

Looking with both eyes open: fact *and* value in psychiatric diagnosis?

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In this article we argue the case for a proposal: that psychiatry should recognise, embrace and take seriously the role of values, alongside facts, in diagnosis. We present a three-step argument in support of our proposal; we raise a number of key questions from the perspectives of different stakeholders in mental health; and we conclude with a note on the significance of our proposal for building a more equal relationship between patients and professionals.

Key words: Classification, patient-centred, values-based practice, idiographic, abuse of psychiatry

Diagnosis is standardly thought to be an exclusively scientific value-free process. In this paper, we set out a three-step argument to the effect that, notwithstanding the standard model, diagnosis in psychiatry, although no less firmly based on science than diagnosis in any other area of medicine, is also based on values. The argument runs from 1) the initial observation that mental disorder is relatively value-laden compared with bodily disorder, through 2) an interpretation of the value-laden nature of mental disorder as a sign not of scientific deficiency but of values complexity, to 3) the practical resources already available to support diagnoses involving complex values as well as complex facts.

INITIAL OBSERVATION: MENTAL DISORDER IS RELATIVELY VALUE-LADEN

The observation on which our proposal is based is that psychiatric diagnostic concepts are relatively value-laden compared with their counterparts in (many areas of) bodily medicine.

The relatively value-laden nature of psychiatric diagnostic concepts is shown in two main ways: in the shifting boundary between psychiatric-diagnostic and moral concepts; and in the persistent and increasingly overt

use of value terms in psychiatric diagnostic classifications.

The shifting moral/medical boundary in psychiatry

High profile examples of the shifting boundary between psychiatric-diagnostic and moral concepts arise in forensic psychiatry with the insanity defence and other determinations of responsibility (1). On one side of the boundary between “mad or bad”, as these determinations are often called, lie such medical-scientific concepts as disease, causes and biological determinism. On the other side lie the moral concepts of guilt, responsibility and freedom of the will. A similar boundary is involved in involuntary psychiatric treatment (2). In both cases the underlying intuition is the same: that with mental disorders we shift across the boundary from moral-humanistic to medical-scientific concepts, from the freedom of action and choice of everyday human discourse to the determinism and causal laws of science.

The boundary is not new, of course. Some have argued that the medical model of mental disorder developed in parallel with the industrial revolution (3). But as early as the fourth century BC, mental health, in Plato’s Republic, had both medical and moral aspects (4). As the American philosopher and

psychologist Daniel Robinson (5) has shown, mental disorder has shifted this way and that across the medical-moral boundary, and in both Christian and Islamic culture, ever since.

The insanity defence, although available in principle for any category of mental disorder, is in practice largely confined to functional psychoses, such as schizophrenia (6,7). The functional psychoses are the focus, similarly, of involuntary treatment (8). Psychiatry’s shifting moral-medical boundary is not confined to the psychoses, however, almost every major diagnostic category having a moral counterpart. The ICD-9, for example, distinguished alcohol dependence syndrome (medical, category 303) from the moral category of drunkenness and “sexual deviations and disorders” (medical, category 302) from the moral category of sexual behaviours that “... serve approved social and biological purposes” (9).

A similar moral-medical boundary is of course apparent with bodily disorders, illness in general excusing from responsibility (10), as when a doctor gives out an “off work” certificate. But the boundary is far more shifting and problematic in psychiatry.

The value terms within the DSM

The standard model, while acknowledging the shifting moral-medical

boundary for psychiatry past and present, predicts that, with future scientific advances, psychiatric diagnostic concepts will become value-free. This was the prediction, for example, of the American philosopher of science Carl Hempel in the World Health Organization sponsored conference on classification in New York in 1959, from which our current ICD and DSM classifications are ultimately derived (11). Hempel spoke about the requirements for psychiatric classification to become more scientific (12). He noted that the classifications of the day (i.e., in 1959) included terms with “valuational aspects”. Such terms, he suggested, impair the scientific status of a psychiatric classification and, as psychiatry becomes more scientific, so they should gradually disappear.

Hempel’s comments represent an important expression of the standard model given both his status as a philosopher of science and his key role in the development of our current classifications. Nonetheless, in this respect at least, Hempel’s predictions have turned out to be wrong. In DSM-IV (13), the latest and most explicitly evidence-based of our classifications, value terms, far from being eliminated, are more evident than in any earlier edition either of DSM or of ICD (14). The term “bizarre”, for example, is used with reference to one kind of delusion that is characteristic of schizophrenia. In addition:

- a) A number of DSM criteria are actually evaluative rather than factual in form. Criterion A for conduct disorder, for example, covers “... behaviour in which the basic rights of others or major age-appropriate norms or rules are violated”.
- b) DSM includes, for many categories, criteria of functioning, which, again, are explicitly evaluative. Criterion B for schizophrenia, for example, is a criterion of “social/occupational dysfunction”. Criterion B, therefore, is not satisfied by a mere *change* in functioning (a matter of fact); there has to be a change for the *worse* (a matter of value).
- c) DSM’s definition of mental disorder,

in addition to including a further criterion of dysfunction (“... in the individual”), makes explicit that a mental disorder may be defined, in part, by social value judgements. Thus the definition states that “Neither deviant behaviour (e.g., political, religious, or sexual) nor conflicts that are primarily between the individual and society are mental disorders *unless* the deviance or conflict is a symptom of a dysfunction in the individual ...”. If, therefore, a mental disorder may not be defined by social value judgements unless a *further* condition is satisfied (i.e., “... dysfunction in the individual”), then it follows that mental disorder is defined *in part* by social value judgements.

The DSM, we should say straight away, makes clear that its definition of mental disorder requires that there be “*clinically significant* distress or impairment”. In the standard model (of diagnosis as exclusively fact-based), “clinical significance” is assumed to be a concept exclusively of medical science. However, in DSM, “clinical significance” is defined, in particular, by reference to “clinical judgement[s]” of dysfunction; and “clinical judgement” is not further defined other than to point out that the decision whether a condition is clinically significant may be a “*difficult* clinical judgement”. Taking these points together, therefore, there is a *prima facie* case that the “difficult clinical judgement[s]” of clinical significance required by DSM, are, in part, difficult clinical *value* judgements.

INTERPRETATION: VALUE-LADEN EQUALS COMPLEX VALUES

Recognising, then, that mental disorders are relatively value-laden compared with bodily disorders is the first (observational) step in the argument supporting our proposal. Whether, though, we embrace the value-laden nature of mental disorder depends on how it is interpreted. This brings us to the second step in our three-step argument.

The standard model, according to

which diagnosis is an exclusively scientific process, allows two interpretive possibilities representing the two poles of the psychiatry/antipsychiatry debate of the 1960s and 1970s: the pro-psychiatry interpretation (of Kendell (15) and others (16)) that psychiatry is underdeveloped scientifically; and the anti-psychiatry interpretation (of Szasz (17) and others (18,19)) that mental disorders are really moral (or “life”) rather than medical problems. We do not have space, here, to consider the wide range of arguments that have been advanced in this debate (20,21). Both interpretations, however, represent, in the terms of our title, one-eye-open views of psychiatry: pro-psychiatry (guided by the standard model) sees only with a fact-eye open; anti-psychiatry (guided by the standard model) sees only with a value-eye open. Neither interpretation, therefore, if our proposal is right, is sufficient to meet the demands of a psychiatry that is complex not only scientifically but also evaluatively.

Other authors, it is true, have recognised that values have a role alongside facts. But in reserving to psychiatric diagnosis a value-free area, they have sought to retain the essence of the standard model: Boorse, for example, reserves disease as a value-free area (22-24); Wakefield, similarly, reserves dysfunction as a value-free area (25). What is needed, then, if our proposal is right, is not a further refinement of the standard model, but a third kind of interpretation altogether, one that, starting from a critique of the standard model itself, allows us to approach psychiatric diagnosis with both fact-eye and value-eye fully open.

One possibility for developing a both-eyes-fully-open interpretation is to start from the resources of philosophical value theory, concerned with the meanings of value terms (26,27), especially the work of a former White’s Professor of Moral Philosophy in Oxford, R.M. Hare (28,29). We will thus briefly outline the both-eyes-fully-open interpretation of the value-laden nature of mental disorder suggested by Hare’s work and then note some of

the many other philosophical possibilities.

Hare's analysis and a both-eyes-fully-open interpretation of the value-laden nature of mental disorder

The nub of Hare's work, as it is relevant to the proposal of this paper, is two observations about the meanings of value terms:

- a) *Two elements of meaning.* The meaning of a value term always contains two elements, a *factual* element as well as an *evaluative element*. This is because the criteria for the value judgement expressed by a value term are *factual* criteria. Thus, to take one of Hare's (non-medical) examples, the *value term* "good strawberry" expresses the *value judgement* "this strawberry is good to eat", the criteria for which include such *facts* about the strawberry in question as that it is red and juicy (28).
- b) *Fact-laden and value-laden meanings.* Which of these two elements in the meaning of a given value term, the factual or the evaluative, is most prominent depends on the extent to which the values expressed by that term are shared: value terms expressing *shared values* are relatively *fact-laden* in meaning, value terms expressing *divergent values* are relatively *value-laden*. Hare (29) pointed out that *shared* values have, by definition, the same *factual* criteria which thus become associated with the meaning of the value term in question. For example, people have largely *shared* values about strawberries – most people like a strawberry that is red and juicy. Hence the *value judgement* "this is a good strawberry" will convey the *factual* meaning that the strawberry in question is red and juicy. By contrast, the value judgement "this is a good poem", in another of Hare's examples, expresses a value judgement over which people's values *differ widely*. Hence there will tend to be disputes over the (aesthetic) *values* involved in judging whether a poem is good, with the result that the

meaning of "this is a good poem" remains strongly *value-laden*.

Our required both-eyes-fully-open interpretation of the relative value-laden nature of mental disorder now follows directly from these two observations. Thus, if "disorder", notwithstanding the standard account, is a value term, it will share with all other value terms the features pointed out by Hare. "Mental disorder", then, if "disorder" is a value term, will be more value-laden than "bodily disorder", not, as the standard account implies, for reasons of scientific deficiency, but because the *values* expressed by the value term "disorder" are (relatively) *divergent* in the areas of diagnosis with which *psychiatry* is concerned and (relatively) *shared* in the areas of diagnosis with which *bodily medicine* is concerned. This is consistent with the fact that in psychiatry diagnosis is concerned with areas of human experience and behaviour, such as emotion, belief, desire, volition and sexuality, in which human values are highly diverse (what is good for one is bad for another), whereas in bodily medicine diagnosis is concerned with areas of human experience and behaviour, such as severe bodily pain, threat of death and paralysis, over which human values are relatively shared (what is bad for one is bad for most of us) (30).

Other philosophical resources for a both-eyes-fully-open interpretation of the value-laden nature of mental disorder

There are many other possible philosophical resources for developing a both-eyes-fully-open interpretation of the relatively value-laden nature of mental disorder.

One whole group of interpretations could start from work in the philosophy of science showing the different ways in which, contrary to the standard model, values and facts work together in science (31): epistemic values, for example, values guiding theory choice, are demonstrably important in the development of DSM diagnostic categories of personality disorder (32).

Another group of interpretations could start from work in moral philosophy showing that values may be redefined in terms of facts (33-35). A third group of interpretations could start from one of the many philosophies that deny the dualism implicit in the standard view: phenomenology (36,37), for example, and related disciplines (38-42), offer fruitful starting points in this respect. Then again, there are the resources of classical philosophy (43) and, coming right up to date, the resources of modern philosophy of mind (44,45).

Each of these approaches, which are in many respects complementary, offers advantages and disadvantages. The interpretation derived from Hare's work has the practical merits of: a) already having been successfully applied in service development and training initiatives in mental health, and b) providing a clear template for research on values in psychiatric diagnosis. It is to these practical applications, then, that we turn next, in the third step in our argument supporting the proposal of this paper.

PRACTICAL APPLICATIONS: RESOURCES ALREADY AVAILABLE

The practical counterpart of the both-eyes-fully-open interpretation of the value-laden nature of mental disorder derived from philosophical value theory is called values-based practice (46). Values-based practice, like evidence-based practice, is a resource for effective decision-making in healthcare. It starts, much as a political democracy starts, from equal respect for all values; and it relies, again like a political democracy, on "good process" for effective decision-making where values conflict. In this section, we outline briefly the practical resources already available for values-based as well as fact-based approaches to diagnosis, under a) policy, service development and training initiatives, and b) research.

Policy, service development and training initiatives

"Good process" in values-based practice depends critically on models

of service delivery that are: a) patient-centred, because values-based practice starts from the values of individual patients, their families and communities (46), and b) multi-disciplinary, because values-based practice depends on the range of different value perspectives represented by a well-functioning multi-disciplinary team for balanced decision-making where values conflict (46).

The development in many parts of the world of mental health services that are based on the principles of patient-centred decision-making and multi-disciplinary teamwork provides a potentially powerful basis for values-based as well as fact-based diagnostic assessment. These two principles, correspondingly, are at the heart of the UK government's "top" policy on mental health, the National Service Framework (NSF, 47). Their links with values-based practice are spelled out in a Values Framework adopted by the body responsible for implementing the NSF, the National Institute for Mental Health in England (NIMHE) (48) (Tables 1 and 2).

Important features of the NIMHE Values Framework as a policy framework for values-based as well as fact-based approaches to diagnosis include, from the Core Principles (Table 1), the first and third of the three "Rs", the

principles respectively of Recognition, that *all* decisions (including decisions about diagnosis) are based on values as well as facts, and of Respect, that decisions start from the values of individual patients; and, from the Policy Implications (Table 2), the explicit exclusion of discrimination (which by definition is inconsistent with the principle of respect); the explicit inclusion of strengths and recovery-based approaches (based on positive values); and the emphasis on the importance of multi-disciplinary working (the key, as noted above, to balanced decision-making where values conflict).

Also important, when it comes to training, is the second of the Core Principles in the NIMHE Values Framework (Table 1), the "R" of "Raising Awareness". At the heart of values-based practice, as a process-based approach to working effectively with complex values, are four key areas of clinical skill: raised awareness of values and of value diversity, reasoning skills, knowledge of values, and communication skills (for both understanding values and resolving conflicts) (46). In the UK, training materials covering each of these four areas have been developed in a partnership between the Sainsbury Centre for Mental Health (a voluntary sector organisation) and the Department of Philoso-

phy and the Medical School at Warwick University (49,50). The NIMHE has supported these training developments and, following the launch of the training manual (51) by the Minister of State with responsibility for mental health, is spear-heading their roll-out as part of a national programme of training (52) within a National Workforce Strategy (53) based on multi-disciplinary team work (54). Training materials are also now being developed specifically for medical students and for primary care physicians, in a joint programme between Warwick University Medical School and the Medical School at the University of Pretoria.

Research

As with training so with research, the ground for developing values-based alongside fact-based diagnostic assessment in psychiatry has been well laid, in this case by the ICD and DSM processes to date. DSM-IV, as we noted earlier, makes more explicit than its predecessors, in either the ICD or DSM series, the values implicit in psychiatric diagnostic categories. From the perspective of the standard model, this is a failure of psychiatric science. From the perspective of philosophical value theory, it is a success.

Table 1 The National Institute for Mental Health in England (NIMHE) Values Framework – Core Principles

<p>1. Recognition – NIMHE recognises the role of values alongside evidence in all areas of mental health policy and practice.</p> <p>2. Raising Awareness – NIMHE is committed to raising awareness of the values involved in different contexts, the role/s they play and their impact on practice in mental health.</p> <p>3. Respect – NIMHE respects diversity of values and will support ways of working with such diversity that makes the principle of service-user centrality a unifying focus for practice. This means that the values of each individual service user/client and their communities must be the starting point and key determinant for all actions by professionals.</p>
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Table 2 The National Institute for Mental Health in England (NIMHE) Values Framework – Policy Implications

<p>Respect for diversity of values encompasses a number of specific policies and principles concerned with equality of citizenship. In particular, it is anti-discriminatory because discrimination in all its forms is intolerant of diversity. Respect for diversity within mental health is also:</p> <ul style="list-style-type: none"> • <i>user-centred</i> – it puts respect for the values of individual users at the centre of policy and practice; • <i>recovery oriented</i> – it recognises that building on the personal strengths and resiliencies of individual users, and on their cultural and racial characteristics, there are many diverse routes to recovery; • <i>multidisciplinary</i> – it requires that respect be reciprocal, at a personal level (between service users, their family members, friends, communities and providers), between different provider disciplines (such as nursing, psychology, psychiatry, medicine, social work), and between different organisations (including health, social care, local authority housing, voluntary organisations, community groups, faith communities and other social support services); • <i>dynamic</i> – it is open and responsive to change; • <i>reflective</i> – it combines self monitoring and self management with positive self regard; • <i>balanced</i> – it emphasises positive as well as negative values; • <i>relational</i> – it puts positive working relationships supported by good communication skills at the heart of practice.
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Making these values explicit is an important step towards a classification that can support values-based as well as fact-based diagnostic assessment (55). The DSM's criterion B for schizophrenia, for example, requires only minor additions – designed to make fully explicit the evaluative elements in its meaning and the processes required to assess those elements – for it to be a fully-fledged values-based as well as fact-based diagnostic criterion (56,57). The move in the ICD, similarly, towards a family of international classifications is entirely hospitable to values-based approaches (58); and the addition of an idiographic assessment tool, sensitive to the personal and cultural values and beliefs of individual patients, would extend this process further (59,60).

There have also been a number of research initiatives specifically on values-based diagnosis in psychiatry. First in the field was the American psychiatrist and philosopher John Sadler, with a conference at the UT Southwestern Medical Centre, Dallas, that brought together established figures in psychiatric classification with philosophers, neuroscientists, clinicians and patients. Published as a foundational edited collection (61), the Dallas conference was the paradigm for two international research methods meetings funded by the NIMHE in London, in 2003 and 2004, proceedings from which have been published in the form of web-based conferences (48). Sadler has also completed a major review of the values involved in all areas of psychiatric diagnosis (62) and there have been a number of important research initiatives on specific disorders: schizophrenia (36,63), Alzheimer's disease (41) and anorexia nervosa (64).

We should not underestimate the technical challenges here. Drawing on the example of physics (58), as the paradigm natural science, it is clear that research on diagnostic values will require a different (individuated) model of reliability; face validity, too, particularly as assessed by patients and carers, will have greater impor-

tance; and the research process itself will have to include users and carers, as “experts by experience”, on an equal basis with the traditional experts by training (65). Technical issues such as these, however, if the history of science is any guide, will be overcome not by *a priori* reflection but by active engagement in the research programmes to which they relate (66).

TEN QUESTIONS AND TEN ANSWERS

In this section we consider a number of questions raised by our proposal from the perspectives of a variety of stakeholders. We start with a question from the (imaginary) chair of a taskforce responsible for developing a new classification of mental disorders.

The taskforce chair's question: Rather than combining fact and value in psychiatric diagnosis, can't we simply split out the values and focus on the facts?

Reply: Hare's model allows us to disentangle fact and value (strictly, description and what he called prescription) (28,29). We could thus, in principle, develop a classification of descriptively-defined *conditions* along the lines, for example, of a descriptive classification of cloud formations (67). Psychiatric classifications, however, are not just of conditions but of *pathological* conditions, i.e. of *negatively evaluated* conditions, of *disorders*. Of course, we *can* split out the evaluative element: the DSM's criteria of good and bad functioning, for example, are split out in a separate classification in the ICD “family” (68). But this amounts to a relocation rather than a resolution of the problems raised by working with complex values in psychiatric diagnosis.

The clinician's question: With future scientific advances, in particular discoveries of the brain-based causes of mental disorder, won't values become less important diagnostically?

Reply: In a word, “no”. It seems obvious that learning more about the

causes of mental disorder will make values less important in psychiatric diagnosis because so much of the diagnostic process in bodily medicine is taken up with identifying the causes of bodily disorders. But remember that the relatively value-laden nature of mental disorder arises not from scientific deficiency (lack of knowledge of causes) but from greater value complexity. In the future we will indeed know much more about the causes (biological, psychological and social) of human experience and behaviour. But this will do nothing to resolve questions about exactly which kinds of experiences and behaviours are negatively evaluated, and, hence, *pathological*. Should it turn out, for example, that there is a difference in the cerebral anatomy of heterosexual and homosexual people, this would no more show that homosexuality is a “disorder” than it would show that heterosexuality is a “disorder” (30).

The patient's question: Everything you say may be true in principle, but it has been helpful for me to think of my depression as a brain disorder. I felt much less stigmatised once this was made clear to me.

Reply: Certainly, the idea that mental disorder is no different from any other bodily disorder is helpful to many people. But other models are helpful to other people (69) and of course there are some in the “user movement” who reject the model of pathology outright (70). Our proposal accommodates this feature of mental disorder – that it is understood differently by different people – and avoids the need for a “top” model, a dominant way of thinking about mental disorder, a one-size-fits-all to which everyone has to conform (71).

The carer's question: From my perspective, having looked after my son with schizophrenia for ten years, I can easily see how important values are in mental health. But does not your talk (as in the NIMHE Values Framework) of positive values, risk romanticising mental distress and disorder?

Reply: That is certainly a risk, and it is crucial to remain fully aware of the burden of distress and suffering from mental disorder (72). But it is also crucial, if we are to respond effectively, to recognise the growing evidence, not least from patients themselves (73,74), that symptom control, which is the focus of the standard model, is often less important than professionals tend to assume. People often have other priorities (a home, a job, etc.) that may actually be prejudiced by over-enthusiastic efforts to control symptoms. Also, the symptoms themselves sometimes have positive aspects [as in hypomania, for example (75)]. Even more important are the positive strengths and resiliences shown by people with mental disorder (76). Values-based assessment thus aims for a balanced approach, not romanticising the problems, but also not neglecting the potential for recovery (77).

The ethicist's question: Your premise of respect for diversity sounds like a recipe for the "anything goes" of ethical relativism!

Reply: As the NIMHE Values Framework makes clear, values-based practice, far from being a recipe for "anything goes", places strong constraints on practice. These constraints arise partly from the premise of values-based practice itself in respect for diversity (see above), and partly from the fact that human values, although indeed diverse, are not chaotic. Values-based practice, then, in taking the rich variety of human values seriously, is no more likely to lead to relativism in psychiatric diagnosis than it is in ethics or indeed in a political democracy (46).

The lawyer's question: That's all very well, but historically psychiatric diagnostic concepts have been notoriously vulnerable to abuse. Will your proposal not make psychiatric diagnosis more vulnerable to being used abusively for purposes of social control?

Reply: That is certainly always a risk in psychiatry. But our proposal suggests that in a values-complex area, like psychiatry, it is actually the

standard model that is more at risk in this respect. This is because the standard model, in neglecting values, is neglecting precisely those aspects of diagnosis from which the vulnerability of psychiatry to abuse arises. A study, for example, of the Russian-language psychiatric literature over the period when abuses of psychiatry became widespread in the former USSR (78) showed that the vulnerability of psychiatry in this case arose, not from an inadequate scientific basis for diagnosis, but from a failure to recognise the extent to which Soviet values were influencing clinical judgements (79). Recognising the role of values, therefore, alongside facts in psychiatric diagnosis, should reduce, not increase, the risks of abuse.

The researcher's question: My worry is that letting values into diagnosis will lead to biases in scientific research.

Reply: This, too, is clearly a risk. But the disentangling of value from fact in Hare's work on value terms is helpful in a number of ways. First, it clarifies what is genuinely scientific (in terms of factually-defined conditions and causal processes) (58,67). Second, it highlights the need for a more sophisticated choice of variables: the experience of delusional perception, for example, contrary to the assumptions of the standard model, may occur in a wide range not only of pathological but also of non-pathological (e.g., spiritual) conditions (63). Hence, studying such experiences in both kinds of condition (normal and pathological) may be more fruitful than concentrating only on abnormal cases.

The training director's question: But with the curriculum already so full, how can we afford to take on yet another area of study?

Reply: There are resource implications here. But if our proposal is right, training in the skills for values-based as well as evidence-based clinical work is essential if psychiatry, as a branch of medicine, is to be not only

science-led but also patient-centred. Precisely the same point, of the need for values as well as evidence, has been made by those developing evidence-based approaches in medicine (80). As to the practicalities, of time constraints and so forth, the training methods noted above have been designed to be readily adaptable to existing training programmes (51).

The philosopher's question: Philosophers have de-bunked the fact-value distinction. So why reintroduce it here?

Reply: You are thinking perhaps of the implications of the work of the American pragmatist W.V.O. Quine (81)? But as another American philosopher, Hilary Putnam, has argued, while Quine's work on the analytic-synthetic distinction by implication undermines the idea that fact and value (and indeed other dualisms) are always fully separable, it leaves the *distinction*, as a tool for analysing the meanings of concepts, intact (82). There are, anyway, as we noted earlier, other philosophical resources for developing relevant models of diagnosis that do not rely on the fact-value distinction. But it is the distinction, not the dualism, that is required for utilising the resources specifically of Hare's work; and it is Hare's work, precisely in giving us a clear account of the distinction, that is helpful for policy, training and research in psychiatry.

The mental health advocate's question: I want to go back to the question of stigma raised earlier. Many experienced champions of mental health believe we will never make progress until we achieve parity with bodily disorders – will your proposal help us to do this?

Reply: Certainly! But not just parity. Why not aim for priority? We are all agreed that stigma is the biggest problem facing everyone concerned with mental health today (83). Our proposal provides a basis for fighting stigma, not by the negative strategy of trying to "catch up" with bodily medicine, which risks reinforcing the prej-

udice that psychiatry is deficient (i.e., needs to catch up), but by the positive strategy of showing that psychiatry is *first in the field* in developing the models of service delivery, the training programmes and the research paradigms needed to work effectively with complex values.

The basis of our proposal, remember, is that we should actively embrace the relatively value-laden nature of mental disorder because it shows psychiatry to be, not deficient scientifically compared with other areas of medicine, but *more complex evaluatively*. So, if this is right, psychiatry has no catching up to do. To the contrary, there is reason to believe that, with scientific advances in the twenty-first century, it is other areas of medicine that will have the catching up to do (46,58,67). This is essentially because scientific advances open up choices, and with choices go values: reproductive medicine, for example, is already becoming more complex evaluatively as a result of advances in “assisted reproduction” (46). In developing the resources to work with complex values, then, psychiatry, in direct contrast with the “psychiatry second” stigmatising attitudes of twentieth century medicine, is leading the field.

CONCLUSIONS

We have argued the case for our proposal that psychiatry should: a) *recognise* the more value-laden nature of mental disorder, b) *embrace* this as a reflection not of scientific deficiency but of values complexity, and thus c) *take it seriously* by developing the resources to work as effectively with complex values as, in the twentieth century, we developed the resources to work with complex facts. We have reviewed a range of questions raised by this proposal, concluding with the anti-stigma point that our proposal, if fully implemented, could put psychiatry in a leading position in twenty-first century medicine.

Our proposal, it is important to emphasise, requires a decisive shift from the standard model of diagnosis,

as a process that is essentially professional-led, to a model of diagnosis as a project of shared understanding in which patient and professional have equal roles to play.

Philosophical value theory, as the basis of our proposal, while fully securing the importance of the knowledge and skills of professionals, also secures, and on an equal basis, the importance of the values – the unique needs, wishes and beliefs – of individual patients, their families and communities. This is why, in the terms of our title, our proposal is a both-eyes-fully-open proposal. It requires that we have both the traditional fact-eye but also the neglected value-eye fully open.

This is also why, as we saw earlier, our proposal differs radically not only from both anti-psychiatry (value-eye open) and pro-psychiatry (fact-eye open) positions in earlier debates about mental illness, but also from more recent positions which partially recognise the importance of values. This is why, finally, our proposal provides the basis for a new and more equal relationship between patient and professional in the diagnostic assessments that are at the heart of psychiatry as a fully science-led but also fully patient-centred medical discipline.

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