently and that it would be a good idea for a more diverse body of people to have some involvement in revising the DSM. I agree that philosophers might usefully play a role when the DSM is being revised.

Overall, though, I'm not convinced that Kayali Browne's committee would be a good idea. In her vision such a committee would constitute a group of wise moral experts who would help make the value-judgments implicit in the DSM as well-informed as possible. Along with many others I'm sceptical of the idea that philosophers should be construed as moral experts in the sense of being particularly good at making practical moral decisions (see, for example, Archard 2011; Engelhardt 2002). I worry that philosophers may not actually be able to make all that much progress in addressing the sorts of deep moral question that Kayali Browne envisages being addressed (for example, how to weight the diffuse social harms caused by medicalisation against the benefits that particular individuals might gain from treatment, how to distinguish between willful wrong-doing and disordered behaviour). While philosophers have an important role to play in reminding people that such issues remain unaddressed and lurking behind the decisions that inform the DSM, I don't think that a committee would be required to achieve this modest goal. I also worry that a committee of philosophers armed with veto-rights over proposed revisions to the DSM would strain relations between philosophy and psychiatry. The risk is that the philosophers would come to be viewed as know-nothing busy-bodies. Some prominent psychiatrists already take such a view when humanities scholars write on mental health topics (for example, Brown 2010, Pies 2010).

Rather than Kayali Browne's committee I shall suggest a more modest proposal. While Kayali Browne focusses on how hard and deep moral questions might be dealt with, I think the priority is to consider how tractable issues might be better addressed. I shall suggest how some value-based problems with the DSM might be avoided fairly easily, and then consider the particular roles that philosophers might play in revising the DSM.

Some of the value-based problems that afflict the DSM arise because the committees that write the DSM tend to be comprised of a certain type of person (typically, middle-aged, affluent, clever, white, male, doctors). When such people write diagnostic criteria they do so with their implicit view of "normality" in mind. It is very easy for such people to assume, for example, that "normal" children will work hard at school and not get into trouble with the police, and that "normal" adults will drink a bit, but not too much, and be fairly independent, and gainfully employed. On occasion, such assumptions creep into diagnostic criteria and place the members of particular communities at increased risk of under- or over-diagnosis. Often all it takes for such criteria to be improved is for other people, with different life experiences and assumptions, to point out the biases that are at work.

To illustrate, consider the DSM-5 diagnostic criteria for phobia. In DSM-IV patients had to recognize their fears as unreasonable. In DSM-5 the fear merely has to be judged by the physician to be out of proportion. The change aimed to make possible the diagnosis of some older adults who develop intense fears, say of falling, but who perceive their fears to be reasonable (LeBeau et al., 2010). However, I suggest the revision was a mistake. Consider the case of someone who develops rational fears on the basis of information that the diagnosing physician lacks. Take a scientist working on avian flu whose studies lead her to the conclusion that a worldwide pandemic is imminent. She comes to develop rational fears about sick birds. Using DSM-IV criteria she did not have a phobia, as she would not have considered her fears unreasonable. Using DSM-5, if a clinician (who we will suppose knows

nothing of these matters) judges her fear as being out of proportion, she can receive a diagnosis. This seems wrong. I suggest that most likely the problem here arose because the committee assumed that clinicians always know more than patients. This is the sort of error that it is easy for doctors to make, but that patients, with their rather different assumptions and life experiences, would be less-likely to overlook.

I suggest that the easiest way to lessen the likelihood of such problems emerging would be to try to include a more diverse body of people when the DSM is being revised. In this case patients would likely spot an assumption that doctors might miss. In other cases input from other under-represented groups might be useful (for example, women, non-white people, poor people, young people, non-academically inclined people).

At this point the admirable efforts that the APA made when the DSM-5 was being produced to make it possible for outsiders to have an input into the processes of revision should be noted. When the DSM-5 was under construction a number of drafts, and a huge amount of background information, was made available online. Anyone who wanted to comment was invited to do so. This was a good initiative. Still, though, more could be done. I suspect that many people who might have spotted errors and oversights in the DSM-5 failed to contribute to the consultation process because they either believed they had nothing to offer, or doubted whether and how their feedback would be utilised. It might be necessary for individuals who likely have different assumptions and values than do the DSM committee members to be specifically invited to comment on draft diagnostic criteria.

So far I have discussed how people from diverse backgrounds might help correct value-laden biases in the DSM. What though of the potential contribution of philosophers specifically? Philosophers likely have slightly different ways of looking at the world than psychiatrists and might spot some problems that would otherwise be overlooked. In addition,

I suggest that certain aspects of philosophical training might mean that philosophers are well-equipped to play a further, important, though modest, role in proof-reading sets of diagnostic criteria.

Consider that a number of problems with past editions of the DSM have arisen because of confusion between "ands" and "ors" in diagnostic criteria. For example between DSM-IV and DSM-IV-TR the diagnostic criteria for the paraphilias were changed. In DSM-IV-T.R. many paraphilias could be diagnosed on the basis of "fantasies, urges **or** behaviours". This was a mistake. The criteria should have required "fantasies, urges **and** behaviours". In the context of the U.S. legal system the error took on added significance: The error implied that those who commit sex crimes could meet the diagnostic criteria for a paraphilia in virtue of their crime alone. And, in many States, sexually violent predator laws meant that offenders with a paraphilia diagnosis could be detained indefinitely (for discussion see Greenberg 2013, Cooper 2014). A somewhat similar confusion occurred in the DSM-IV criteria for PDD-NOS. Here, as a result of a misplaced "or", diagnosis was theoretically possible for an individual whose sole symptom was "stereotyped behaviour, interests and activities" (First & Pincus, 2002).

Philosophical training (eg in formal logic) makes the distinctions between different types of logical connective salient to philosophers. Philosophers rarely confuse "ands" and "ors", and I think it likely that a philosophical proof-reader would pick up such problems.

In this discussion I note that people from different backgrounds have different values, assumptions, life experiences and training. This makes different types of people better at spotting the different sorts of problem that can emerge when the DSM is revised. With Kayali Browne I agree that it would be a good idea if non-psychiatrists played a role in revising the DSM, and think that philosophers might have special skills to offer. I also agree

that decisions regarding values are important and might be more explicitly addressed. Unlike Kayali Browne's proposal, however, mine aims to be modest. I don't think a new committee is required. I think that some mistakes could be avoided if diverse outsiders (including a couple of philosophers) were asked to read through drafts of the diagnostic criteria to see if they could spot any problems.

In this commentary I have focussed on how progress might be made in fixing tractable problems. To finish I should also make clear that I think that the work that philosophers do on deep and difficult moral and conceptual issues is also hugely important and should continue. It's just that I don't see such work as being ready to shape the DSM any time soon.

References

Archard, D. 2011. Why moral philosophers are not and should not be moral experts. *Bioethics*, 25(3), 119-127.

Brown, CF 2010. Schatzberg cites reasons to be proud of APA. June 18, 2010. *Psychiatric News*

Cooper, R. 2014. *Diagnosing the Diagnostic and Statistical Manual of Mental Disorders.* London: Karnac.

Engelhardt, H. T. 2002. The ordination of bioethicists as secular moral experts. *Social Philosophy and Policy*, 19(02), 59-82.

First, M. & Pincus, H. 2002. The DSM-IV Text Revision: Rationale and potential impact on clinical practice. *Psychiatric Services*, 53: 288-292.

Greenberg, G. 2013. *The Book of Woe: The DSM and the Unmaking of Psychiatry*. New York: Blue Rider.

Kendler, K., Kupfer, D., Narrow W., Phillips, K., & Fawcett, J. 2009. Guidelines for making changes to DSM-V. Revised 21.10.09. Available at www.dsm5.org/ProgressReports/Documents/Guidelines-for-Making-Changes-to-DSM_1.pdf [Last accessed 7 July 2015].

LeBeau, R., Glenn, D., Liao, B., Wittchen, H., Beesdo-Baum, K., Ollendick, T., & Craske, M. 2010. Specific phobia: a review of DSM-IV specific phobia and preliminary recommendations for DSM-V. *Depression and Anxiety*, 27: 148-167.

Pies RW. American Psychiatric Headquarters Seized by Giant English Teachers! *Psychiatric Times*, March 3, 2010.