

PSYCHIATRY AND RESENTMENT:  
A PHILOSOPHICAL EXAMINATION OF THE PSYCHIATRIC SURVIVORS'  
MOVEMENT

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## ABSTRACT

In this thesis I set out to show that the ethical literature dealing with psychiatry contains a serious omission: it does not discuss the issue of humiliation in the psychiatric context. I claim that the reason for this lies in the “objective attitude” that typifies both discourse on psychiatric ethics and actual clinical practice. Psychiatrists and psychiatric ethicists tend to view patients as things to be “controlled, studied, cured or trained,” an attitude inimical to the “participant attitude” that sees others as responsible members of the moral community. This leads not only to a distorted view of the patient, but it also prevents doctors and ethicists from addressing the normative content of patient grievances. On the other hand, Axel Honneth and Charles Taylor’s theories of “recognition” emphasize the subjective experience of humiliation and show how feelings of wounded dignity can motivate social struggles -- including, I claim, the psychiatric survivors’ movement. I argue further that psychiatric ethics must take account of what the patients themselves say about their experience of psychiatry; to this end I juxtapose some of the main ideas found in psychiatric ethics with quotations from psychiatric survivors about their experience of humiliation at the hands of psychiatry.

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## INTRODUCTION

In September of 1995, a University of Maryland conference on the links between criminal behaviour and genes was disrupted by a group of approximately 30 protesters from several left-wing activist groups. One of these groups was Support Coalition, a self-proclaimed “psychiatric survivors’ liberation movement.” According to a *New York Times* article on the incident,<sup>1</sup> the groups involved in the protest objected to the conference on the grounds that its speakers were promoting “Nazi” eugenics and a pseudo-scientific, crudely sociobiological approach to the study of crime. The protest, though intense, was short-lived – the protesters left the meeting room peacefully after one hour.

According to the *Times* article, the conference was in actuality anything but an endorsement of eugenics. In fact, the presenters were overwhelmingly in favour of social spending on “bleeding heart programs” to combat crime, rather than investment in prisons. This was the case even for researchers who see crime, at least in part, as a biological question. One such researcher, Dr. Diana Fishbein, wondered why the government does not spend more money on social programs such as treatment facilities for drug addicts. In light of such left-liberal sentiments, the objections of the psychiatric survivors seem shrill and ill-founded. Overall, the *Times* article suggests that the

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<sup>1</sup> Natalie Angier, “At conference on links of violence to heredity, a calm after the storm,” *New York Times*, 26 Sept. 1995.

conference was a politically correct, scientifically mainstream event which a group of Marxists and other radicals inappropriately disrupted with virulent, misdirected criticism.

Interestingly, the article contains no explicit discussion of *why* the protesters were so incensed – none, that is, besides the vague implication that ignorance combined with political extremism were at work. Certainly, the protesters did seem to be largely mistaken about the content of the conference, and may even have found themselves to be in agreement with some of the academics who delivered papers had they heard them read. However, I do not think that the confrontation in Maryland can be explained merely as a question of an ignorant knee-jerk reaction on the part of a handful of activists. The confrontation points instead to a radical disjunction between the attitudes of those who call themselves “psychiatric survivors” on the one hand, and those who speak for psychiatry on the other, be they psychiatrists or academics or ethicists.

The same sort of discrepancy is also evident when one reads the first-person accounts of patients alongside the philosophical literature on psychiatry – the writers in these respective fields seem, in large part, not to agree on any solutions to ethical problems in psychiatry (for example, the seriousness of psychiatric “labeling,” the morality of involuntary treatment, and even the very definition of “mental illness”). In fact, these two camps often seem not to agree on what the most pressing moral issues *are* in the first place. A cursory look at the philosophical literature reveals a large number of articles on, for example, professional ethics (e.g. sex with patients, confidentiality), the issue of involuntary commitment (when it is and when it is not justified), and the thorny problem of legal responsibility and the mentally ill – pressing and important questions all, to be sure. Psychiatric survivors also discuss these topics, certainly, but their emphasis is



somewhat different: they rarely discuss issues such as involuntary commitment or legal responsibility separately from what they see as the main issues, namely, dignity, respect, and freedom from humiliation.<sup>2</sup> Moreover, psychiatric survivors claim that the very institution of psychiatry violates their dignity and their right not to be humiliated.

Unsurprisingly, psychiatrists deny that this is so. They respond to such criticism by saying that psychiatry is an institution which sincerely tries to help its patients by treating diseases which not only cause profound suffering, but which can attack a patient's autonomy and rationality. Psychiatrists are frequently at pains to distance themselves from psychiatry's sordid history of unnecessary and barbaric treatments. To this end, they assert that modern psychiatry's treatments are becoming increasingly sophisticated scientifically, as opposed to the crude psychosurgery of the past, and that its practitioners are becoming increasingly morally enlightened, especially as compared with certain doctors of the 50's and 60's such as Dr. Ewen Cameron of Allan Memorial Gardens Hospital, who used his patients as subjects in brainwashing experiments without their consent.

Judging between the two sides of the controversy is, to some extent, an empirical question. Do psychiatrists regularly prescribe dangerous drugs without informing their patients of the risks? Are conditions in psychiatric wards humane and hygienic? Are treatments such as ECT (electroconvulsive therapy) really safe? However, I think that at base, the question of how to understand the psychiatric survivors' movement is a

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<sup>2</sup> For example, the "Bill of Rights for Psychiatric Inmates in Canada," written by psychiatric survivors, includes, among other things, "the right to wear our own clothes at any time while incarcerated," "the right to be provided with nutritious food," and "the right to be treated with dignity and respect at all times." In Bonnie Burstow and Don Weitz, eds., *Shrink Resistant: the Struggle Against Psychiatry in Canada*. (Toronto: New Star Books, 1988), pp. 308-310.

philosophical one, one which can best be sorted out by availing ourselves of philosophical tools. In the section which follows, I want to show how Peter Strawson's article "Freedom and Resentment" contains a useful distinction for this purpose. Therein, he contrasts what he calls the "objective attitude" to human interaction with the "participant attitude." This distinction, I think, sharpens and illuminates the opposing positions taken by psychiatric survivors and psychiatrists concerning whether activists are justified in claiming that psychiatry as an institution is humiliating. Furthermore, I will try to show that Strawson's insights might give us reasons to be skeptical of psychiatry's self-understanding, especially with respect to the "objectivity" of diagnoses (without, however, accusing psychiatrists in general of intentional cruelty and cynicism). If I am successful in this, it ought to encourage us to take a closer and perhaps more sympathetic look at the moral claims raised by psychiatric survivors.

Before I begin, I would like to clarify a few issues. Firstly, there is the question of which terms are appropriate for referring to those who have been diagnosed as "mentally ill." The term "psychiatric survivor" is used by very many, but not all, anti-psychiatry activists; however, one activist notes that "a survivor, literally, is someone who really faced death and escaped. And most psychiatric patients were not facing death. I'll support the use of the term but I think it should be recognized as a metaphor."<sup>3</sup> Others object to the term "mental patient" because it has for them pro-medical connotations which they would rather avoid.<sup>4</sup> The term "consumer" is also problematic, since it carries pro-corporation connotations; others find it offensive because it implies that people using psychiatric drugs or warehoused in hospitals choose their treatments as

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<sup>3</sup> Quoted in Irit Shimrat, *Call Me Crazy* (Vancouver, Press Gang Publishers, 1997), p. 55.

<sup>4</sup> Shimrat, p. 33.

they would their brand of breakfast cereal.<sup>5</sup> However, for sake of ease and clarity, I shall use the term “psychiatric survivors” when referring to the activist movement and the term “mental patient” on occasion to refer to people who have received psychotherapy, drug therapy, or who have been hospitalized.

I will avoid referring to patients and ex-patients as “mentally ill” where possible, since this would imply that there is truth of the matter which has been settled by the act of psychiatric labeling. Moreover, I prefer to bracket out the question of the ontology of mental illness. This brings me to my second point of clarification. There is an extensive literature which examines whether mental illness is “real” or not.<sup>6</sup> There are good reasons to doubt that “mental illness” is a purely descriptive term, and on the other hand, there are some good reasons to believe that certain conditions such as schizophrenia have a biochemical basis. It is true that most psychiatric survivors are passionate proponents of the view that mental illness is a social construction. I respect this view, but I do not think that one must accept the truth of this thesis in order to accept the validity of the normative claims psychiatric survivors raise through their activism – claims which I will try to clarify and assess in this thesis.

Finally, I would like to point out that “mental illness,” as understood by doctors, is an extremely broad category which encompasses conditions as disparate as manic depressive disorder and attention deficit disorder. Very often philosophers who write on psychiatric questions use schizophrenia – especially its most extreme manifestations – as

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<sup>5</sup> Ex-patient and self-proclaimed “psychiatric survivor” Don Weitz says “There’s no real choice around treatment, so I think the word ‘consumer’ is totally inappropriate and demeaning.” Quoted in Shimrat, p. 48.

<sup>6</sup>For a brief sampling, see Thomas Szasz, *The Myth of Mental Illness* (New York: Harper & Row, 1961); R.D. Laing and A. Esterson, *Sanity, Madness, and the Family* (Harmondsworth, England: Penguin Books, 1964); Peter R. Breggin, *Toxic Psychiatry* (New York: St. Martin’s Press, 1994).

the paradigm example of a psychiatric disorder. For many authors, the very definition of mental illness is predicated upon the irrationality of the agent.<sup>7</sup> The use of schizophrenia as an example of mental illness also works toward justifying coercive treatments such as involuntary hospitalization, since few people object to the idea that we ought to protect society at large from dangerous persons. However, the emphasis on schizophrenia does not accurately reflect the reality that most psychiatric patients suffer from more mundane afflictions like panic disorder or depression,<sup>8</sup> diagnoses which do not require that the individual be significantly lacking in rationality. My use of the terms “mental illness” or “mental disorder” in the following paper are meant to refer to all its disparate manifestations.

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<sup>7</sup> See, for example, Roger Scruton, “Mental Illness,” *Journal of medical ethics*, 1981, 7, 36-38; Michael S. Moore, “Some Myths About Mental Illness” in Rem B. Edwards, ed., *Ethics of Psychiatry*, (Amherst: Prometheus Books, 1957).

<sup>8</sup> Elliot S. Valenstein, *Blaming the Brain* (New York: The Free Press, 1998), p. 214.

## CHAPTER 1

### MENTAL ILLNESS AND RESPONSIBILITY

This section will look at some writings on the subject of mental illness and responsibility. There is a huge philosophical literature encompassing the areas of legal philosophy, ethics, and even metaphysics, that attempts to answer whether the “mentally ill” should be held morally responsible for their actions. However, I do not want to enter into the complex legal and moral issues at the heart of this debate, and my aim is not to offer an opinion on whether those considered mentally ill ought to be legally punished for their misdeeds. Rather, I am interested in what psychiatric ethicists say about the “mentally ill” and responsibility for a quite different reason: I want to point out some unstated yet operative philosophical habits that doctors/ethicists display when they subject mental illness to philosophical scrutiny. Specifically, I want to draw attention to the objectivity of attitude characteristic of very many discussions of mental illness and responsibility, an attitude which makes empathy towards (and identification with) mental patients difficult, if not impossible. I want to show that psychiatric ethicists, for the most part, view people in distress as malfunctioning machines in need of technical medical expertise.

Part of this expertise involves making judgments as to whether a person is “responsible”; and since rationality is often considered necessary for responsibility, doctors are charged with determining a patient’s capacity for rational thought. Philosophers of psychiatry see their job as applying the analytic tool of conceptual

analysis to concepts like “rationality,” “responsibility,” and “autonomy.” They hold that if we can get clear about the meanings of these terms, then we can judge the behaviour and thought processes of mental patients against our arsenal of clarified concepts in order to determine with certainty whether patients are rational, responsible, and autonomous. Understanding the mentally ill, on this view, is a matter of clinical observation and accurate application of philosophical concepts.

However, the “objective observer” stance has serious limitations. First of all, it is questionable to what extent doctors can remain entirely objective and detached from their objects of study. Feminist biomedical ethics has drawn our attention to the ways in which supposedly abstract concepts obscure the power relationships at work in health care by downplaying any contextual factors. I will address feminist critiques of health care and will suggest that we ought to be suspicious of psychiatric ethicists’ accounts as to how we should evaluate mental illness and responsibility.

A second limitation of the observer stance is that it is inimical to the “participant attitude”: insofar as psychiatrists adhere exclusively to the objective point of view, they are unable to recognize certain behaviours as, if not “rational” in the sense defined by ethicists, at least as understandable responses to particular circumstances. I borrow the “objective attitude/participant attitude” distinction from P.F. Strawson’s article “Freedom and Resentment.” The distinction, I think, is extremely helpful. It contrasts two different ways of viewing human beings, viz., as objects to be studied and manipulated, or as members of the moral community, meriting emotional responses from others in the community. I maintain that the former stance is characteristic of the psychiatric attitude; the latter stance is perhaps the exact expression of how psychiatric survivors want to be

treated – indeed, how they *demand* to be treated. Since Strawson’s article contains ideas crucial for understanding why psychiatrists adopt objective attitudes towards patients – and also why ex-patients resent psychiatry and its practitioners – I will examine it in some detail in Chapter Two.

### **Responsibility as Rationality: Edwards and Moore**

In this chapter, I present the views of three representative authors on the subject of mental illness and responsibility. Rem B. Edwards is a psychiatric ethicist; Michael Moore writes about legal philosophy, specifically the insanity defense; and Lawrie Reznek is a practicing psychiatrist who has written a defence of psychiatry against ethical, scientific, and epistemological attacks. While Edwards and Moore regard rationality as the single most important condition of responsibility, Reznek downplays rationality in favour of autonomy. Regardless of their differences, they share a commitment to the view that responsibility (along with rationality or autonomy, depending on the author) are intrinsic characteristic of individuals, and is amenable to observation and evaluation.

Before discussing these writers’ views, I need to make some general remarks regarding the definition of “responsibility.” As H.L.A. Hart pointed out, there are a number of senses of the term “responsibility.” He identifies four distinct classes: role-responsibility, causal-responsibility, liability-responsibility, and capacity-responsibility.<sup>9</sup> Hart’s schema also helps to clarify the ways in which a person is considered to depart from responsible behaviour. For example, a person who neglects to fulfill her duties as a

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<sup>9</sup> H.L.A. Hart, *Punishment and Responsibility* (Oxford: Oxford University Press, 1968), p. 212.

parent is “irresponsible,” while someone who lacks *mens rea*, for example, is often considered “not responsible.” Interestingly, it seems that only those considered responsible in the accountability sense can be considered irresponsible in the role-responsibility sense, and this is borne out in the articles of Edwards, Moore and Reznick, for they consider mental illness to be a condition of *non-responsibility* and not *irresponsibility*.<sup>10</sup> However, when discussing responsibility in its positive sense, these writers do not draw the sorts of distinctions that Hart does; and so we find that often, the characteristic of responsibility which characterizes the mentally healthy means at times the proper fulfilling of roles; at other times it means the capacity for rational judgment, and at others still, it refers to moral accountability.

For Edwards, responsibility is a matter of rationality and autonomy. His article “Mental Health as Rational Autonomy” begins by proposing a definition of “mental health” which attempts to avoid the sort of medical imperialism implicit in other formulas.<sup>11</sup> Such definitions, he thinks, err in allowing social or personal problems to be considered as disease. Not just any harmful condition (such as poverty) ought to be considered an illness – so what criterion can we use to distinguish mere conditions that cause suffering from *bona fide* illnesses? Edwards thinks that mental illness ought to be defined as a condition that attacks an individual’s capacity for rationality and responsibility. If an individual is rational and responsible, she is not mentally ill.

Edwards proposes the following definition of mental illness:

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<sup>10</sup> One might be tempted to see a parallel between responsible/irresponsible/non-responsible and rational/irrational/non-rational. This is not the case, however. All three psychiatric ethicists refer to mental patients as non-responsible; at the same time, they frequently describe them as irrational.

<sup>11</sup> In particular, Edwards singles out the definition advanced by the World Health Organization: “Health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity” (quoted in Edwards, p. 58).



“Mental illness” means only those undesirable mental/behavioral deviations which involve primarily an extreme and prolonged inability to know and deal in a rational and autonomous way with oneself and one’s social and physical environment. In other words, madness is extreme and prolonged practical irrationality and irresponsibility.<sup>12</sup>

By way of elaboration, he adds that the undesirable “mental/behavioural deviations” must be manifested by actions that others can observe.<sup>13</sup> Furthermore, since psychiatric labeling is a morally problematic practice – it is psychologically damaging to those who are so labeled – Edwards is careful to specify that the tag “mentally ill” be reserved for only “serious” and “prolonged” cases.<sup>14</sup> Mental illness is to be diagnosed in these cases only. Furthermore, serious and prolonged irrationality, in Edwards’s view, is sufficient for the diagnosis of illness: it is not necessary to show that illness has a biological basis.<sup>15</sup>

By “autonomy,” Edwards means the capacity to make decisions and take care of oneself, as well as the ability to take responsibility for one’s “own life, its station and its duties.”<sup>16</sup> The value of mental health, for Edwards, is not that the healthy individual is sane enough to see that certain socially desirable values are the correct values. Rather, the value of mental health consists in having the ability to make one’s own decisions about which values one will promote. So, Edwards would say, if a person rationally decides to commit her time to revolutionary political activism (and, in addition, she is fully cognizant of the repercussions), she may become a nuisance to society, but she is not insane.

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<sup>12</sup> Edwards, pp. 52-53.

<sup>13</sup> Edwards, p. 53.

<sup>14</sup> Edwards, p. 54.

<sup>15</sup> Edwards, p. 54.

<sup>16</sup> Edwards, p. 53

Autonomy, on Edwards's view, is a characteristic of a *rational* person; since "rationality" is the centrepiece of his conception of psychological health, he spends most of his article drawing out what he sees as the implicit assumptions underlying our everyday use of the term. For this reason, he does not propose an original definition, but says that our everyday usage of the word "rationality" points to "widespread agreement" as to what it involves.<sup>17</sup> According to Edwards, rationality is comprised of seven criteria. Rational individuals are able to distinguish means from ends, think logically and intelligibly, do not hold contradictory beliefs, reject beliefs when they are contradicted by factual evidence, are capable of being impartial, and hold beliefs that are compatible with the values of freedom, enlightenment, and impartiality.<sup>18</sup> He thinks that rationality is something individuals can exhibit in varying amounts, though only persistent and extreme departures from the above criteria should count as symptoms of a mental illness.<sup>19</sup>

Edwards wants to advance a set of criteria for rationality that does not impose any values on the patient beyond rationality and autonomy, since, he thinks, it is self-evident to the members of our moral community that these values are good in themselves.<sup>20</sup> We should be wary, he thinks, of promoting any values other than those of rationality and autonomy in the clinical setting, lest we fall into the trap of medical imperialism and find the borders of "psychiatric disease" expanding to include ailments which do not belong.<sup>21</sup>

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<sup>17</sup> Edwards, p. 55.

<sup>18</sup> Edwards, p. 55.

<sup>19</sup> Edwards, p. 55.

<sup>20</sup> Not all communities recognize rationality and autonomy to be goods, says Edwards: "In the former Soviet Union, it was the rationally autonomous person who was involuntarily institutionalized in mental hospitals!" Edwards, p. 60.

<sup>21</sup> "I wish... to assert that not every disapproved mental/behavioural phenomenon should count as mental illness, that we should make a concerted effort to disentangle legitimate psychiatric valuations from moral and religious ones, and that we should attempt to put a screeching halt to the rampant proliferation of

The reluctance to add to the scope of psychiatric diagnoses also explains Edwards's desire to exclude substantive criteria from his definition of rationality. He says that "rationality is a function of how we know, not of what we know."<sup>22</sup> Mental illness ought to be diagnosed only when the individual deviates from rational behaviour and thought processes, not when the content of her beliefs or values differs from those of the psychiatrist. The more objective the criteria for diagnoses become, the less likely it will be that societies will embrace erroneous and morally repugnant psychiatric diagnoses such as "drapetomania" (the "disease" that supposedly afflicted black slaves who ran away from their owners), or "homosexuality."

Philosophers often assert rationality and freedom of will to be the elements necessary for the ascription of responsibility<sup>23</sup> – if a person exhibits behaviour which is rational and autonomous, she will be considered a responsible person, a member of the moral community. Edwards's formulation follows this model, even though he does not discuss responsibility as such in any great detail. He does say, however, that we consider a person a moral agent when she exhibits behaviour which fits the criteria for rationality and autonomy outlined above.<sup>24</sup> Responsibility, Edwards would say, is an intrinsic property of individuals, a property whose presence or absence can be observed, or indeed, we might infer, *diagnosed* by psychiatrists. Determining whether an agent is responsible is a matter of judging her speech and behaviour against a standard of rationality.

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psychiatric diagnostic categories because of the grossly detrimental effects of the very act of psychiatric labeling if for no other reason." Edwards, p. 57.

<sup>22</sup> Edwards, p. 55.

<sup>23</sup> Edwards, "Ethical Issues in Forensic Psychiatry," in *Ethics of Psychiatry*, p. 488.

<sup>24</sup> Edwards, 60.

Like Edwards, Michael Moore also thinks that rationality is the defining characteristic of mental health; unlike Edwards, he explicitly discusses the relationship between rationality, mental health, and responsibility in some detail. Moore's view is that rationality is a function of an agent's beliefs and goal-directed behaviour, and he refutes radical psychiatrists' claims that schizophrenic behaviour can in many cases be interpreted as rational. He finishes his article with an argument in support of the common intuition that mental illness excuses agents from blame.

According to Moore, mental illnesses are diseases that attack rationality.<sup>25</sup> Moore defines a rational person as "one who...will act so as to further his desires in light of his beliefs; and we need to know that...the agent does not have desires and beliefs that conflict with the desires and beliefs on which he is about to act."<sup>26</sup> Furthermore, the agent's desires and beliefs must also be intelligible to others. For example, a desire to soak one's elbow in mud is not a rational thing to want, and the belief that uttering certain words will make one pregnant is not a rational belief.<sup>27</sup> Another characteristic of irrational agents is the clinging to beliefs, even when faced with evidence that such beliefs are false. Thus, rationality is a matter of intelligible motivations for actions: the ascription of rationality requires knowledge that the agent's beliefs and desires provide acceptable reasons for her actions. When an agent's actions seem incomprehensible to us and we do not know her reasons for acting in this way, we are not entitled to attribute to her reasons which would render the behaviour intelligible. This, says Moore, is the error

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<sup>25</sup> Moore, p. 41. Throughout the article, Moore uses only schizophrenia and catatonia as examples of mental illness. He does not acknowledge that many of the disease categories in use by psychiatrists do not involve extreme departures from rational thought, so it is unclear whether he thinks, with Edwards, that we ought to narrow the scope of the term "mental illness," or whether he chooses to focus on schizophrenia as a sub-species of mental illness for ease of argument.

<sup>26</sup> Moore, p. 34.

<sup>27</sup> Moore, p. 35.

radical psychiatrists such as R.D. Laing are guilty of: they do not recognize the importance of rational beliefs in explaining seemingly irrational behaviour. The onus is on the psychiatrist to prove that the behaviour *is* rational, and not merely that there is a possible situation in which the behaviour *would* be rational.<sup>28</sup>

According to Moore, we cannot view irrational actors as persons because seeing others as persons requires that we see them as responsible and, by extension, rational. Irrationality estranges us from the other, making it impossible to carry on a normal human relationship:

The presupposition of rationality is a necessary condition for understanding the other in human terms, that is, in the idioms of practical reasoning, beliefs, motives, intentions, desires, and the like. Absent from such explanations we cannot understand another in the same fundamental way in which we understand our fellows in daily life, as set forth earlier. It is only beings that we understand in this way that we regard as moral agents.<sup>29</sup>

When we cannot make sense of another's motives or beliefs, or when the other's actions do not accord with "regularly practical syllogisms,"<sup>30</sup> or when irrational beliefs do not change in the face of evidence to the contrary, we cannot consider the agent to be morally responsible – that is, we cannot hold her accountable for the things she does. For the same reasons, we do not hold infants or animals responsible for their behaviour – we cannot include them as part of the moral community because they are incapable of rationally purposive activity.<sup>31</sup> Contrary to the views of some philosophers,<sup>32</sup> Moore

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<sup>28</sup> Moore, pp. 35-40.

<sup>29</sup> Moore, p. 47.

<sup>30</sup> Moore, "Legal conceptions of mental illness," in B. Broody and T. Engelhardt (eds.), *Mental Illness: Law and Public Policy* (Dordrecht: Reidel, 1980), p. 60.

<sup>31</sup> Moore, p. 47.

<sup>32</sup> See, for example, Roderick M. Chisholm, "Responsibility and Avoidability," in Joel Feinberg (ed.), *Reason and Responsibility* (Belmont, California: Dickenson Publishing Company, 1969).

does not think that in order to absolve an individual from blame, we must show that her behaviour was determined in some sense; rather, the feature most relevant to responsibility is rationality, which is necessary for the ascription of moral maturity.

So we see that like Edwards, Moore thinks that whether or not a person is mentally ill is a question of how rational she is, and, by extension, how responsible she is. Moore does not say in his article whether he thinks that psychiatrists *actually* arrive at diagnoses of mental illness by applying rationality criteria like the schema he puts forward, or whether this is merely the way psychiatrists *ought to* arrive at diagnoses. Moore's adamant defence of psychiatry in response to critics Thomas Szasz and R.D. Laing does not tackle questions of psychiatric diagnoses, but only the issues of the ontology of mental illness and the morality of the insanity defense. However, his vehemence in defending a particular conception of mental illness and his disdain for the anti-psychiatrists imply that he does think that actual psychiatric practice involves the determination of how rational patients are. If Moore is indeed saying that the conception of rationality outlined in his article informs the practice of psychiatry, he can be taken to be saying something about how doctors settle on diagnoses. It seems not unreasonable to attribute to Moore the view that valid medical diagnoses of mental illness are based on external manifestations of irrationality only, viz., the patient's behaviour and her motivations and beliefs as conveyed to others through speech.

So far I have discussed two writers who think that the very condition of mental illness entails irrationality and nonresponsibility. Both Edwards and Moore also think that irrationality and nonresponsibility are intrinsic characteristics of individuals,

characteristics which are observable and even quantifiable by others<sup>33</sup> (the implication being that such observations are most appropriately undertaken by psychiatrists). Though I have only discussed two ethicists representative of this view, it is a common ethical stance in the philosophical literature on mental illness.<sup>34</sup> Despite its popularity, there are problems with the view that psychiatrists are capable of accurately evaluating how responsible and rational their patients really are; furthermore, it is doubtful that assessing the rationality of patients really *is* central to the practices of diagnosis and treatment. It is not my aim to thoroughly refute the claim that mental illness equals irrationality, but I think it is important to insert a brief excursus suggesting reasons why we should doubt that evaluating rationality is as clear-cut as the above writers make it out to be.

First of all, there are problems with the criteria Moore and Edwards think are requirements of rationality. To take one example: both writers assert that a person, in order to be considered rational, must evince a willingness to modify her beliefs when these beliefs are contradicted by evidence. A problem with this criterion is that it is not unusual for devout Roman Catholics to refuse to jettison a belief in miracles even when faced with scientific evidence that no such miracles could occur. Even though so-called “free thinking” people might consider this irrational behaviour, very few would assert that these people need medical treatment. It seems that “when a belief that is false from an empirical-scientific standpoint is held by a large enough number of people, it is no

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<sup>33</sup> Edwards says that “mental illness will be a matter of degree of both time and severity of impairment and as such will be on a continuum with the whole of life; and there will be a grey area of controversial borderline cases” (Edwards, p.54).

<sup>34</sup> Roger Scruton, for example, draws the same conclusions about the connection between rationality, responsibility, and mental illness. Extreme mental illness is a condition which affects rationality, and obliterates the sufferer’s capacity for responsibility. The mentally ill person’s loss of intention and judgement “makes it impossible to treat the patient as other than an object” (p. 38). Roger Scruton, “Mental illness,” *Journal of medical ethics*, 7 (1981), pp. 37-38.

longer defined as delusional.”<sup>35</sup> As for the requirement that a rational person does not hold beliefs that are contradictory, there are reasons to think that this is not the clear sign of a disorder. It is common for people to hold beliefs that are implicitly, if not explicitly, contradictory.<sup>36</sup> In fact, it has been pointed out that reasoning patterns of “normal” people quite consistently deviate from standards of logical inference.<sup>37</sup>

Secondly, the concept “mental illness” as construed by Edwards and Moore is abstracted entirely from all contextual considerations. Both writers want to say that mental illness is a real entity which can be identified by judging a person’s behaviour against an objective standard; but neither writer acknowledges any contextually derived limitations to the application of this objective standard. Feminists have drawn our attention to the ways in which medicine in general (not only psychiatry) has either discouraged rational decision-making in its female patients, or has not recognized it when it has been present – largely due to the fact, they say, that medicine is a hierarchical, male-dominated profession which reflects the attitudes of a patriarchal society. A number of feminists have found it significant that most psychiatric patients are women and that women’s madness has historically posed a special problem for psychiatrists.<sup>38</sup>

The sexism that contributes to the view that women are predisposed to irrational behaviour is compounded by the host of negative ascriptions accompanying the sick role: Susan Sherwin observes that “when a group is characterized as ill, they are subject to...judgments that they are not fully competent.”<sup>39</sup> Female patients are also prevented

<sup>35</sup> Brendan A. Maher, “The Irrelevance of Rationality to Adaptive Behavior,” in Manfred Spitzer and Brendan A. Maher, eds., *Philosophy and Psychopathology* (New York: Springer-Verlag, 1990), p. 84.

<sup>36</sup> Frank Doring, “Limits of Irrationality,” in *Philosophy and Psychopathology*, p. 91.

<sup>37</sup> Maher, p. 78.

<sup>38</sup> Among these are Denise Russell, *Women, Madness and Medicine* (Cambridge, U.K.: Polity Press, 1995), and Elaine Showalter, *The Female Malady* (New York: Penguin Books, 1985).

<sup>39</sup> Susan Sherwin, *No Longer Patient* (Philadelphia: Temple University Press, 1992), p. 195.



from exercising their capacity for competent, rational decision-making by the hoarding and mystification of medical information. Doctors often treat medical knowledge as specialized, technical knowledge beyond the patient's understanding, thereby encouraging dependence on authority. This state of affairs, Sherwin says, is not exactly conducive to fostering rational autonomy and in fact may evoke fear in the patient, which the doctor may interpret as evidence of irrationality.<sup>40</sup> Sherwin's point here has special relevance for psychiatric contexts, where fear is a common reaction to doctors, hospitals, and especially to therapies such as ECT.<sup>41</sup> While these criticisms do not in themselves show that every ascription of irrationality is mistaken, it does alert us to the ways in which sexism influences such ascriptions, and it ought to make us guarded about uncritically accepting any discussions of "mental illness" and "irrationality" that do not refer either to the patient's personal context or to the wider socio-cultural context.<sup>42</sup>

The emphasis on rationality in Moore's and Edwards's articles might, in the final analysis, render their contributions irrelevant to the understanding of the ethical problems arising from psychiatry *as it is actually practiced*. This is because many, if not most, psychiatrists do not seem to think their main task is to correct defects of rationality. Philosopher of psychiatry Lawrie Reznick, himself a psychiatrist, says that "even though there is some evidence to support the notion that depressed people are more rational than

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<sup>40</sup> Sherwin, p. 143.

<sup>41</sup> Peter Breggin, "Coercion of Voluntary Patients in an Open Hospital," in *Ethics of Psychiatry*, p. 429; also numerous references to fear of ECT in literature written by ex-patients.

<sup>42</sup> Philosophers have the habit of emphasizing the "irrationality" of beliefs or utterances by neglecting to provide the context in which these take place; often this is not an oversight, but an impossibility, because they are using imaginary examples to make their point in the clearest, least complicated way. Moore, for example, refers to the "belief that saying 'storks' instead of 'stocks' will make one a mother" (p. 35) without indicating whether this is an actual belief that someone holds or an example he dreamed up; similarly, Habermas shores up a point about irrational speech with the example of a person who complains of rotten apples' "vertiginous" and "unfathomable" smell. Jurgen Habermas, *The Theory of Communicative Action, Vol. 1*, trans. Thomas McCarthy (Boston: Beacon Press, 1984), p.17.

normal people, we would not want to prioritize rationality over happiness and productivity”<sup>43</sup>; furthermore, he defines mental illness as “an abnormal and involuntary process that does (mental) harm and should best be treated by medical means.”<sup>44</sup>

Reznek’s conception of mental illness coheres with DSM-IV list of mental illnesses, most of which do not specify irrationality as a symptom. Edwards may escape criticism on this front since he states that not everything included in the diagnostic manuals ought to be considered a disease.<sup>45</sup> Though I believe he is certainly correct in this, he does not provide compelling reasons for accepting “irrationality” rather than “suffering” as the salient characteristic of disease.

As for Moore, he does not discuss any illness categories other than schizophrenia – the paradigm of a mental illness which affects rationality. If we interpret Moore as saying that psychiatrists, in their actual practice, consider mental illness synonymous with irrational thinking and behaving and sanity synonymous with rationality, then he is wrong. Again, psychiatrists do not seem to think that lack of rationality is a necessary component of mental illness, as a glance at the Diagnostic and Statistical Manual IV (DSM-IV) reveals. Philippe Pinel (1745-1826), an early specialist in the treatment of the insane, wrote in his memoirs “errors of reasoning are much rarer among madmen than is commonly thought.”<sup>46</sup> More recently, a study has suggested that depressed subjects show a heightened capacity for rational thought,<sup>47</sup> answering the possible counter-argument

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<sup>43</sup> Lawrie Reznek, *The Philosophical Defence of Psychiatry* (London, Routledge, 1991), p. 162.

<sup>44</sup> Reznek, p. 163.

<sup>45</sup> Edwards, p. 57.

<sup>46</sup> Denise Russell, *Women, Madness and Medicine* (Cambridge, U.K.: Polity Press, 1995), p. 15.

<sup>47</sup> L. Alloy and L. Abramson, “Judgement of contingency in depressed and nondepressed students: Sadder but wiser?,” *Journal of Experimental Psychology*, 108 (1979), pp. 441-485; cited in Reznek, *The Philosophical Defence of Psychiatry*, p. 35.

that depressed people are often depressed “about nothing,” which indicates that they are not rational.

There are good reasons, then, to be skeptical of 1) the attempt to make mental health (whatever that might be) dependent on “rationality”, and 2) the claim that “rationality” is an objective, medically observable characteristic. Furthermore, it is questionable whether psychiatrists are in a position to evaluate how rational their patients are, given that doctors often do not have extensive knowledge of their patients’ circumstances. Construing irrationality as a set of rigid criteria abstracted from the individual’s context might encourage doctors to see patients as irrational when patients are merely adapting to a situation that demands dependence on authority and obedience. Should we extend such skepticism to all other attempts at theorizing objective criteria for mental illness? In what follows, I will look at an attempt to ground responsibility not in rationality, but autonomy.

### **Responsibility as Autonomy: Reznick**

Lawrie Reznick, a philosopher who is a practicing psychiatrist, does not think that mental illness necessarily affects the individual’s capacity for reason, nor does he think that irrationality is sufficient to render an individual incapable of responsibility for her actions. Though his view departs from those of Edwards and Moore with respect to the relationship between rationality, illness and responsibility, his view is similar to theirs in another way. Reznick’s account of why mental illness excuses agents from responsibility, like Moore’s and Edwards’s accounts, is a question of making a correct judgement about the nature of the individual’s disease.

Before putting forward his own theory as to why mental illness excuses agents from blame, Reznik first considers some current theories and shows how they fall short in accounting for the ascription of responsibility. One theory is that mental illness excuses because a mentally ill person cannot intend her actions and so cannot help but act in the way she does. We do not blame such a person for committing acts that are seen as crimes under normal circumstances for the same reason that we excuse any person who acts under compulsion: a person can only be responsible for voluntary actions.<sup>48</sup> Reznik introduces a counterexample here to show that this cannot be the reason mental illness exculpates. He asks us to imagine the case of an epileptic who becomes involuntarily violent during his seizures, but who purposely induces seizures while knowing full well that he will become violent (an analogue to this case is that of crimes committed under the influence of alcohol or drugs). The violence in this case is involuntary, but the person is blameworthy because he formed the intent to be violent.<sup>49</sup>

Others think that mental illness excuses because in its most serious manifestations, it affects the subject's rationality – and our intuition is that irrational agents should not be blamed for their actions. Again, Reznik has a counterexample to show that this view cannot be correct: he says that there are cases in which an agent might be fully rational yet not responsible. For example, a man might, as a result of a brain tumour, undergo a personality change which makes him homicidal. It is conceivable for such a personality change to leave his reason unaffected while changing his desires: the disease might make him utterly unconcerned about the possibility of his

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<sup>48</sup> Reznik, p. 197.

<sup>49</sup> Reznik, p. 199.

killing someone.<sup>50</sup> Yet Reznik thinks that we would say he is not responsible for his homicidal actions because the disease has turned him into another person. It is not “him” who is acting reprehensibly.<sup>51</sup>

Reznik thinks we need an account of responsibility that explains the difference between two different sorts of cases. In the first case, a man contracts tuberculosis and as a result commits terrorist acts against the state to protest its neglect of concern for the poor living conditions that cause the spread of the disease. In the second case, a previously normal man acquires a new desire to kill innocent people; after his suicide he is discovered to have had a brain tumour, the supposed cause of his homicidal impulses.<sup>52</sup> In the first case, Reznik thinks, our intuition tells us that the man is responsible; in the second, our intuition tells us that he is not. What is the relevant distinction between these two cases?

According to Reznik, the real reason mental illness exculpates is because it affects the agent’s autonomy. He thinks that autonomy consists in acting rationally, in accordance with one’s own desires: “If an agent acts because of alien desires, or because his rationality is undermined, or because he is being coerced, it is not *he* who is acting. Only when the self determines his actions do we consider it fair to praise and blame him.”<sup>53</sup> We might ask how we can know whether the true self is determining an individual’s action or whether “alien” desires are at work. On this view, it seems that we

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<sup>50</sup> Reznik, p. 201. Another good example is found in a case study of a man with Alzheimer’s disease who, over a period of time, grows colder and colder to his wife, whom he previously loved dearly, until finally he ends up completely hostile to her. Tony Hope, “Personal Identity and Psychiatric Illness,” in A. Phillips Griffiths, ed., *Philosophy, Psychology, and Psychiatry* (New York: Cambridge University Press, 1994), pp.131-133.

<sup>51</sup> Reznik, p. 200.

<sup>52</sup> Reznik, p. 203.

<sup>53</sup> Reznik, p. 204.

cannot trust the agent's stated views on the subject: though she might say that she acts in accordance with her beliefs and desires, these may not be her *authentic* beliefs and desires. We can only conclude that the agent is acting autonomously once we have decided that her beliefs and desires were formed in the "normal" way.<sup>54</sup>

Take the example of the man with tuberculosis. His desire for justice from the state derives from his disease, but in a normal way, viz., in the same way most new desires are formed: by rational deliberation, motivated by authentic desires. For this reason, "the new desire is not alien and therefore autonomy is not undermined."<sup>55</sup> Likewise, in the case of the epileptic who induces seizures even though he knows it will make him violent: he is responsible because his desire to induce the seizure is not the result of an alien disease process. On the other hand, the sniper's desires are not formed in the normal way. The brain tumour replaces his authentic intentions with alien ones, perhaps without the man even being aware of what is happening. Similarly, schizophrenia counts as an excuse for criminal behaviour because the new desires are the results of disease and are therefore not the authentic desires of an autonomous agent. To sum up, "only if behaviour is determined in a certain way (by rational deliberation on desires and beliefs normally formed) will the agent be responsible."<sup>56</sup>

Reznek's view, then, differs from those of Edwards and Moore: his account of responsibility rests on autonomy rather than rationality as its defining feature. Though his account has (on the face of it) a certain plausibility, and though he does indicate reasons why we should not accept the competing views that responsible action is a case

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<sup>54</sup> Reznek, p. 204.

<sup>55</sup> Reznek, p. 204.

<sup>56</sup> Reznek, p. 205.

of either rationality or the absence of deterministic forces, we ought to question whether his view constitutes an improvement over the rationality-based theories of Edwards and Moore. A major problem with Reznek's article is that he seems to think that the idea of an authentic self on the one hand, and a diseased, inauthentic self on the other is philosophically unproblematic. He says that in the case of the sniper, "it is not *he* who is acting," and assumes that the brain tumor is the cause of the new personality. This is somewhat facile.

In an article entitled "Personal Identity and Psychiatric Illness," author Tony Hope discusses the case of a man diagnosed with mild mania. On lithium (let's call this state P1), he is a committed family man and a reliable schoolteacher. Off lithium (P2), he carries on an affair with a co-worker, becomes bored with his family, and composes songs. He frequently goes on and off lithium. The case is puzzling, says Hope, because there are no sound philosophical reasons for saying that either of these personalities is the "authentic" one. Hope's intuition that the manic personality is the authentic one cannot be convincingly defended by appeal to an underlying disease. To say that P2 is an inauthentic state is to beg the question, he says: "in the absence of a detailed theory of illness it would be just as reasonable to regard the unmedicated Mr. M as the normal and healthy one, and the medicated Mr. M as a sufferer from mild depressive illness."<sup>57</sup>

Part of the reason that Reznek's argument does not convince is because of the unreliability of the medical knowledge about those very diseases which, according to Reznek, cause the alien desires. He uses brain tumors, schizophrenia, and kleptomania as examples of conditions that cause the sufferer to have desires they would not otherwise

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<sup>57</sup> Hope, p. 142.

have. Brain tumors, however, are considered neurological diseases, not psychiatric diseases. It has been widely documented that by and large, psychiatric disorders do not have a known etiology; in fact, the architects of the DSM-III pride themselves on having compiled a manual based almost entirely on symptomatology rather than etiology.<sup>58</sup>

Critics of psychiatry have also pointed out that no one has yet shown that bio-chemical brain-states *cause* behaviour, moods or intentions – the best that anyone has done is to show that there is a *correlation* between brain chemistry and altered mood/behaviour.<sup>59</sup>

Finally, if Reznek is correct in saying that mental disorders cause the agent to hold new, alien desires and beliefs incompatible with her “authentic” desires and beliefs, we would expect the agent to disavow the former once she is “restored” to sanity.

However, though this does happen, it is not always the case. In many first-person accounts by people who have been diagnosed as mentally ill, the authors do not, as we might expect, look upon their former thoughts and actions as the thoughts and actions of strangers. Instead, they often offer meaningful explanations of their behaviour while hospitalized with severe depression or schizophrenia. For example:

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<sup>58</sup> Stuart A. Kirk and Herb Kutchins say that those who compiled the DSM-III “carefully avoided any etiological explanation for mental disorders that did not already have widely recognized, well-established organic causes,” and that this constituted the major change in the move from DSM-II to DSM-III. Stuart A. Kirk and Herb Kutchins, *The Selling of DSM: the Rhetoric of Science in Psychiatry* (New York: A. de Gruyter, 1992). Denise Russell notes that in the absence of a known etiology, the claim that symptoms are caused by diseases is a “mere conjecture” (p. 29).

<sup>59</sup> Elliot Valenstein, *Blaming the Brain* (New York: Free Press, 1998), pp. 125-132; Russell, p. 81. Reznek tries to evade this possible criticism by adding that “whether we regard someone as responsible depends on whether their behaviour is the product of a disease, and since this depends on our values and not on the facts, a person’s responsibility is not a factual matter (Reznek, p. 206). When he says that whether something is a disease depends on our values and not the facts, he is alluding to his view that we only consider conditions to be diseases when we as a society do not value them, and see them as harmful. However, Reznek is disingenuous when he says that whether something is a disease is a matter of values and not of fact. His definition of mental illness also includes the requirements that it be involuntary (not something that can be reversed at will) (Reznek p. 164), and that it be a process (it must have an onset and a natural history) (Reznek, p. 163). These are not exactly value judgements in the way that seeing something as a harm is a value judgement, and in any case, it would be problematic to say that mental illnesses are defined *only* in terms of disvalues – then anything that society disvalues can be seen as a disease (crime or political dissidence for example).



Everyone around me clearly thought that I was crazy – maybe I was crazy. After all, I was screaming and crying like a crazy person. What else did crazy people do? I picked up a bedside lamp and began to smash the little windows of the door to my room. Swinging the lamp was the only way left to feel powerful. It only lasted a few minutes. Several nurses and aides subdued me, although I fought them with a strength I didn't know I had.<sup>60</sup>

Actions which provide further “proof” to mental health workers of the patient’s illness are seen by the patient as an understandable response to her feelings of powerlessness. Many other ex-patients echo this sentiment; they feel that their former “craziness” should not be seen as the actions of a disease-induced, alien self.<sup>61</sup> Another woman who was committed to several psychiatric facilities describes the delusions and hallucinations that led to her eventual hospitalization; and though she does not provide explanations for her thoughts and behaviour designed to render them understandable to others, she does not see this behaviour as evidence that she was “not herself”; instead, being crazy was preferable to taking the neuroleptic drug Haldol: “eventually, despite the drugs and the terrible environment, I stopped being crazy. Boredom and the passage of enough time can do that. All the magic shriveled up and withered away.”<sup>62</sup> She adds that on the contrary, it was the drugs and hospitalization that made her feel like she was “not herself.”<sup>63</sup> That many people formerly diagnosed with extreme mental illness do not view themselves as having been a different person when they were crazy surely throws doubt on Reznick’s claim that mental illness exculpates for this reason.

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<sup>60</sup> Judi Chamberlin, *On Our Own: Patient-Controlled Alternatives to the Mental Health System* (New York: Hawthorn Books, 1978), p. 33.

<sup>61</sup> Ex-patient Don Weitz explains his former bouts of “mental illness” as the result of non-conformity and depression, combined with lack of understanding on the part of his parents. Quoted in Shimrat, p. 46.

<sup>62</sup> Shimrat, p. 16.

<sup>63</sup> Shimrat, p. 17.

Reznek's attempt to ground responsibility solely in autonomy, then, seems as questionable as Edwards's and Moore's attempts to ground it solely in rationality. All three authors want to elucidate a concept of responsibility which has applications for psychiatry – for the act of diagnosing mental illness or for the forensic purpose of determining criminal responsibility. However, these authors' discussions of mental illness are so abstract as to be distorting, and so divorced from personal and social realities of mental illness that the applicability of their concepts (autonomy, rationality) is rather doubtful. I have already criticized some of the unstated and hence undefended assumptions that inform their essays; now I would like to address what I think is the most important assumption these authors make about those regarded as mentally ill. All three authors' attempts to address the question of responsibility and the mentally ill are inadequate because the authors take an objective attitude toward the ascription of responsibility; they think that determining whether or not a person is responsible is a question of objectively observing her and assessing whether she is rational and autonomous.

The limitations of this view will become clear when it is contrasted with P.F. Strawson's approach in "Freedom and Resentment." He thinks that we see others as responsible when we stand towards them in a certain kind of relationship; responsibility is not something we discover by judging an individual's behaviour against a list of criteria, nor does it evaporate only after a physician concludes that the individual's beliefs and intentions are caused by a disease. Rather, responsibility emerges from *our* seeing the other in a certain way – it emerges from relationships, from a context. Strawson is, of course, talking about the ascription of responsibility in general, and does not discuss the

peculiar context of psychiatrist-patient encounters. Nevertheless, his insights have, I think, special relevance for understanding the impasse between the psychiatric survivor movement and psychiatry.

## CHAPTER 2

### THE OBJECTIVE ATTITUDE

P.F. Strawson's paper "Freedom and Resentment" sets out to show that notwithstanding the arguments of incompatibilist philosophers, our practices of blame and punishment do not lose their moral force if the thesis of determinism happens to be true. He claims that theoretical considerations are irrelevant to the ascription of responsibility. Instead, we hold others responsible for their misdeeds because the practices of blame and punishment are underwritten by emotions to which we have a strong commitment, and which we cannot dispense with at will. Though ostensibly an effort toward settling a metaphysical dispute, Strawson's article has taken on importance as a contribution to ethics.<sup>64</sup> It is in this ethical capacity that I wish to address his argument; in particular, I want to show that the "objective attitude"/"participant attitude" distinction is useful for understanding the impasse between the psychiatric interpretation and the psychiatric survivor interpretation of doctor-patient encounters. I should make it clear that I do *not* want to address the responsibility debate head-on. Rather, I want get at the issue of psychiatric objectivity obliquely *via* the responsibility debate. Once I have sketched Strawson's argument and described the objective/participant dichotomy, I will detail its application for clinical psychiatric phenomena, particularly psychiatric labeling and doctor-patient communications.

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<sup>64</sup> R. Jay Wallace, *Responsibility and the Moral Sentiments* (Cambridge, Massachusetts: Harvard University Press, 1996), p. 96.

“Freedom and Resentment” is a work of moral phenomenology.<sup>65</sup> That is to say, Strawson’s argument starts from the *experience* of holding people responsible and moves backwards, so to speak, drawing out the assumptions that make such a practice possible – or even, as we shall see, necessary. Under what conditions do we find it appropriate to hold someone accountable for her deeds? Strawson thinks that to answer this question we have to look to a set of feelings known traditionally as the “moral sentiments” (though he refers to them as the “reactive attitudes”)<sup>66</sup>: these are a special class of emotions, which includes gratitude, resentment, indignation and guilt. The reactive attitudes are interesting because they necessarily express a moral disposition, as opposed to immediate, almost reflex, responses such as rage and fear.<sup>67</sup> For example, if someone expresses ill will towards another person, perhaps by physically harming her, the injured party will respond with resentment – an expression of moral disapprobation. Analogously, resentment experienced vicariously on behalf of an injured third party is known as “indignation,” and it too expresses moral disapprobation of an action; guilt is aroused by our feeling that we have ourselves done something morally wrong; and so on, for all the reactive attitudes.

Strawson has a particular interest in resentment and indignation, since they are closely tied to the ascription of responsibility. In feeling resentment, I am implicitly holding the offending party “responsible,” or “accountable,” for her behaviour. In other

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<sup>65</sup> Strawson does not use the term “phenomenology” himself, but I think this is an apt description in light of his intention to “try to keep before our minds something it is easy to forget when we are engaged in philosophy... viz. what it is actually like to be involved in ordinary inter-personal relationships, ranging from the most intimate to the most casual.” Peter F. Strawson. “Freedom and Resentment,” in *Freedom and Resentment and Other Essays* (New York: Methuen & Co. Ltd., 1974), p. 6.

<sup>66</sup> Strawson, p. 6.

<sup>67</sup> Jürgen Habermas, *Moral Consciousness and Communicative Action* (Cambridge, Massachusetts: MIT Press, 1996), p. 45.

words, resentment is an emotional expression of the moral belief that the actor deserves blame or punishment. However, Strawson points out that there are three types of situation in which we judge that resentment is inappropriate. In these cases we suspend our reactive attitudes. First, we deem resentment inappropriate in cases when the actor was coerced, when she acted under ignorance, or when she committed the injury by accident.<sup>68</sup> Second, resentment is inappropriate when the individual was acting under peculiar stresses and strains<sup>69</sup>: so, for example, we are likely to be much more charitable towards a friend's emotional outbursts when we know that she has just been laid off work and is having severe financial difficulties. In both of the above cases, we suspend resentment because we regard the circumstances as exceptional – no one facing similar conditions ought to be blamed for breaches of appropriate behaviour. We continue to regard the agent, however, as one who under normal conditions merits the full range of interpersonal reactive attitudes.

The third type of case is somewhat different from the preceding two. It is typified by statements such as “he’s only a child,” “he’s a hopeless schizophrenic,” or “that’s purely compulsive behaviour on his part.”<sup>70</sup> Judgments such as these indicate a suspension of the reactive attitudes, but for different reasons than the ones discussed above. Here we consider the *circumstances* to be normal, but the *agent* to be abnormal: she is psychologically deranged or morally undeveloped (such as a child is). When such a person insults us or harms us, we dismiss the behaviour and we do not take it personally. This is because we see the agent as one who does not merit the full range of

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<sup>68</sup> Strawson, p. 7.

<sup>69</sup> Strawson, p. 8.

<sup>70</sup> Strawson, p. 8.

interpersonal reactive attitudes. In other words, a psychologically abnormal agent “is not...seen as a morally responsible agent, as a term of moral relationships, as a member of the moral community.”<sup>71</sup>

Strawson introduces the participant attitude/objective attitude distinction to illustrate the difference between the way we interact with those we consider normal members of the moral community and those we see as standing outside it. Strawson says that when we view someone as psychologically abnormal or morally undeveloped, we tend to adopt the objective attitude. We not only suspend our reactive, “participant” attitudes towards the agent (we do not feel resentment, gratitude, forgiveness, or mature adult love), but we also take on a utilitarian, instrumental view that is usually absent from our everyday dealings with those we consider normal. We see the agent as a problem to be solved, something to be controlled, studied, cured or trained.<sup>72</sup> The objective attitude and the participant attitude are, for the most part, mutually exclusive:

If your attitude towards someone is wholly objective, then though you may fight him, you cannot quarrel with him, and though you may talk to him, even negotiate with him, you cannot reason with him. You can at most pretend to quarrel, or to reason, with him.<sup>73</sup>

The above description might sound harsh, but on Strawson’s view, it is a *fact* about human behaviour that we adopt the objective attitude in certain circumstances; furthermore, it is sometimes the only option open to the “civilized” in dealing with those seen as abnormal, i.e. those we see as morally or intellectually incapacitated.<sup>74</sup>

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<sup>71</sup> Strawson, p. 17.

<sup>72</sup> Strawson, p. 9.

<sup>73</sup> Strawson, p. 9.

<sup>74</sup> Strawson, p. 9. Notwithstanding Strawson’s defense of the objective attitude in certain circumstances, I think that there are some conclusions we can draw about the normativity of such an attitude in general. I will return to this matter in the Conclusion.

Strawson does say, however, that objectivity of attitude is not as rare as it might seem from the accent on “abnormality”:

we can sometimes look with something like the same eye on the behaviour of the normal and mature. We have this resource and can sometimes use it: as a refuge, from say, the strains of involvement; or as an aid to policy; or simply out of intellectual curiosity.<sup>75</sup>

When we have an instrumental interest in a person, then, we can adopt the objective attitude at will. We can also adopt it as a respite from the stresses that arise from relationships with trying individuals. Strawson is careful to add, though, that we cannot adopt a thoroughgoing objectivity of attitude all the time because that would violate our deep commitment to participation in interpersonal relationships, as well as to the reactive attitudes essential to these relationships: this is not something we can change about human nature, nor would we want to, even if we could.<sup>76</sup>

Strawson has up to this point described responsibility as deriving from the way we see others. As such, responsibility is not an intrinsic feature of individuals that would exist even in the absence of all other human beings; rather, it springs from our relationships with other human beings. Strawson is always very careful to avoid formulations that would imply that we adopt the objective attitude in situations where the other person *is* deranged, abnormal, or immature, and he never deviates from saying that the attitude is an outgrowth of how *we see* the other. For example, Strawson does not say that it is the psychological abnormality that excludes people from the moral community,

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<sup>75</sup> Strawson, pp. 10-11.

<sup>76</sup> Strawson, p. 13. Later in his paper, Strawson writes: “to the further question whether it would not be *rational*, given a general theoretical conviction of the truth of determinism, so to change our world that in it all these attitudes were wholly suspended, I must answer, as before, that...it is *useless* to ask whether it would not be rational for us to do what is not in our nature to (be able to) do” (p. 18).



but rather, that *we see* them as so excluded<sup>77</sup>; “Seeing someone...as warped or deranged or compulsive in behaviour...seeing someone so tends, at least to some extent, to set him apart from normal participant reactive attitudes on the part of one who so sees him.”<sup>78</sup> To take another example, he says that objective attitudes take over “in so far as the agent *is seen as* excluded from ordinary adult relationships by deep-rooted psychological abnormality.”<sup>79</sup> Strawson is consistent in this regard throughout his entire paper.

Because responsibility derives from our commitment to interpersonal human relationships (specifically, the demands we place upon others for good will towards us), it is wrong-headed to claim, as many philosophers do, that the issue of responsibility is tied to the issue of determinism. It is not the case that we deem someone responsible only after we have engaged in philosophical deliberation and have come to the conclusion that her behaviour was not determined in any sense. Instead, Strawson says, withholding the ascription of responsibility “is a consequence of our abandoning, for different reasons in different cases, the ordinary interpersonal attitudes.”<sup>80</sup> He does not go into any great detail about what these reasons might be, but he does say that seeing someone in a certain light – as deranged, schizophrenic, compulsive, or immature (in short, as morally or psychologically incapacitated) – makes ordinary interpersonal relationships difficult, if not impossible.<sup>81</sup>

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<sup>77</sup> Strawson, p. 11.

<sup>78</sup> Strawson, p. 9.

<sup>79</sup> Strawson, p. 11; my italics.

<sup>80</sup> Strawson, p. 13.

<sup>81</sup> Strawson, p. 11

### **Comparison with the Psychiatric Ethicists**

At first glance, it might not seem that “Freedom and Resentment” would have any direct relevance to the ideas that Edwards and Moore put forward in their papers. These authors do not discuss determinism at all, but think instead that rationality is the concept most relevant to responsibility. However, if Strawson is right when he says that the wellspring of responsibility is our relationships with others, then Moore and Edwards are wrong in attempting to construe it as dependent on rationality assessed independently of all relationships (i.e. rationality understood as an intrinsic quality amenable to objective observation). I will compare their views with Strawson’s in more detail below. Reznick’s view, on the other hand, differs from these writers – we will remember that he thinks that when a disease causes a person to commit certain actions, we ought to excuse her from blame and/or punishment. I will therefore deal with the “Strawsonian” objections to Reznick’s argument separately.

Though neither Edwards nor Moore see determinism as the reason for declining to see a person as responsible, Strawson’s article can serve as a rejoinder to their views. One way in which “Freedom and Resentment” undermines Edwards’s and Moore’s lines of argument is by casting doubt on the idea that the ascription of responsibility is the result of a prior theoretical conviction. In his article, the theoretical conviction he has in mind concerns the truth or falsity of determinism, but the objection I think works equally well for any other theoretical conviction. So, if a philosopher wants to say that responsibility is predicated on rationality, we might say, along with Strawson, that this is wrong: the relevant question to ask is “how do we see this person?” or “what kind of

difficulties do we experience in our relationship with this person?” instead of asking whether she exhibits the seven characteristics of a rational human being.

Edwards and Moore could respond that we see a person as not meriting reactive attitudes *because* she is irrational: the way we see people is grounded (or ought to be grounded, at least) in a correct assessment of their characters. The individual’s character, and not the attitudes of others, is what alienates her from the moral community. My response to this possible objection is twofold: first of all, this view implies that it makes sense to talk about responsibility as though it can exist in a vacuum. Since responsibility (on Moore’s and Edwards’s views) is predicated on rationality and autonomy and nothing else, a person could be “responsible” even if she were stranded on a desert island, and this seems absurd. Similarly, the idea that a physician has a completely unprejudiced, unlimited “god’s eye view” on such a matter also seems suspect. Against the conclusions of Edwards and Moore, I think Strawson is persuasive in arguing that responsibility is a matter not of intrinsic features, but rather of the demands to which we hold others.<sup>82</sup>

Secondly, Edwards’s and Moore’s papers suggest that we refrain from seeing a person in a particular way – specifically, as mentally ill – until we have settled the question of whether or not she is rational.<sup>83</sup> Neither author understands himself to be spelling out the implicit assumptions underlying the practice of ascribing responsibility; rather, both Edwards and Moore seem to think that responsibility is, so to speak,

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<sup>82</sup> Wallace also agrees with this approach, even though he finds Strawson’s pragmatic and naturalist arguments unconvincing. Wallace states in the Introduction to his text that resentment, indignation and guilt have a “distinctive connection with expectations.” He draws on his understanding of these emotions in order to provide a convincing account of what we are doing when we hold someone responsible (p. 12). Because responsibility is so closely tied to our expectations of one another, we cannot talk about it as though it were a matter of intrinsic characteristics existing independently of relationships.

<sup>83</sup> Moore says that “the more irrational behavior we observe of an individual in any of these five senses, the less rational we will judge him to be” (Moore, p. 35); Edwards thinks that “only those disorders that involve the absence of [rationality] are to count as mental disorders” (Edwards, p. 55).

discovered once we have properly applied sound philosophical concepts to concrete psychiatric cases. Not only is this dubious, for the reasons I suggested in Chapter One (because the concept of rationality itself hardly has an uncontroversial, agreed-upon meaning and because the ascription of rationality is problematic from a feminist perspective), but it is also disingenuous to suggest that this is how psychiatrists actually go about making a diagnosis. In fact, there are good reasons to believe that physicians are not quite so procedural, and that they do not suspend all character judgments until the matter of rationality is settled. I will return to this idea below, in the next section, to show how Strawson's model makes better sense of actual psychiatric practice than the models Edwards and Moore put forward.

Reznek's account of responsibility also seems inadequate when compared with Strawson's. Although he offers no metaphysical position on the question of whether human beings in general act freely or unfreely, and so seems to escape Strawson's gentle attack on determinist metaphysicians, he nevertheless (like Edwards and Moore) neglects to discuss the act of ascription and the role of those who do the ascribing. For Reznek, responsibility consists in mental health, and mental health is something for doctors to determine, since they are the experts able to ascertain whether a person has a disease capable of causing disruptive or immoral behaviour. Because Reznek thinks determinations of this kind are straightforward matters of medical diagnosis,<sup>84</sup> he does

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<sup>84</sup> I should point out here that Reznek does not think that diseases are entirely matters of "fact"; rather, he says that "disease status cannot be settled by the facts. Instead, it is our values that determine the disease status of a condition. Ethics precedes nosology" (Reznek, p. 157). This is because we only consider something a disease if its effects are undesirable, and the undesirability of behaviour/conditions is a question of values and not of facts. One problem with Reznek's argument is that he says on the one hand that diseases are firstly and fundamentally a matter of values. But if Reznek is right, then drapetomania (the "disease" that afflicted American slaves who ran away from their masters) and "sluggish schizophrenia" (Soviet shorthand for "political dissidence") are diseases. To extricate himself from this problem, he resorts to the very dubious strategy of appealing to "our" values. "Because we value free

not address the factors that might prevail upon doctors to encourage them to see the patient as insane, delusional, or morally immature.

One could make the following objection to my “Strawsonian” criticisms of the psychiatric ethicists: perhaps Strawson’s account works only as a *general* description of what we do when we hold people responsible under ordinary circumstances. Certainly Strawson is right when he argues that we do not require answers to complex theoretical questions before we praise or blame others, but perhaps the clinical setting demands a different way of looking at people, one that demands some theoretical reflection before arriving at a conclusion. Although on the face of it this objection may seem to have some plausibility, I will argue that Strawson’s account of the ascription of responsibility makes more sense of actual psychiatric practice, as well as of the fact that there exists a movement whose *raison d’être* is to protest psychiatry, than the contributions of Moore, Edwards, and Reznek.

This is not because Strawson is particularly sensitive to the plight of psychiatric patients. In fact, Strawson says twice in “Freedom and Resentment” that the objective attitude is the only civilized response to the “deranged” or “warped”<sup>85</sup>: “in the extreme case of the mentally deranged...no other civilized attitude is available than that of viewing the deranged person simply as something to be understood and controlled in the most desirable fashion.”<sup>86</sup> But because Strawson’s account recognizes that ascription is

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political expression,” he says, “we do not regard [sluggish schizophrenia, ] as a disease” (Reznek, p. 159). The choice of sluggish schizophrenia to illustrate this point is sneaky, because this is a case on which most people are likely to agree, and hence, it is a case where it makes some sense to talk about “our” values. The problem is that Reznek nowhere in his book acknowledges that many people seriously question the values promoted by psychiatry, let alone that there is a politically organized opposition to psychiatry. The appeal to “our” values, then, will be wholly unconvincing in a great many cases.

<sup>85</sup> Strawson, pp. 9, 12.

<sup>86</sup> Strawson, p. 12.

an activity undertaken on the basis of one's attitudes towards another, and that it is influenced by the stresses and strains attendant on interpersonal relationships, he opens the door to a critical look at ascription. If we take Strawson's argument seriously, we cannot talk as though ascription takes place outside the messy world of stressful relationships, wounded feelings, or utilitarian calculations. This stands in marked contrast to philosophical accounts that leave out one half (the "ascriber" half) of the responsibility equation.

There are, then, two models of the ascription of responsibility that I have considered. The first model is that put forward by the psychiatric ethicists, which I discussed at some length in Chapter One. This model sees responsibility as a quality intrinsic to a person: it is not dialogical, nor is it negotiated through contact with other human beings. Determining whether someone is or is not responsible is a matter of first formulating a set of clear concepts that will act as a standard, and then applying them to particular cases of behaviour. The second model I have discussed is Strawson's. He thinks the ascription of non-responsibility occurs when a person sees another in a certain way – viz., as psychologically defective or morally retarded – which makes normal interaction impossible and gives rise to an objectivity of attitude toward the one whose behaviour is considered offensive.

### **The Objective Attitude and Psychiatric Labeling**

In Chapter One I tried to provide reasons to show that the psychiatric model of ascription might be impaired by philosophical problems, problems which limit the usefulness of such contributions towards understanding the ethical issues raised by the

psychiatric survivors' movement. In the first part of this chapter, I claim that a further problem with these attempts to understand responsibility from a psychiatric perspective is that these ethicists discuss ascription as though it can be abstracted from the context of human relationships, whether they are intimate relationships or not. Though I think Strawson's arguments are sufficient in themselves to suggest that there is something lacking in the psychiatric ethicists' pictures, many empirical studies on psychiatric institutions provide empirical support for the idea that the ascription of non-responsibility is strongly influenced by the contexts of the psychiatric hospital and the doctor-patient relationship.

One study that is especially interesting in this regard is one conducted by sociologist David Rosenhan in 1973. The subsequent report, called "On Being Sane in Insane Places,"<sup>87</sup> illustrates how the institutional hospital setting places demands on those who work within them (doctors, nurses, and orderlies) to see patients in a certain way, namely, as mentally ill and in need of psychiatric intervention. Insofar as it is a foregone conclusion that patients are in need of treatment, the stage is set for the objective attitude. Strawson remarks in "Freedom and Resentment" that there is a tension between the objective and participant attitudes: "they are not altogether *exclusive* of each

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<sup>87</sup> Many authors who write on psychiatry have commented on this paper. Many of the attempts by psychiatrists to attack the study are themselves instructive, for they show the extent to which psychiatrists wish to bracket out the ethical implications of labeling in favour of a more scientific and fact-based discourse. Kirk and Kutchins point out that DSM author Robert L. Spitzer's critique of Rosenhan, though "forceful and clever," (Kirk and Kutchins, p. 94) distorts Rosenhan's observations and misunderstands the main thrust of his argument. Spitzer mistakenly attributes to Rosenhan the view that psychiatry is the only branch of medicine to frequently misdiagnose patients. However, Rosenhan explicitly says otherwise and further notes that psychiatry differs from other branches of medicine in that "medical illnesses...are not commonly pejorative" (Rosenhan, p. 59). I would like to point out that this is not entirely true: witness the current AIDS epidemic. Nevertheless, the idea he tries to put across does not concern reliability in diagnosis, but the consequences of psychiatric misdiagnosis.

In a similar vein, Reznick says that the ability to fool psychiatrists does not prove that diagnostic categories are invalid; if someone were to fake having an ulcer by swallowing blood and then regurgitating

other; but they are, profoundly, *opposed* to each other.”<sup>88</sup> Rosenhan’s experiment shows the extent to which objective attitudes can sometimes ‘crowd out’ all participant attitudes.

Rosenhan’s study involved eight subjects who had never been diagnosed with any mental disorder. They were instructed to present themselves at the emergency rooms of various hospitals, and tell the staff that they had been hearing muffled voices which seemed to be saying the words “empty,” “hollow,” and “thud.” Rosenhan’s choice of these particular words was intended to suggest that these schizophrenic symptoms were existentially meaningful – a phenomenon that had never been documented in the psychiatric literature. All of the subjects were nevertheless admitted to the hospital with diagnoses of schizophrenia<sup>89</sup> for periods as long as fifty-two days, with an average of nineteen days. Once having gained admission, the experiment required the subjects to act normally while in the hospital, discontinuing all pretense of mental illness and complying with orders (except with respect to medication – subjects hid the drugs under their tongues and disposed of them later).<sup>90</sup> The eight “pseudopatients” participating in the study were asked to write down their observations of the ward. At first this activity was carried on in secrecy, but as it became clear that the staff did not find this peculiar, the note taking was conducted out in the open. These notes, together with the official hospital records gathered after the pseudopatients were discharged, provided the basis for Rosenhan’s article.

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it, this would not prove that “peptic ulcer” is never a correct diagnosis (Reznek, p. 22). Reznek, like Spitzer, avoids the ethical question of the consequences of mistaken psychiatric diagnosis.

<sup>88</sup> Strawson, p. 9.

<sup>89</sup> Except in one case, where the diagnosis was “manic-depression.”

<sup>90</sup> David L. Rosenhan, “On Being Sane in Insane Places,” in Thomas Scheff, ed., *Labeling Madness* (Englewood Cliffs, New Jersey: Prentice Hall, 1975), pp. 56-57.



The major idea which emerges from this article concerns the power of psychiatric labels to exclude those who are so labeled from normal interpersonal treatment (and hence, exclude them from basic respect, in some cases), even when their behaviour is not offensive or abnormal. Because the pseudopatients in Rosenhan's study were labeled as "mentally ill," the staff saw them in a way which precluded normal participant attitudes; nurses and doctors frequently described the pseudopatients' normal behaviour so as to make it intelligible from an outside (i.e. non-participant) point of view – from a point of view that assumed that the pseudopatients were insane. There are a great number of examples of this sort of psychiatric objectivity in the study.

It is remarkable, for example, how the hospital staff continually interpreted perfectly normal behaviour as further evidence of the schizophrenia diagnosis. Nurses saw the pseudopatients' frequent note-taking as pathological; one wrote in her report: "patient engages in writing behavior," an assessment she made without questioning the pseudopatient about what he was writing or why he was doing so. A nurse asked another pseudopatient if his pacing up and down the hallway was because he was nervous; he told her rather that he was bored.<sup>91</sup> Ordinary personal details offered in the psychotherapeutic setting were translated into a psychiatric idiom. One pseudopatient in describing his family revealed that his relationship with his father grew increasingly close as he grew into adulthood, while he and his mother became more distant. The case summary reported this as follows:

This white 39-year-old male...manifests a long history of considerable ambivalence in close relationships, which begins in early childhood. A warm relationship with his mother cools during his adolescence. A distant relationship

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<sup>91</sup> Rosenhan, p. 61.

with his father is described as becoming very intense.  
Affective stability is absent.<sup>92</sup>

All three above examples show how an objective psychiatric attitude prevented health care professionals from recognizing the pseudopatients' perfectly reasonable feelings and behaviour. Since there was an easy psychiatric explanation for any and all behaviours ready to hand, professionals evidently did not think it necessary to enlist the patient's help in understanding his feelings or behaviour.

Seeing patients as excluded from the ranks of normal society also encouraged the staff at times to treat patients as less than human. According to Rosenhan's study, patients in mental hospitals sometimes suffered outright physical abuse;<sup>93</sup> more common than this, though, were the subtle insults from staff such as refusing to respond to patients' questions,<sup>94</sup> ignoring them,<sup>95</sup> invading their privacy,<sup>96</sup> and having conversations about a patient in her presence.<sup>97</sup> Some might explain such indifference towards patients as a consequence of the fact that many hospitals are understaffed; hence, staff is too busy to pay close attention to patients or to answer all their queries. Rosenhan has two arguments that address this objection. First of all, he says that all hospitals have priorities. Patient contact is evidently not a priority, because when budgets are cut it is the doctor-patient contact time that suffers, and neither the incidence of staff meetings nor the volume of record keeping.<sup>98</sup> Secondly, a study conducted at Stanford University

<sup>92</sup> Rosenhan, p. 60. Rosenhan adds that nothing of an ambivalent nature was described by the patient.

<sup>93</sup> Rosenhan, p. 67.

<sup>94</sup> "The encounter frequently took the following bizarre form. Pseudopatient: 'Pardon me, Dr. X. Could you tell me when I am eligible for grounds privileges?' Physician: 'Good morning, Dave. How are you today?' (Moves off without waiting for a response.)" Rosenhan, p. 65.

<sup>95</sup> Rosenhan, p. 68.

<sup>96</sup> Rosenhan, p. 68.

<sup>97</sup> Rosenhan, p. 68.

<sup>98</sup> Rosenhan, p. 69.

shows that even very busy university faculty found the time to answer random requests for directions, information about the medical school, etc., that were put to them as they walked to their offices. Not only did they answer questions, but they also made eye contact, stopped to talk, and in some cases tried to help the student find her destination.<sup>99</sup>

“On Being Sane in Insane Places,” then, is a powerful empirical complement to Strawson’s phenomenological description of the objective attitude. Even though Rosenhan’s study does not deal with the question of “responsibility” as such, it provides numerous examples to show that how we see others can sometimes lead us to exclude them from normal interpersonal relationships – and, perhaps unfortunately, from the respect and courtesy that we normally accord to others whom we view as standing within our moral community.<sup>100</sup> Moreover, the study suggests that there might be more at work than simply scientific diagnosis when psychiatrists deem patients to be not responsible.

The foregoing consideration of Rosenhan’s article also suggests a possible refinement of Strawson’s account of the adoption of the objective attitude. Strawson says at times that we adopt the objective attitude *because of* the way in which we see the other.<sup>101</sup> I do not think this is *wrong*, exactly; but it is only partly correct. I think it is important to recognize that we often see others in a certain way because we already have a commitment to objectivity of attitude. This is perhaps most often the case where

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<sup>99</sup> Rosenhan, p. 67.

<sup>100</sup> I should mention here that Rosenhan does not think that doctors and other hospital staff treat patients in this way out of malice or stupidity: “Where [the staff] failed...it would be more accurate to attribute those failures to the environment in which they, too, found themselves than to personal callousness.” Rosenhan, p. 72.

<sup>101</sup> He says that “seeing someone...as warped or deranged or compulsive in behaviour or peculiarly unfortunate in his formative circumstances – seeing someone so tends...to promote, at least in the civilized, objective attitudes.” Strawson, p. 9; also, “when we do in fact adopt such an attitude in a particular case, our doing so is not the consequence of a theoretical conviction which might be expressed as ‘Determinism in this case’, but is a consequence of our abandoning, for different reasons in different cases, the ordinary interpersonal attitudes.” Strawson, p. 13.

doctors (specialists in particular, as opposed to general practitioners), immigration officials, prison guards, and certain types of social workers are concerned. It is misleading to suggest that either the way in which we see people or the objective attitude is temporally and causally prior to the other; on the contrary, both seem to be of a piece. This is an important thing to keep in mind. Otherwise, we might fall into the habit of thinking that we see people as insane *only because* the insane manifest irrationality or lack of autonomy, and that therefore we are always justified in seeing them in this way. To say instead that the prior commitment to objectivity can (and often does) influence the way we see people introduces an element of self-consciousness into our practice of ascribing responsibility, rationality, or sanity.<sup>102</sup> In saying that a pre-existing objective point of view often makes us utterly unreceptive to the other as a participant in a moral community, we acknowledge that we are part of the context in which ascription takes place. This is preferable, I think, from a moral point of view.

### **The Objective Attitude versus Interpretational Charity**

There is a common opinion that psychiatry as practiced today is radically different than it was in the 50's, 60's, and 70's. Forced hospitalizations, wet packs, straitjackets, insulin coma treatment, and lobotomies are things of the past, and as our knowledge of medical science (specifically brain chemistry) increases, diagnoses become less pejorative and more reliable; treatments become more humane and effective. On this view, there is no reason for ex-patients to resent psychiatry. Rosenhan's article, however,

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<sup>102</sup> This point raises the question of the general normativity of the participant attitude vis-à-vis the objective attitude. I will take up this issue in more detail in the conclusion.

shows that psychiatric institutions can be humiliating to patients<sup>103</sup> even when they are not physically abusive. In what follows, I would like to argue that the sort of objective attitude showcased in Rosenhan's article is not a contingent, empirical aberration from psychiatry's stated aims and goals. Rather, there is evidence that psychiatrists and psychiatric ethicists embrace the objective attitude in theory as well as in practice, and that they tend to dismiss the participant attitude.

Ⓟ Here I would like to insert a brief excursus on Habermas's distinction between interpretation, on the one hand, and objectivity of understanding on the other. This formulation can be seen as a further elaboration of Strawson's "participant attitude"/"objective attitude" dichotomy. The difference between Habermas's discussion of the phenomenon and Strawson's is that Habermas explicitly examines its implications for communicative action, and so his theory is perhaps more easily applied to this inquiry into doctor-patient encounters. He characterizes the objective attitude as "the third-person attitude of someone who simply says how things stand," and the interpretive (or participant) attitude as "the attitude of someone who tries to understand what is said to him."<sup>104</sup>

Habermas says that there are three implications of the adoption of an interpretive stance vis-a-vis the other. First, interpreters "relinquish the superiority that observers have by virtue of their privileged position."<sup>105</sup> That is to say, interpreters are equal participants in the conversation, and as such, cannot impose meanings on their

<sup>103</sup> It's true that Rosenhan only discussed the psychiatric hospital setting from the perspective of the pseudopatient, but only someone who was indifferent to human dignity would claim that similar treatment would not be humiliating to "real" patients.

<sup>104</sup> Habermas, *Moral Consciousness and Communicative Action*, p. 26.

<sup>105</sup> Habermas, p. 26.

interlocutors; rather, they must negotiate meanings and the validity of utterances with her. He notes further that in such a situation, “it is impossible to decide a priori who is to learn from whom.”<sup>106</sup> Second, interpreters must become aware that their interpretations are necessarily context-dependent. Third, interpreters are not merely concerned with determining the truth of factual statements, but must also come to an interpretation that fits “the meaning of the *interpretandum*, that which the interpreter is to understand”<sup>107</sup> – this must necessarily take account of values. Habermas says that these elements create special problems for the social sciences, because the performative or participant stance makes possible interpretations that cannot be accurately translated into an objective account: “for the purposes of measurement the performative attitude must be subordinated to a single attitude, namely the objectivating attitude.”<sup>108</sup>

It should be especially clear how Habermas’s discussion of the interpretive stance relates to the psychiatric context after the previous discussion of Rosenhan’s experiment. We saw how objectivity of attitude led staff to understand pseudopatients’ statements from a third-person “scientific” perspective. One pseudopatient’s quite ordinary and certainly non-pathological family history was translated into the psychiatric vernacular (“affective stability is absent,” for example) by an observer with a store of technical knowledge not open to modification or negotiation. In most clinical encounters, facts about the patient are often presented without any discussion of the meanings the patient herself attaches to them. Psychiatric interpretations such as the ones in Rosenhan’s study are only shared with the patient in exceptional situations, and it is not hard to see why:

<sup>106</sup> Habermas, p. 26.

<sup>107</sup> Habermas, p. 27.

<sup>108</sup> Habermas, p. 27.

the patient is to be observed, doctors are to remain observers. If doctors were to reveal the content of their assessments, they might be drawn into the performative participant role of justifying their beliefs to the other person with reasons, and this is not an activity considered appropriate to the role of the physician.<sup>109</sup>

The psychiatric commitment to objectivity at the expense of the participant attitude shows up also in the philosophical literature. Philosophers of psychiatry display hostility to the ideas of R.D. Laing in particular on the grounds that the participant attitude evident in his writing is inappropriate for a psychiatrist. Here I should give some idea of the theory animating Laing's early work. He and his collaborator Aaron Esterson described their project in *Sanity, Madness, and the Family* in the following way:

Each person not only is an object in the world of others but is a position in space and time from which he experiences, constitutes, and acts in his world. He is his own centre with his own point of view, and it is precisely each person's perspective on the situation that he shares with others that we wish to discover.<sup>110</sup>

Toward this goal, they presented the case studies of eleven schizophrenic women, based on interviews with the patients and their families in various combinations (e.g. "Jill" alone, "Jill" with mother, mother alone, "Jill" with both parents, both parents together, etc.). Laing and Esterson tried to show that their utterances were not complete nonsense, as had been previously thought. For example, one young woman who said that her

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<sup>109</sup> Sociologist Waitzkin thinks this is a fact about doctor-patient encounters that ought to be changed. "In a progressive relationship, both participants try to overcome the domination, mystification, and distorted communication that result from asymmetric technical knowledge. Professionals try to communicate thoroughly, honestly, and in comprehensible language both the content and the limitations of their knowledge about physical problems. When patients disagree or do not understand, they say so openly...doctors actively seek full discourse by encouraging patients' participation, skepticism, and disagreement." Waitzkin, *The Politics of Medical Encounters* (New Haven: Yale University Press, 1991), pp. 275-276.

<sup>110</sup> R.D. Laing and A. Esterson, *Sanity, Madness and the Family* (Harmondsworth, Middlesex, England: Penguin Books, 1964), p. 19.

parents were not married to each other but were merely business partners had been judged delusional by psychiatrists, while Laing and Esterson explain that this was her metaphorical way of expressing the belief that her parents did not love each other, and that they were controlling and manipulative of her.<sup>111</sup> Another young woman who said “I don’t think, the voices think” was interpreted by the authors as relinquishing responsibility for her own thoughts in order to avoid harsh criticism from her family.<sup>112</sup>

Many authors have made astute criticisms of Laing’s work from a number of different philosophical perspectives,<sup>113</sup> but I am only concerned with the responses to Laing by two philosophers of psychiatry, Moore and Reznek. I reintroduce them here in order to show that they prejudicially hold an objective attitude that is inimical to participant attitudes. Moore thinks that Laing’s approach is mistaken because it falsely attributes a kind of rationality to schizophrenic behaviour. Laing does this by appeal to goal-directed behaviour or strategies, rather than to the beliefs and reasons the individual holds. So, for example, he criticizes Laing’s attempts to find meaning in the utterances of a catatonic woman named “Joan.” Joan remarked that she “tried to be dead and grey and motionless,” and that “one time a boy hurt my feelings very much and I wanted to jump in front of a subway. Instead I went a little catatonic so I wouldn’t feel anything.” Moore does not agree with Laing’s interpretation of these statements as existentially meaningful.

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<sup>111</sup> Laing, p. 77.

<sup>112</sup> Laing, p. 45.

<sup>113</sup> Elaine Showalter criticizes Laing from a feminist standpoint in *The Female Malady*. Her objection is that Laing, while *illustrating* how oppressive ideas of women’s roles contribute to the “madness” of his female subjects, falls considerably short of drawing this conclusion explicitly, and does not offer any coherent theory of women’s oppression (p. 246). Showalter quotes Simone de Beauvoir as saying, “At bottom anti-psychiatry is still psychiatry. And it doesn’t really address itself to women’s problems” (p. 246); Peter Sedgwick’s “Self, Symptom and Society” (in *R.D. Laing and Anti-Psychiatry*) levels a number



None of this would convince us that Joan or others like her were rational in effective catatonic withdrawal.... Her action is based on a series of beliefs that are irrational, including her belief in a disembodied self, a belief in her parents' complete determination of her worth, and a belief in her own omnipotence and impotence.<sup>114</sup>

Furthermore, Moore adds that it would be wrong to conclude that Joan and others like her are not irrational, but just mistaken about the facts. He says it is characteristic of schizophrenics to cling to beliefs even when they are clearly contradicted by the evidence.<sup>115</sup>

Moore is showing a concern to say what is true from a third-person point of view. Joan's beliefs do not fit the criteria of rationality; therefore, we need not look into what she says so that we can make sense of her inner world. I think the quote from Moore above is particularly instructive in showing the extent to which the objective attitude militates against interpretational charity. Moore is too hasty in concluding that Joan's beliefs are irrational. Many people believe in a disembodied self; the idea that others determine our worth is hardly ridiculous, since the value of anything at all is a matter of the value people attach to it; and although feelings of omnipotence are not common in the general population, feelings of impotence are not unusual – especially when circumstances do in fact render an individual powerless. According to Moore, however, we should not give the benefit of the doubt to those who do not act according to the strictures of rationality.

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of criticisms of Laing's method, one being that his studies suffer from an absence of comparative analyses (p. 29).

<sup>114</sup> Moore, p. 39.

<sup>115</sup> Moore, p. 39.

Reznek's criticism of Laing is similar to Moore's: he too thinks that there are no compelling reasons for "charitable" interpretations of schizophrenic speech and behaviour. He argues that the Laingian perspective on schizophrenic speech is philosophically problematic because in order to make sense of schizophrenic speech Laing has to posit the agent's beliefs and intentions. However, Reznek charges, Laing first of all does not know that these are in fact the agent's beliefs and wishes, and furthermore, he has no good reasons for attributing these to the agent. Reznek says that "Laing invents bizarre reasons that purport to make schizophrenic behaviour rational but produces no evidence that schizophrenics actually possess these."<sup>116</sup> As support for this statement, he footnotes Moore's argument to this effect, which I addressed above, an argument that does not convincingly argue that Laing's interpretations are "bizarre."

Reznek then goes on to attack the "principle of charity." Charity is a heuristic device employed in textual interpretation which holds that interpreters ought to approach a text with the assumption that it makes sense; the interpreter's task is to discover the interpretation that yields the richest reading of the text.<sup>117</sup> Donald Davidson has also discussed charity in the context of philosophy of language. On his view, charity is required for linguistic understanding.<sup>118</sup> In his chapter on Laing, Reznek refers to Davidson's view, albeit very briefly, and subsequently argues that we cannot accept the principle of charity:

Donald Davidson argues that we should accept the translation, which makes a person's beliefs turn out to be

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<sup>116</sup> Reznek, p. 55.

<sup>117</sup> For example, Hans-Georg Gadamer, in *Truth and Method*, says that the search for truth "consists not in trying to discover the weakness of what is said, but in bringing out its real strength" (p. 367).

<sup>118</sup> Hacking, *Why Does Language Matter to Philosophy?* (New York: Cambridge University Press, 1975), p. 147.

largely true. But this is not helpful, especially in the realm of mental disorder. If we accept this principle of charity then no one can ever be translated as having a system of false beliefs – i.e. no one can be grossly deluded. It seems that Davidson’s view excludes the very possibility of madness, which cannot be right! And therefore we must reject it.”<sup>119</sup>

Let us leave aside the fact that Reznick has taken Davidson’s view out of the context of linguistic philosophy, and the fact that he has not dealt with Davidson’s argument whatsoever, only his conclusion. The argument Reznick has put forward here begs the question. He says that Davidson’s view cannot be right because it assumes that sense can be made of anyone’s speech, while *we*, on the other hand, know that schizophrenic utterances are, by definition, “incoherent babble.”<sup>120</sup> This, however, is what Laing and Esterson deny: they say we can arrive at plausible interpretations of schizophrenic speech by taking into consideration the patient’s family context. Reznick does not provide any compelling arguments against any of Laing’s particular interpretations of schizophrenic speech except to say that his interpretations are “bizarre.”

But perhaps we ought to be charitable toward Reznick and grant him the existence of insanity. Accepting madness as a fact does not mean that we cannot still adhere to the principle of charity. The principle of charity does not require that we accept outlandish interpretations of a text – or, in the psychiatric context, the patient’s speech and behaviour – but only that we look for *plausible* explanations.<sup>121</sup> Psychiatrists often do not do this. If the physicians and other staff in Rosenhan’s study had taken the time or effort to look for plausible explanations, they might not have reached so hastily for

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<sup>119</sup> Reznick, p. 59.

<sup>120</sup> Reznick, p. 58.

<sup>121</sup> Hacking says there is nothing wrong with charity when it is construed as “commonsense rules of thumb”; *Why Does Language Matter...*, pp. 149-150.

medical labels, pathologizing the pseudopatients' non-pathological behaviour. Rosenhan comments that there is a reason for the prejudice that results in over-diagnosis (in all branches of medicine, not just in psychiatry): it is less dangerous to diagnose sickness than to diagnose health. However, since psychiatric diagnosis carries with it social stigma, doctors ought to be extra careful in this regard.<sup>122</sup> Sensitivity to the harm that psychiatric labels can inflict, then, seems to go hand in hand with the principle of charity.<sup>123</sup>

Objectivity of attitude, then, is closely allied with the practice of psychiatric labeling, and largely unfavourable to the principle of interpretational charity. The overall effect of objectivity is to suppress the voice of the patient herself: She is to be explained, not understood. The prevalence of the objective attitude (to the extent that it excludes participant attitudes) in psychiatry gives rise to a number of problems: misdiagnosis, depersonalization, and the suppression of the patient's point of view are three examples. In the ethical literature, the effect is the same: the psychiatric ethicists I have looked at above put forward justifications for dismissing patients as insane, and their talk as "babble;" for this reason, none of them incorporates patient viewpoints when considering ethical problems. This, I shall argue, is a gross oversight. In my third and final chapter, I

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<sup>122</sup> Rosenhan, p. 59.

<sup>123</sup> It is not surprising that Reznek attacks the principle of charity in light of the fact that nowhere in his book does he take the problem of psychiatric stigma seriously. To wit: in order to show that the medical model of behavioural disturbance has benefits over other models (such as sociological or pragmatic models) Reznek discusses the example of children diagnosed with Attention Deficit Hyperactivity Disorder who are prescribed Ritalin. In the utilitarian calculus he puts forward to prove this point, he says that the benefits to parents and schoolteachers of putting children on Ritalin (as well as the benefits to the children themselves) are so large as to annul the negativity of any side-effects. He concludes by saying that the medical model "seems to have so many virtues as to be almost unassailable!" (Reznek, p. 24) He does not introduce issues of social stigma into his calculus, nor does he consider the social disvalue of solving ever more problems with drugs.

will address the ethical aspects of the psychiatric survivors' movement; more specifically, I will attempt to reconstruct the moral claims that lie beneath their political activism.

### CHAPTER 3

#### THE IMPORTANCE OF THE PSYCHIATRIC SURVIVORS' MOVEMENT TO PSYCHIATRIC ETHICS

In the previous chapter, I argued that psychiatric objectivity tends to crowd out participant attitudes toward psychiatric patients. The result is that doctors often hold distorted views of their patients and interact with them largely with a view to diagnosing and classifying them rather than understanding them. The objective attitude so prevalent in the clinical setting is paralleled in the ethical literature on psychiatry, where one only rarely encounters any discussion of the desires and opinions of the patients.<sup>124</sup> The omission of any mention of what patients themselves want is particularly remarkable when we consider that the introduction to *Psychiatric Ethics* makes special reference to what was at that time called “the medical consumer movement.” The editors, Sidney Bloch and Paul Chodoff, say that “we are now seeing growing demands that the views of the patient and his family be acknowledged and respected,”<sup>125</sup> and they also refer to the “vociferous” opposition to electroconvulsive therapy and psychosurgery from patients’

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<sup>124</sup> I have only come across two papers on psychiatric ethics that assigned importance to the patient’s point of view. Both were written by psychiatrists: Peter Breggin, “Coercion of Voluntary Patients in an Open Hospital,” in *Ethics of Psychiatry*; and Benno Müller-Hill, “Psychiatry in the Nazi Era,” in *Psychiatric Ethics*, eds. Sidney Bloch and Paul Chodoff (New York: Oxford University Press, 1991). Breggin’s article considers psychiatric coercion from the perspective of the patient: “the focus must be upon the patient’s feeling or response, otherwise the patient is subjected to another imposition whereby he loses even his right to decide what is coercive” (p. 425). Müller-Hill’s examination of Nazi psychiatry leads him to conclude, among other things, that “the (poetic, metaphorical) description of reality which the patient gives should be understood and accepted” and that “if a patient claims that the psychiatric treatment offered him is inadequate or undesirable, this view should be honoured, and new alternative options should be explored” (p. 470).

<sup>125</sup> Bloch and Chodoff, p. 4.

advocacy groups.<sup>126</sup> They claim that the current professional interest in psychiatric ethics arose only recently, mainly in response to such demands from ex-patients.<sup>127</sup>

It is strange that such importance should be assigned to the ex-patients' movement, and yet the existence of this movement is not addressed directly in the literature on psychiatric ethics. Nor do many ethicists discuss the *patient's* evaluation of the care she has received. In this section, I propose to take steps toward filling in this lacuna by examining the psychiatric survivors' movement from a philosophical perspective. The first part of my argument will deal with the concept of "recognition," an idea found in the political/social philosophies of Charles Taylor ("The Politics of Recognition") and Axel Honneth (*The Struggle for Recognition*). Their views are similar: both philosophers claim that we require recognition from others in the forms of respect and esteem in order for us to develop a positive self-image. The withholding of respect and esteem gives rise to a feeling of humiliation that in many cases provides the motivation for the social "struggle" for recognition.

In the second part of this chapter, I will focus on the concept of humiliation. Psychiatric survivors raise many objections to psychiatry – for example, that it is scientifically suspect, that it erodes individuals' legal rights, and that it is a tool of political and social control – but I will show that the main objection seems to be that psychiatry is a humiliating institution. I claim that all other objections raised by the movement can be understood in light of this one principal criticism. To this end, I will quote liberally from first-person accounts written by psychiatric survivors about their

<sup>126</sup> Bloch and Chodoff, p. 5.

<sup>127</sup> It is interesting also that Bloch and Chodoff see the grassroots movement as more important in this regard than the academic critique of psychiatry popular in the 60's and 70's (as represented by the writings of Thomas Szasz and R.D. Laing). Most philosophers who defend psychiatry against criticism see the

feelings of humiliation. I will finish with the suggestion that the psychiatric survivors' movement is important from a moral point of view, and that their criticisms of psychiatry ought to be taken seriously by anyone who is concerned about the decency of our society – and by ethicists especially.

### **Respect and Recognition**

Before I introduce the idea of recognition directly, I would like to begin by mentioning Peter Strawson once more. For although “Freedom and Resentment” did not contain any allusions to social movements, did not say anything at all about politics or society, and never once referred to the idea of “recognition,” it contains an argument that, as we will soon see, bears a strong resemblance to arguments that Taylor and Honneth put forth to support the idea that the struggle for recognition is a central component to social movements. We will remember that Strawson says throughout his paper that we necessarily attach great importance to the attitudes that others show towards us; specifically, we demand that others treat us with “good will.”<sup>128</sup> When this is not forthcoming, we react emotionally, i.e. with resentment. According to Strawson, this is because we experience the love and esteem of others as a need, as something vitally important for our self-respect.<sup>129</sup> Strawson’s comments to this effect in “Freedom and Resentment” were rather brief: they seem to have been intended as a reminder to the reader of something she already knows. An argument similar to Strawson’s appears in Taylor’s and Honneth’s discussions of recognition in a more elaborated form.

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*latter* as their adversaries. Moore is one example of one who singles out Szasz and Laing in his critique (*Ethics of Psychiatry*, pp. 35-40).

<sup>128</sup> Strawson, p. 5.

<sup>129</sup> Strawson, p. 5.



Taylor's approach makes ample reference to the history of ideas. He claims that in order to understand the concept of recognition underlying many contemporary social movements, we must look back to the emergence of the ideal of authenticity in the 1700's. Taylor follows Lionel Trilling's formulation of authenticity as a voice within ourselves which calls us to be unique, to find our individualized way of being, including our own individual way of acting morally.<sup>130</sup> He dubs this (i.e. of the inner self as the wellspring of authenticity) the "monological ideal."<sup>131</sup> It supposes that our identities derive from deep within ourselves, independently of others. According to Taylor, however, the monological ideal is wrong. On the contrary,

The crucial feature of human life is its fundamentally dialogical character. We become full human agents, capable of understanding ourselves, and hence of defining our identity through our acquisition of rich human languages of expression. People do not acquire the languages needed for self-definition on their own. Rather, we are introduced to them through interaction with others who matter to us – what G.H. Mead called "significant others."<sup>132</sup>

Taylor supports this point by saying that many good things are enjoyable only when enjoyed with others, and that sharing things with other people who matter to us can profoundly modify (for the better) our values, our aesthetic sensibilities, and our attitudes towards the project of living.<sup>133</sup> By sharing experiences, others become part of our identities. The importance of others for our identities makes an absolutely monological

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<sup>130</sup> Charles Taylor, "The Politics of Recognition" in *Philosophical Arguments* (Cambridge, Massachusetts: Harvard University Press, 1995), p. 227. He adds that such a notion is only compatible with the decline of societies based on honour and the rise of democracies.

<sup>131</sup> Taylor, p. 230.

<sup>132</sup> Taylor, p. 230.

<sup>133</sup> Taylor, pp. 230-231.

ideal impossible.<sup>134</sup> Our need for recognition from others is not something that we can dispense with at will.

Honneth's account of the importance of others for the development of personal identity is somewhat more systematic in that he borrows a tripartite schema from Mead and Hegel outlining the ways in which recognition from others is necessary for our identity. Recognition, on Honneth's view, takes the forms of love, rights and solidarity, and each is crucial in its own way for the development of an individual's positive "relation-to-self": "these relationships [of love, rights and solidarity] establish the moral infrastructure of a social life-world in which individuals can both acquire and preserve their integrity as human beings."<sup>135</sup>

Love is the first of these relationships, both psychologically and conceptually. Honneth refers to the importance of early relationships based on love for the development of emotional stability. A well-integrated personality, on Honneth's view, requires the shared concern of the love relationship.<sup>136</sup> Secure in the knowledge that she is loved, an individual develops the self-confidence that allows her to attain independence and to be recognized as an autonomous being.<sup>137</sup> Honneth says that Hegel was right "to discern within [the love relationship] the structural core of all ethical life," for it creates the conditions by which human beings can participate in public life.<sup>138</sup> Without a sense of an autonomous self, individuals cannot share in social relationships.

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<sup>134</sup> Taylor, p. 231.

<sup>135</sup> Axel Honneth, "Integrity and Disrespect: Principles of a Conception of Morality Based on a Theory of Recognition," in Axel Honneth, *The Fragmented World of the Social*, Charles W. Wright, ed. (Albany: SUNY Press, 1995), p. 253.

<sup>136</sup> Axel Honneth, *The Struggle for Recognition* (Cambridge, Massachusetts: The MIT Press, 1996), p. 97.

<sup>137</sup> *The Struggle for Recognition*, p. 107.

<sup>138</sup> *The Struggle for Recognition*, p. 107.

The next kind of relationship that Honneth considers is a social one – that of rights. Whereas the love relationship is particular, the rights relationship is universal: it requires that we see all other human beings as meriting the same rights that we do. Rights are extremely important because without them the formation of self-respect would be impossible.<sup>139</sup> Civil and political rights and obligations enshrined in law enable the individual to see herself as someone who is recognized by her society as a morally responsible person. In addition to this, she is considered to have a right to participate in “discursive will-formation”; that is to say, she is able to participate in the political process.<sup>140</sup>

The third and last relationship Honneth considers is that of solidarity. Here we move back to the realm of the particular, for whereas the rights relationship recognizes people for the characteristics that are common to all human beings equally, relationships characterized by solidarity recognize people for their particular traits. The paradigm of a relationship based on solidarity is what Honneth calls “group pride,” which may remind us of the pride that functions as a social glue within national groupings based on a common language: members of linguistic communities hold each other in esteem for their collective accomplishments.<sup>141</sup> With the collapse of pre-modern social hierarchies, people must find sources of esteem that are not derived from one’s place in a rigid social

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<sup>139</sup> In discussing the relation between right and self-respect, Honneth approvingly cites Joel Feinberg’s argument to this effect. In *The Decent Society* (Cambridge, Massachusetts: Harvard University Press, 1996), Avishai Margalit disputes Feinberg’s view. Margalit thinks that it is possible to imagine a society which has no conception of rights, but where its members do have the notion of self-respect, saying that societies based on duties and those based on ends fit this description (p. 37). However, I think that Honneth is right in saying that only in a society based on rights can an individual be *guaranteed* that her claims will be taken seriously (*The Struggle for Recognition*, p. 108). This certainty seems to me to be crucial to the development of self-respect.

<sup>140</sup> *The Struggle for Recognition*, p. 120.

<sup>141</sup> *The Struggle for Recognition*, p. 128.

system. In the modern era, “social esteem begins to be oriented not towards collective traits but towards the capacities developed by the individual in the course of his or her life.”<sup>142</sup> Only when an individual feels that her traits and achievements are considered valuable is she able to develop a sense of self-esteem.<sup>143</sup>

So far we have considered the positive, enabling, side of recognition that allows individuals to form integrated personalities through the acquisition of self-confidence, self-respect and self-esteem. What is more interesting however, from the perspective of social philosophy, is the *corollary* of this positive face. What happens when love, rights and solidarity are withheld from people? Honneth says that the denial of each of these three human needs are forms of disrespect; the denial of rights and esteem in particular bring into being the motivation for social change, or what he calls a “struggle for recognition.”

I will now consider what Honneth takes to be the main types of insult or humiliation. Self-confidence, which derives from a relationship of love with others, is destroyed by physical abuse. In its extreme forms, like torture or rape, physical abuse robs a person of her feeling of control over her body. This has serious repercussions for the victim’s emotional stability: “the suffering of torture or rape is always accompanied by a dramatic breakdown in one’s trust in the reliability of the social world and hence by a collapse in one’s own basic self-confidence.”<sup>144</sup> Self-respect is diminished by the denial of a person’s status as a morally responsible agent; this constitutes a form of

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<sup>142</sup> *The Struggle for Recognition*, p. 125.

<sup>143</sup> *The Struggle for Recognition*, p. 129. In everyday speech, notions such as “self-respect,” “self-confidence,” and “self-esteem” are not so distinct and are often used interchangeably. In order to adduce further support for Honneth’s conceptual analysis, I would like to mention that Margalit argues convincingly that we can imagine a person who has self-respect but no self-esteem, and vice versa (Margalit, pp. 45-46).

<sup>144</sup> *The Struggle for Recognition*, p. 133.

disrespect that affects the person's normative understanding of herself. When someone is considered a member of the community but is denied certain rights, "the implication is that he is not deemed to possess the same degree of moral accountability as other members of society."<sup>145</sup>

Honneth refers to the denial of social esteem as "degradation." A society is considered degrading when it attacks its members' sense of social worth by downgrading their value to the society at large; it can do this by deprecating their culture or lifestyle.<sup>146</sup> Denying the value of the subculture's contribution to the society at large prevents the members of these groups from seeing themselves as worthy of esteem for their abilities and achievements, and hence prevents self-esteem.<sup>147</sup> On Honneth's view, the larger society is not obligated to value or praise (in actual fact) each particular concrete contribution from a subculture in order to be considered a decent, non-degrading society. Instead, the society merely must guarantee that it does not dismiss out of hand the subculture's contributions: it must create and safeguard the conditions for the realization of its members' self-esteem.<sup>148</sup> Like Honneth, Taylor also thinks that a lack of

<sup>145</sup> "Integrity and Disrespect," p. 251.

<sup>146</sup> "Integrity and Disrespect," p. 251.

<sup>147</sup> *The Struggle for Recognition*, p. 136.

<sup>148</sup> *The Struggle for Recognition*, Translator's Introduction, p. xvii. Taylor provides an example of such an out-of-hand dismissal of cultural (in this case literary) contributions by those who are not part of the mainstream or dominant culture: he quotes the remark attributed to Saul Bellow, "when the Zulus produce a Tolstoy we will read him" (Taylor, p. 236). This remark is insulting because it assumes that the Zulus have not produced anything culturally valuable; however, Bellow is presumably not expert in this matter and hence unable to make such a judgment. It is also insulting because it judges other cultures by perhaps narrow criteria which should be expanded to accommodate literary works that do not fit the western mold (Taylor, p. 255). The problem is not that the spokespeople for western society find particular works not up to scratch, but that these spokespeople seem to rule out the possibility of value from the outset. I must add, however, that unlike Honneth, Taylor is troubled by the tensions that arise from the demand for respect in the cultural arena. Specifically, he says that the demands for the expansion of the literary canon, for example, do not take the form of "include this because it's good," but rather, "include this because it's exclusion reflects back to us a demeaning picture of ourselves." On Taylor's view, this is to equate aesthetics with ethics, and he finds this philosophically incoherent (Taylor, pp. 253-254).

recognition from others has grave consequences. He says that “our identity is partly shaped by recognition or its absence, often by the *mis*recognition of others, and so a person or group of people can suffer real damage, real distortion, if the people or society around them mirror back a confining or demeaning or contemptible picture of themselves.”<sup>149</sup>

The hunger for recognition, then, becomes the impetus for a social and political struggle. The denial of recognition is seen as unfair; this evaluation serves as the normative motivation for a social movement. Taylor applies this thesis to the situation of Quebec vis-à-vis the rest of Canada, while Honneth discusses the philosophical assumptions that support the idea that social movements are motivated in the main by feelings of injured pride. Honneth’s view is the same as that which he attributes to Ernst Bloch, namely, that “were it not for the added feeling of wounded dignity, the mere experience of economic distress and political dependence would have never become a driving force of the practical revolutionary movements in history.”<sup>150</sup>

Honneth’s view cuts against a standard social-scientific view of social movements that explains them as the result of objective interests, such as an interest in economic redistribution aimed at correcting dramatic inequalities of wealth.<sup>151</sup> The same is true for utilitarian conceptions of human action<sup>152</sup>: Honneth says that such theories are not equipped to deal with the normative dimension of political struggles. Only a *moral* theory of social rebellion can give an adequate account of not only the thwarted

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<sup>149</sup> Taylor, p. 225.

<sup>150</sup> “Integrity and Disrespect,” p. 256.

<sup>151</sup> *The Struggle for Recognition*, p. 161.

<sup>152</sup> *The Struggle for Recognition*, p. 163.

expectations of those who feel humiliated, but also the positive role such rebellions play in helping humiliated individuals forge a new, positive, “relation-to-self.”<sup>153</sup>

This last point relates to the previous chapter’s distinction between the objective attitude and the participant attitude. Honneth is saying that an objective theoretical attitude can only see social struggles as the results of objective, observable cause-and-effect relationships, but miss altogether the normative dimension of such struggles; much sociology, for this reason, cannot accommodate the normative claims of the actors studied. Honneth’s critique of sociology has some relationship to the critique of psychiatry that I put forward in Chapter Two: there I said that psychiatrists often explain puzzling patient speech as a result of objective causes (excess of dopamine, say) at the expense of addressing the *content* of the speech. And as far as philosophy of psychiatry goes: if psychiatric ethicists were prepared to truly take seriously the importance of the psychiatric survivors’ movement (as Bloch and Chodoff say they in fact do), they would address head-on the normative content of the movement’s claims.

### **The Normative Claims of the Psychiatric Survivors’ Movement**

I now turn to the question of the psychiatric survivors’ movement. What relevance does the concept of recognition, as delineated by Taylor and Honneth, have for *this* social movement? Some might question the assumption that it has any relevance whatsoever. They might say that psychiatric patients do not experience humiliation in the sense of *justified* humiliation and go on to point out that Honneth’s and Taylor’s accounts do not stipulate that feelings of humiliation must be justified and not simply be extreme

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<sup>153</sup> *The Struggle for Recognition*, p. 164.

reactions to another person's perfectly appropriate behaviour. The days of Dr. Ewen Cameron and his nefarious brainwashing experiments are long behind us, and psychiatrists, insofar as they adhere to their codes of conduct, do not humiliate their patients, abuse them, or unfairly deprive them of their rights. Since psychiatrists do not intentionally oppress their patients, but in fact strive to help them, any feelings of humiliation on the part of the patient are unwarranted, and hence any claims that psychiatry is a humiliating institution are unfair.<sup>154</sup>

However, actions do not have to be intentional in order to be humiliating. Avishai Margalit makes this argument in *The Decent Society*. He says, "only humans can produce humiliation, although they need not actually have any humiliating intent."<sup>155</sup> He does say, though, that a person must have good reasons for her claim that she has been humiliated; humiliation, on his view, "is any sort of behaviour or condition that constitutes a sound reason for a person to consider his or her self-respect injured."<sup>156</sup> In what follows, I will examine the normative claims made by ex-patients who charge that they were robbed of their self-respect and self-esteem by psychiatry. In doing so, I hope to show that psychiatric survivors do have a normative understanding of the denial of recognition; and I also want to argue that the reasons they provide for their wounded self-image are sound.

"Humiliation" is a word that appears frequently in first-person accounts of psychiatric survivors. Certainly, in cases where patients have been abused by staff, put

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<sup>154</sup> I should point out here that many writers who are critical of psychiatry do not conclude that psychiatrists are bad or uncaring people. See Rosenhan, p. 72; Shimrat, p. 119; Jeanine Grobe, ed., *Beyond Bedlam: Contemporary Women Psychiatric Survivors Speak Out* (Chicago: Third Side Press, 1995), p. 194.

<sup>155</sup> Margalit, p. 10.

<sup>156</sup> Margalit, p. 9. I should note that Margalit's understanding of self-respect is somewhat different than Honneth's. Margalit says that self-respect "is the honor a person grants herself solely on the basis of the



into four-point restraints, or medicated against their will, most would readily agree that they have sound reasons for feeling humiliated. However, the examples of degradation in ex-patient stories often are not of outright abuse; rather, the degradation stems from being shown a demeaning picture of oneself. For instance, psychiatric survivor Pat Capponi relates the story of attending a meeting in Toronto's Parkdale neighbourhood. Residents were concerned about the "dumping" of the deinstitutionalized in the area, and complained that the profusion of mental patients in the neighbourhood made them afraid and drove down property values.<sup>157</sup> Capponi, who was living in a psychiatric boarding house in Parkdale at the time, was outraged:

I was getting angrier and angrier, and fighting with myself to keep quiet. It was hard. I kept thinking about Alice and Gary and Haddie, what they went through every day, and how humiliated they'd be to hear all this.... I identified myself as one of the "nuts" they'd been discussing, assured them that I hadn't killed anybody or raped anybody (for at least a week), objected to being spoken of as garbage, which is what their use of the term "dumping" brought to mind. I...strongly suggested their energies might be better spent investigating living conditions in their community than in alarmist meetings like these.<sup>158</sup>

We shall see that much of the indignation expressed by ex-patients takes a similar form: by and large, the objection to psychiatry concerns the presentation of a demeaning image of the "mentally ill." Politically active ex-patients reject this picture and they argue in their writings that the existence of such a picture seriously hampers their ability to develop a positive self-image. That social esteem is blocked by the denigrating attitudes

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awareness that she is human" (Margalit, p. 24). This seems less compelling to me than Honneth's definition, for reasons which I explain in footnote 18.

<sup>157</sup> Pat Capponi, *Upstairs in the Crazy House: the Life of a Psychiatric Survivor* (Toronto: Penguin Books Canada, 1992), p. 194.

<sup>158</sup> Capponi, p. 195.

of others in the community is particularly serious because the development of a positive relation-to-self is necessary for emotional stability. I will pay special attention to three issues – those of the “sick role,” autonomy and “dangerousness” – to show that the main theme of psychiatric survivors’ writings is the rejection of the pejorative picture of the “mentally ill” which the institution offers up.

### **The “Sick Role”**

The “sick role” is a concept that was formulated by sociologist Talcott Parsons to describe the obligations and privileges accruing to the ill. It states that 1) the individual is not responsible for her illness; 2) the sick individual is to be exempted from normal obligations (for example, work) until she is well; 3) illness is undesirable; and 4) those who are ill should seek the help of a physician.<sup>159</sup> These four tenets sum up what we normally believe to be the proper attitude toward the sick.

The sick role, at first glance, does not seem objectionable – it seems only fair that one who is sick should not be obliged to work, that an individual should not be blamed for being sick, and that those who are sick should evince a willingness to get better by cooperating with medical professionals, rather than malingering. Reznek says that the sick role is something an individual is “entitled” to, indicating that he considers it a privilege deserved only by those who are “really” sick.<sup>160</sup> The implication of this is that

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<sup>159</sup> Parsons, “Illness and the Role of the Physician: A Sociological Perspective” in Peter Hamilton, ed., *Readings from Talcott Parsons* (New York: Tavistock Publications and Ellis Horwood Ltd, 1985), pp.149-150. For Parsons, the physician's role is to represent and communicate these norms to patients to control their deviance.

<sup>160</sup> Reznek, p. 133.

doctors confer a benefit when they diagnose someone as ill or (for our purposes here) “mentally ill.”

All this assumes, however, that the individual so diagnosed actually *is* sick; it also assumes that she does not *dispute* the diagnosis that she is sick. The constituent elements of the sick role as enumerated above are humane – humane, that is, unless the role is foisted upon an individual without her consent. This is the claim that many ex-psychiatric patients put forward. They claim that they do not see themselves as sick; that seeing themselves in this way is detrimental to their self-image; that the sick role unfairly excludes them from participation in the workforce; and that the inappropriate application of the sick role sanctions coercive treatment of those who are so labeled. I will examine in more detail below the argument that seeing one’s own psychological distress as a manifestation of an illness can be detrimental to one’s self-esteem.

The first component of the sick role states that a person is not responsible for her illness. A commonly heard remark concerning the historical transition from seeing deviance as “madness” to seeing it as a manifestation of “mental illness” is that the medical model of psychological distress constitutes a dramatic improvement on the past: not too long ago, those who would now be diagnosed with an illness and given medications were considered morally “bad,” locked up and treated abominably. The view that mental suffering is due to an illness destigmatizes the sufferer; mental illness is widely regarded as nothing to be ashamed of. Notwithstanding such conventional wisdom, some ex-patients do not agree that the illness label is destigmatizing. Shimrat says that

The...mental health industry has been putting out literature that tries to alleviate prejudice against crazy people. But

these educational efforts have been based on the notion that crazy people are sick and that it's okay to be sick. This approach doesn't work. For one thing, not all physical conditions are stigma-free: for example, people who have AIDS or cerebral palsy.... In any case, 'the public' does not think that crazy people are okay, any more than it ever has. And we crazies are in no way helped by the belief, used to justify dubious treatments, that craziness is an illness.<sup>161</sup>

The problem with seeing emotional disturbance as signs of an illness reaches beyond its utility as a justification for dubious treatments, as Shimrat goes on to point out. The larger problem that she and others identify is that this view – the view that emotional suffering is a disease that invades the personality as a result of faulty brain chemistry – alienates the individual from her own pain.

A number of quotations from survivors will make this clear. One ex-patient says that her experience of psychiatry has left her bereft of a number of things, including privileged access to her emotions. “No longer can you know if you're sad – or if you're depressed. Your feelings – the very essence of you – get questioned, get re-labeled, and the doubt begins.”<sup>162</sup> Another says that he is glad that psychiatry was not successful in convincing him that his craziness was something that should be cured, because “if someone came along and “fixed” me, I wouldn't be myself anymore. And that would be a problem for me, because all that stuff is part of who I am.”<sup>163</sup> These ex-patients here express a reluctance to see their thoughts and emotions as the symptoms of a disease, because they do not see these as “alien” (we will remember that this is the term Reznick uses in his discussion of autonomy and responsibility), but the medical model in many

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<sup>161</sup> Shimrat, p. 26.

<sup>162</sup> Grobe, p. 17.

<sup>163</sup> Shimrat, p. 81.

cases expects the patient to adopt this opinion and denies the judgment of “health” until she “realizes” that she is this way because of her disease.<sup>164</sup> The partition between the patient’s “real” self and her “sick” self is often imposed on her involuntarily. I think it is for this reason that one activist asserts that “to think that the mind is ill is to annihilate the person.”<sup>165</sup>

Thus, the medical model sees emotional pain as a symptom of a disease that the doctor must work to eliminate. This view is largely incompatible with another idea: that pain is a necessary part of life, and that pain often has meaning. One ex-patient said that she began to feel better after she “met a shaman/healer. This woman met my pain and confusion with stories, stories that provided a framework for my experiences.... She didn’t reduce my pain to some brain abnormality. She simply made it meaningful.”<sup>166</sup> She describes how this shaman, after their first meeting, gave her the unusual prescription of a book to read. The book, about Amerindian women in “unbearable situations,” made this ex-patient feel less alone.<sup>167</sup>

A crude utilitarian view that values happiness and abhors all pain, regardless of the kind of pain it is, and regardless of what it signifies, is not the only philosophical approach possible. Hans-Georg Gadamer, for one, has questioned the notion that emotional pain is always a disvalue. He asks, “Is there not a terrifying challenge involved in the fact that through psychiatric drugs doctors are able not only to eliminate and deaden various organic disturbances, but also to take away from a person their own

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<sup>164</sup> Shimrat, p. 15.

<sup>165</sup> Anti-psychiatry activist Lanny Beckman, quoted in Shimrat, p. 57.

<sup>166</sup> Grobe, p. 71.

<sup>167</sup> Grobe, p. 107.

deepest distress and confusion?”<sup>168</sup> Emotional dispositions such as distress, confusion, and in particular, anxiety, have a disclosive existential function, on his view; in support of this claim, Gadamer refers to the Heideggerian notion that an “authentic existence... is prepared to face anxiety” instead of fleeing from it into a preoccupation with everyday matters.<sup>169</sup> To the extent that his remarks on emotional suffering may seem peculiar – who in their right mind would want to suffer? – it shows how one particular view of the good of human life has become hegemonic, at least in Western culture.

Notwithstanding the unpopularity of this sort of outlook, a similar conception of suffering is put forward by Ivan Illich. He argues that the explosion of technical medical expertise has the effect of destroying people’s ability to deal with their pain and suffering in individual and autonomous ways,<sup>170</sup> and he bemoans the fact that contemporary medicine does not encourage people “to seek a poetic interpretation of their predicament or find an admirable example in some person... who learned to suffer.”<sup>171</sup> And he sounds very much like one of the ex-patients quoted above when he criticizes medical intrusion into subjective experience: “it is medicine which stamps some pain as ‘merely subjective,’ some impairment as malingering, and some deaths – though not others – as suicide.”<sup>172</sup>

Thus, the objection to the medical model of emotional suffering is that it excludes alternative interpretations of pain. The ex-patients quoted above consider it objectionable that they are expected to agree with their doctors that their distress is a troublesome

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<sup>168</sup> Hans-Georg Gadamer, *The Enigma of Health* (Stanford, California: Stanford University Press, 1996), p. 77.

<sup>169</sup> Gadamer, p. 157.

<sup>170</sup> Ivan Illich, *Limits to Medicine* (Harmondsworth, England: Penguin Books, 1976), p. 42.

<sup>171</sup> Illich, p. 122.

<sup>172</sup> Illich, p. 54.

symptom of a disease. Certainly, for those who already experience their psychological distress as something that is not part of their “real” selves, the medical interpretation is not distasteful. However, most psychiatrists do not seem to consider the medical interpretation as simply one valid model among other valid models – it is imposed on many people who do not find it helpful, or worse yet, find it harmful. Insofar as doctors impose such a view on those who are unwilling to accept it, they hold up to the patient a picture of herself as broken, malfunctioning, in need of “fixing.” This could be considered a sound reason for feeling humiliated.

### **Autonomy/Control**

Ex-patients’ descriptions of violations to their autonomy run the gamut from relatively minor indignities such as are experienced in many psychiatric hospital settings, to more serious infringements like coercive treatment. I will address the issue of coercive treatment below; here I will consider some of the claims that psychiatry is humiliating because it holds up a view of the patient as someone who cannot be trusted to control even minor aspects of her life – in short, it holds up a view of the patient as incompetent.

A common complaint about lack of patient control centres on the issue of clothing. Patients regularly have their clothing taken from them upon their admission to the hospital and are made to wear pyjamas. The reason for this is utilitarian: it prevents patients from leaving the hospital without authorization.<sup>173</sup> Those who must obey this stricture, however, find it humiliating. One woman’s diary reads, “my personal clothing was forcibly taken from me when I was admitted. I have worn pyjamas, housecoat, and

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<sup>173</sup> This is true even in cases where the patient is voluntarily hospitalized.

slippers for eighteen days now. Is this a form of punishment?"<sup>174</sup> Shimrat quotes another unidentified ex-patient to the effect that wearing pyjamas is a sign of patients' diminished power vis-à-vis the white-coat-clad doctors.<sup>175</sup> Since the right to wear one's own clothes is regarded as necessary for the maintenance of personal dignity, it is included in Burstow and Weitz's "Bill of Rights for Psychiatric Inmates in Canada."<sup>176</sup>

There are other, less subtle, indications that patients are regarded from the outset as having a less-than-normal capacity for control over their lives. A nurse tells one woman, "you're in no condition to make decisions for yourself"; the woman retorts: "I made the decision to come here, didn't I!"<sup>177</sup> Another woman points out the contradiction of offering "assertiveness" class inside a hospital where "no mental patient is free to choose, refuse, speak, or act."<sup>178</sup> If a patient refuses to attend an activity, she is badgered until she gives in.<sup>179</sup> Complaints of this sort are echoed in many other accounts.<sup>180</sup>

The effect of such treatment is that the patient becomes aware that others see her as incompetent. In being denied the opportunity to make even minor decisions for herself, the implication is that she does not have the *capacity* to make such decisions; or that the right to have control over such matters is superseded by the hospital's interest in maintaining order within the facility and preventing disruptions of routine. In cases

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<sup>174</sup> Burstow and Weitz, p. 113.

<sup>175</sup> Shimrat, p. 90.

<sup>176</sup> Burstow and Weitz, p. 308.

<sup>177</sup> Burstow and Weitz, p. 150.

<sup>178</sup> Grobe, p. 26.

<sup>179</sup> Grobe, p. 27.

<sup>180</sup> For example: Grobe, p. 108; Goffman discusses how "secondary adjustments" (activities undertaken by patients in institutions such as bartering goods, sneaking messages "outside", etc.) help the patient feel that "he has some selfhood and personal autonomy beyond the grasp of the organization" in *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates* (Garden City, New York: Doubleday and Company, 1961), p. 314.



where a patient is denied control over decisions such as what she wears and what daily activities she will participate in, she has a sound reason for feeling humiliated.

### Coercive Treatment and “Dangerousness”

People who have been diagnosed as “mentally ill” are often forced to comply with doctors’ orders on the grounds that their mental illness constitutes a threat to others in the community. The argument from “dangerousness” has been used to justify the involuntary commitment of individuals in psychiatric hospitals; today, in a time of severe hospital funding cuts, there is a push toward “involuntary outpatient commitment,” which means that outpatients are visited at home by nurses who administer psychiatric medications by order of the state. Before an individual’s liberties may be abridged in these ways, psychiatrists are asked to give expert medical opinion as to whether or not an individual is “dangerous.”

The concept of “dangerousness” as a justification for preventive psychiatric intervention has been criticized as deeply problematic from a philosophical standpoint. Predictions of dangerousness are notoriously unreliable – studies show that the accuracy of psychiatrists’ predictions of future violence is as low as 15%. We might also wonder why “dangerousness” caused by mental illness ought to be susceptible to preventive intervention, whereas other sorts of predictors – history of incarceration or membership in a gang, for example – are *not* considered adequate justifications for coercion.<sup>181</sup>

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<sup>181</sup> Edwards, “Introduction” to “Ethical and Conceptual Issues in Civil Commitment,” in *Ethics of Psychiatry*, p. 420.

Others criticize the notion as lacking a proper legal definition, and say that as a result the idea is inconsistently applied across a range of cases.<sup>182</sup>

Still, some writers think the practice of predicting dangerousness can be ethically sound. Grisso and Appelbaum make this argument in their article, “Is it Unethical to Offer Predictions of Future Violence?” Their answer to this question is that such predictions are not *necessarily* unethical: the evaluation of the ethics of this practice must consider the nature, the foundation, and the legal consequences of the psychiatric prediction.<sup>183</sup> When they refer to “nature,” they mean the type of prediction offered: is it dichotomous or risk-based? Dichotomous predictions are of the “yes, the patient is dangerous/no, she is not dangerous” sort; the authors are more approving of the risk-based type of prediction, which expresses dangerousness as a percentage (“the patient has a 30% of committing a violent act”), because it has a higher rate of statistical reliability.<sup>184</sup> They claim that many U.S. statutes support the conception of dangerousness as probability of risk, since they are worded in such a way to convey the idea that dangerousness consists in “reasonable fear” or “sufficient risk.”<sup>185</sup>

When the authors speak of the “foundation” of predictions, they are referring to the data used in support of predictions. It is unethical, for example, to provide a prediction in response to a hypothetical situation posed by a prosecuting attorney without having had the opportunity to interview the individual in question. By contrast, a

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<sup>182</sup> “A person could be in one hospital one day and considered dangerous because he’s threatened his mother or because he’s kicked an orderly, and be kept in hospital. In another hospital, on another day, another person may be exhibiting the same behaviours but may not be considered dangerous, and may be freed.” David Cohen, quoted in Shimrat, p. 31.

<sup>183</sup> Thomas Grisso and Paul S. Appelbaum, “Is it Unethical to Offer Predictions of Future Violence?” in *Ethics of Psychiatry*, p. 447.

<sup>184</sup> Grisso and Appelbaum, p. 452.

<sup>185</sup> Grisso and Appelbaum, p. 452.

psychiatrist may offer an ethical opinion when it is backed by data that shows that certain diagnostic groups pose a certain risk of violent behaviour, and that the individual in question does reliably share this diagnosis.<sup>186</sup> The legal consequences of predictions should also be considered, say the authors. Psychiatrists ought to be careful to leave the final judgement to the judge or jury; the profession as a whole ought to discuss the fact that testimony given in a capital sentencing has more weight than that given in a civil commitment trial.<sup>187</sup>

The issue looks rather different to those who have had to bear the label “dangerous.” In their writings, they often express a view of “dangerousness” as an extra-legal and hence unfair practice:

The lady psychiatrist certified me as an involuntary patient. She stated that in her opinion I was of “serious bodily harm to others and of imminent and serious impairment” to myself.... My psychiatrist always drags up my past hospitalizations and the fact that I hit an elderly lady to support her opinion that I am “dangerous.” I’ve more than paid for that offence, yet here in the mental hospital we’re condemned for life.<sup>188</sup>

Another common complaint against the practice is that mental health workers are prone to seeing a person as dangerous when she expresses anger, but they do not consider the reasons for the anger. One woman who was incarcerated against her will writes that “one of the social workers told my husband there was no way I could be discharged because I was ‘dangerous.’ At the time, the staff kept saying to me, ‘You’re almost exploding. You’re angry! You’re angry!’ Of course I was angry!”<sup>189</sup> Yet another patient, upon

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<sup>186</sup> Grisso and Appelbaum, p. 453.

<sup>187</sup> Grisso and Appelbaum, p. 455.

<sup>188</sup> Burstow and Weitz, p. 94.

<sup>189</sup> Burstow and Weitz, p. 152.

reading her patient records years after she was discharged, was shocked to read that the doctors considered her “homicidal”; she asserts that the assessment was a “pure fabrication.”<sup>190</sup>

In Grisso and Appelbaum’s article, on the other hand, statistical accuracy is the salient feature when assessing the morality of predictions of violence. The reduction of ethics to scientific reliability, I think, is a good example of the objective attitude that I criticized in Chapter Two. The objective attitude sees people as things to be controlled, studied, and treated,<sup>191</sup> and therefore cannot accommodate the moral claims of the individual from a participant or dialogical point of view. Grisso and Appelbaum do say that a prediction based on thin statistical evidence that results in an involuntary hospitalization is wrong because it “demeans the rights of the individual,”<sup>192</sup> but they make this comment only in passing. Questions of human rights and dignity are only relevant when dangerousness cannot be proved, but the authors do not see anything wrong with the very idea of depriving someone of liberty based on statistical analysis – they assume that this is a philosophically unproblematic practice. However, I have shown that there are good reasons to think that diagnostic validity and reliability is in many cases negatively affected by psychiatric objectivity. Moreover, Grisso and Appelbaum nowhere address the question of why preventive intervention is justified in the case of the mentally ill, but not in other cases where an individual’s personal characteristics or social situation might be able to furnish evidence of probable future violence.

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<sup>190</sup> Grobe, p. 67.

<sup>191</sup> Strawson, p. 9.

<sup>192</sup> Grisso and Appelbaum, p. 455.

Mental patients themselves are aware of the questionable features of the “dangerousness” issue. They see the label “dangerous” as a sign of “rejection from the human commonwealth.”<sup>193</sup> When an individual is incarcerated because she presents a threat (albeit an unrealized one) to others, she is left to conclude that society considers her undeserving of the rights which other citizens enjoy. Where ordinary citizens are accountable for what they *do*, psychiatric patients are held accountable for what they *are*.

This is an idea that Michel Foucault has explored in “The Dangerous Individual”:

...by bringing increasingly to the fore not only the criminal as author of the act, but also the dangerous individual as potential source of acts, does one not give society rights over the individual based on what he is? No longer, of course, based on what he is by statute...but based on what he is by nature, according to his constitution, character traits, or his pathological variables.<sup>194</sup>

Being shown such a picture of oneself provides reasonable grounds for feeling humiliated. The message that the psychiatric patient absorbs is that she does not merit the same rights as those who are not patients, and as we have seen from our discussion of Honneth, this is grounds for considering one’s self-respect injured.<sup>195</sup> For this reason, the psychiatric survivors’ movement has demanded an end to incarceration based on “dangerousness.” The “Bill of Rights for Psychiatric Inmates in Canada” includes “the right to remain free of incarceration in psychiatric facility. Alleged dangerousness or criminal acts should be dealt with in the criminal justice system,”<sup>196</sup> and The “Declaration of Principles” of the Tenth Annual International Conference on Human Rights and

<sup>193</sup> This is a further formulation of the concept of humiliation put forward by Margalit, p. 112.

<sup>194</sup> Michel Foucault, “The Dangerous Individual,” in *Politics, Philosophy, Culture*, ed. D. Kritzman (New York: Routledge, 1988), p. 150.

<sup>195</sup> *The Struggle for Recognition*, p. 133.

<sup>196</sup> Burstow and Weitz, p. 307.

Psychiatric Oppression stated that “only proven criminal acts should be the basis of [the] denial [of personal liberty].”<sup>197</sup>

### **Self-Esteem and Self-Respect**

Now that I have presented a few of the statements made by psychiatric survivors to support the claim that psychiatry is a humiliating institution, I would like to make a few remarks in order to clarify the relationship between these claims and the struggle for self-esteem and self-respect. It might not seem obvious to some readers that psychiatric survivors are even entitled to self-esteem. For if everyone without exception is entitled to self-esteem, does that not mean that society would never be able to display disapproval of anyone’s goals? Does that not mean that society would never be able to express the view that some personal attributes are undesirable, or that some achievements are less worthy than others are? In saying that everyone is entitled to self-esteem, are we asking for judgments of value on demand?

We will remember from a footnote earlier in this chapter that Charles Taylor expressed a similar concern in his discussion of the politics of multiculturalism: his claim was that certain formulations of the demand for recognition were “shot through with confusion.”<sup>198</sup> When minority groups insist that their cultural contributions be

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<sup>197</sup> Burstow and Weitz, p. 306. Psychiatric ethicists, on the other hand, often claim that it is unfair to punish the “mentally ill” in the criminal justice system (Moore, p. 45); this might also be why Strawson feels that the objective attitude is the only “civilized” view to take in the case in the severely mentally disturbed). However, Reznick and Moore do not consider that incarceration in mental facilities might hinder a person’s recovery; nor do they acknowledge that psychiatric incarceration on the basis of “dangerousness” may continue indefinitely because patients are not sentenced, as prisoners are. The fact that this is the case removes the issue of sentencing from ethical scrutiny. In any case, what is interesting to note here is that measures ostensibly undertaken on behalf of patients are largely not, in fact, supported or desired by psychiatric survivors. The view, espoused famously by Hegel, but also by other philosophers, that people have a “right” to punishment, might be operative in the two quotations cited above.

<sup>198</sup> Taylor, p. 254.

considered equal in worth to the best work of the dominant culture, regardless of whether they are *in fact* as good, they are asking for a judgment of quality on demand. If judgments can be delivered on demand they become worthless, not to mention “breathtakingly condescending.”<sup>199</sup> Taylor concludes his paper by wondering whether there can be a middle way between judgments of quality on demand on the one hand and unacceptable ethnocentrism on the other.<sup>200</sup>

A version of the anti-psychiatry argument says that we ought to esteem certain individuals *because* they are schizophrenic. This is the view espoused by R.D. Laing in his works of the late 1960’s: in *The Politics of Experience* he characterizes the schizophrenic episode as a voyage that should be met not with psychiatrization, but with an “initiation ceremonial.”<sup>201</sup> He says that the madman “can be to us, even through his profound wretchedness and disintegration, the hierophant of the sacred.”<sup>202</sup> Showalter shows how such a view led to the somewhat strange fanfare over Laing’s schizophrenic patient Mary Barnes. Barnes’s episodes of madness were indulged by the staff at Kingsley Hall (the therapeutic community established by Laing in London in 1965), who “took turns feeding, bathing, and nursing her as she “went down,” or regressed to passive infancy.”<sup>203</sup> Therapists applauded the artistic creations she produced out of her own feces, and she even had a one-woman show of paintings consisting of oil smeared on canvas. Many of the literary talents (such as Doris Lessing) who congregated around Kingsley Hall in the late-60’s and early-70’s wrote novels that glorified schizophrenia as

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<sup>199</sup> Taylor, p. 255.

<sup>200</sup> Taylor, p. 256.

<sup>201</sup> R.D. Laing, in *The Politics of Experience and the Bird of Paradise* (Harmondsworth, England: Penguin Books, 1967), p. 106.

<sup>202</sup> Laing, *The Politics of Experience*, p. 109.

<sup>203</sup> Showalter, p. 232.

the hallmark of a higher mental capacity.<sup>204</sup> Views of this sort are not absent from the contemporary writings of psychiatric survivors. One former patient offers a list of things one can do to respond humanely to a psychiatrically labeled friend or relative, including “realize that they have a special gift – a genetic endowment that increases creativity and perceptions of reality.”<sup>205</sup>

Nevertheless, I do not think the claim that psychiatric patients are entitled to self-esteem requires that society approve of everything they do or say, or to approve of the very fact of their strangeness to the rest of the community. To explain why, I must return to Honneth’s concept of self-esteem. Honneth does not make the argument that society must approve of individuals’ particular attributes and accomplishments in actual, specific cases; rather, he says that in order for self-esteem to be a realizable goal, there must be a rough symmetry between the things that society values and the things its members value.<sup>206</sup> Self-esteem depends on the *existence of conditions* for the recognition of individuals’ contributions as valuable; these conditions exist in societies that have an “open, pluralistic, evaluative framework” for judgments of social worth. In such a society, no one is denied outright the opportunity to earn esteem.<sup>207</sup>

I see this as the main kernel within the various normative claims made by psychiatric survivors: the institution of psychiatry denies patients the *opportunity* to earn social esteem. It does this by the practice of labeling, which patients experience as an institutional badge of disapproval. The mental illness label can, as we have seen, prevent mental health professionals from taking the content of patient’s feelings and opinions

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<sup>204</sup> Showalter, p. 240.

<sup>205</sup> Grobe, p. 149.

<sup>206</sup> *The Struggle for Recognition*, p. 122.

<sup>207</sup> Translator’s Introduction to *The Struggle for Recognition*, p. xvii.



seriously, since they consider these to be simply manifestations of the disease. Patients' verbal expressions, which can in some cases be insightful or even poetic, are often taken by professionals to be evidence of an underlying disorder. But this is not to say that doctors must find *all* such utterances insightful or poetic. It is merely to say that they ought not to exclude out-of-hand such valuations. This, however, is exactly what Reznick and Moore, speaking from the psychiatric viewpoint, do, as we saw in Chapter Two. The objective attitude so often characteristic of psychiatry, which sees people as objects of treatment, policy, and control, has difficulty recognizing the value of intelligent non-conformity, sensitivity to injustice, or creativity when these attributes are present. Psychiatry furthermore does not encourage the patient to interpret her distress as the meaningful aspect of her being in the world; rather, it tries to inculcate in her the view that distress is a symptom of a disease that must be eradicated; but this is not to say that episodes of madness ought to be encouraged, as they were at Kingsley Hall; but rather, it is to say that understanding the *meaning* of pain might help the sufferer get past it.

Psychiatric survivors also say that their experience in the mental health system prevents them from earning esteem from the wider community. They claim that the idea of mental patients as potentially "dangerous" and therefore not deserving of due process encourages people to see them as excluded from the human commonwealth; it also in many cases leads to fear of the deinstitutionalized who might live in their communities.<sup>208</sup> As many psychiatric survivors have pointed out, the idea that the emotionally troubled among us are "sick" is not stigmatizing, but has the opposite effect of inviting others to dismiss all the individual's beliefs, actions and utterances as the signs of disease.

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<sup>208</sup> Shimrat, p. 122; Capponi, p. 194.

Activists say further that psychiatrization keeps people out of the workforce not only through extended hospitalizations but also because of the side-effects of psychotropic medications, and the sheer force of the label “mentally ill” itself;<sup>209</sup> the exclusion from meaningful work often means being considered unworthy of social esteem.

Hence the significance of the psychiatric survivor activist movement: it provides a subculture that creates the conditions for mutual esteem between ex-patients. As one survivor says, “community arises from meaningful encounters with other people. The encounters are generally with fellow inmates who share the same suffering, the same dreams, the same tasks.”<sup>210</sup> Because this is the case, members of this community are uniquely positioned to recognize traits in each other that are worthy of esteem. Some members are singled out as being good public speakers, others as good organizers, others as good, sensitive listeners, etc. In the words of one patient, “Finally, here are people I can talk with about myself and feel comfortable, and not be judged. I’ve been able to make and sustain friendships with people like never before.”<sup>211</sup>

The movement also enables ex-patients to struggle for recognition from the wider community and thereby forge a new “relation-to-self.” Fragmented experiences now become “the moral motives for a collective ‘struggle for recognition.’”<sup>212</sup> This aspect of the movement is not frequently thematized as a struggle for recognition, but in my view the very existence of the movement attests to it. The psychiatric survivors’ movement calls for more pluralism in social values in that it demands an expansion the range of behaviours considered acceptable by society; it also asks for society’s recognition that

<sup>209</sup> Shimrat, p. 108.

<sup>210</sup> Burstow and Weitz, p. 29.

<sup>211</sup> Shimrat, p. 109.

<sup>212</sup> *The Struggle for Recognition*, p. 164.

people need jobs,<sup>213</sup> quality housing,<sup>214</sup> and love<sup>215</sup> in order to feel good, rather than drugs, ECT, and hospitalization. I would like to close with a quotation from Shimrat, on what she believes the achievements of the movement have been:

We have done effective advocacy both inside and outside psychiatric facilities. We have changed mental health legislation, won compensation for victims of psychiatric abuse and played key roles in court cases involving crazy people. We have developed convincing arguments about the non-existence of mental illness, psychiatry as social control, psychiatric drugs as chemical straitjackets, psychiatry's inability to predict dangerousness, and how the community mental health system infantilizes people.... We have taken the focus off the defects of those who've been through the mental health system and put it on their strengths.<sup>216</sup>

All the above endeavours are aimed at securing the recognition from the community that mental patients are worthy of social esteem.

### **Justifying Respect**

In the previous section, I showed how the experience of disrespect can be damaging to a person's relation-to-self. This is merely an empirical claim about human psychology, and it begs the larger philosophical question: why should we even care about the psychological damage suffered by people who do not stand in any particular relationship to us? A critic could make the objection that those diagnosed with "mental illness" somehow do not *merit* respect in the first place; indeed, this is the unspoken, and

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<sup>213</sup> One man who owns a farm that employs exclusively ex-psychiatric patients says, "It's hard for some professionals to accept that this is good stuff we're doing here. They feel that we should be sitting in an office talking to people. They don't recognize the value of work and how people need to be valued through their work." Shimrat, p. 161.

<sup>214</sup> Pat Capponi's *Upstairs in the Crazy House* documents the horrible living conditions endured by the deinstitutionalized in Toronto.

<sup>215</sup> Activist Lanny Beckman says, "I think that when people are in a lot of pain they need to be with someone who'll love them. And you don't get love in psychotherapy." Shimrat, p. 55.

<sup>216</sup> Shimrat, p. 152.

perhaps dark, underside of arguments that purport to show that sanity = rationality = personhood.<sup>217</sup> However, it is my view that those diagnosed as such *do* in fact deserve respect, although this cannot be justified by an appeal to any particular human trait.

Kantian ethics is the point of departure for many philosophical explorations of the idea of respect for persons, and many have borrowed his idea that our respect for others derives from their status as rational beings. This idea is contained in Kant's *Groundwork of the Metaphysics of Morals*, where we find many of the famous formulations generally associated with his moral theory including his description of the "Kingdom of Ends," a theoretical community of rational beings whose wills necessarily accord with the universal law.<sup>218</sup>

Kant says that each rational being in the Kingdom of Ends treats all other rational beings as ends in themselves and never merely as means. To treat someone as a means is to treat her as having a price; it is to treat her as something that is interchangeable with something else. Human beings do not have a price – they have a dignity, or in other words, intrinsic worth.<sup>219</sup> This is because the transcendental capacity for morality, which distinguishes human beings from all other creatures, has itself intrinsic value. Whereas the goods which we buy in order to subsist – food, clothing, shelter – have a market price, and the goods we enjoy because they lead to our pleasure have what Kant calls a "fancy

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<sup>217</sup> Moore, for example, says that "absent such an assumption of rationality, one cannot be fully regarded as a person, for our concept of what it is to be a person is centred on assuming rationality in the senses introduced earlier"; he goes on to add that the mentally ill "lack an essential attribute of our humanity" (Moore, p. 41). In my view, this implies that the mentally ill need not be treated as fully human.

<sup>218</sup> Kant, *Groundwork of the Metaphysics of Morals* (Cambridge, England: Cambridge University Press, 1997), p. 41.

<sup>219</sup> Kant, p. 42.

price,” goods such as kept promises, kindness to others and following duty in general are goods *in themselves*.<sup>220</sup>

According to Kant’s moral philosophy, respect for persons is justified insofar as they are rational and autonomous lawgivers within the Kingdom of Ends. What are the implications of such a view for those who are deemed not to be rational – does this mean that they are not worthy of respect? This question is difficult to answer, not only because Kant himself did not discuss the possible exceptions to his theory, but also because his philosophy is so uncompromisingly transcendental that it is not clear whether madness is merely an empirical and therefore irrelevant consideration. Indeed, the difficulty of accounting for such exceptions leads philosophers to shunt the issue of the mentally ill to the margins when discussing justifications for respecting human beings. Bernard Williams, for example, decides to omit from his article on equality and respect “the clinical cases of people who are mad or mentally defective, who always constitute special exceptions to what is in general true of men”<sup>221</sup>; Habermas likewise excludes the paradigmatically irrational mentally ill person from his ethical theory, since he thinks that morality inheres in rational communication intelligible amongst members of a community.<sup>222</sup>

By contrast, R.S. Downie and Elizabeth Tefler do not shrink from the task of justifying respect for those we do not regard as rational, namely, children, animals, “lunatics,” and the senile: “that [such cases] present difficulties to any theory of morality

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<sup>220</sup> Kant, p. 43.

<sup>221</sup> Bernard Williams, “The Idea of Equality,” in *Problems of the Self; Philosophical Papers 1956-1972* (Cambridge, England: Cambridge University Press, 1973).

<sup>222</sup> Habermas, *The Theory of Communicative Action Volume 1*, p. 17.

is not really an excuse for failing to make an attempt to account for them.”<sup>223</sup> They argue that it is not a matter of moral indifference how we treat children, animals and the mentally ill, even though they are not rational and lack personhood in varying degrees. The authors claim that these beings are sentient, and that for this reason they resemble persons (in the sense of rational beings) enough for us to justify respect for them.<sup>224</sup> This is, however, a respect that is granted as *an extension* of that which we feel towards those we deem to be persons in the full sense. Downie and Tefler say that we cannot derive a justification for respect from exceptional cases by themselves; rather, we require the prior experience of respecting rational human beings before we can extend respect to the non-rational. Respect for the non-rational, then, is analogous to but not the same as respect for rational persons.

I find this attempted solution unsatisfying. First of all, it would provide only a very weak justification for respecting those whom psychiatrists diagnose as “irrational.” Granting respect to the non-rational as a kind of gesture of ethical largesse – as an imitation of the prior respect we feel for normal adults – does not provide a compelling reason to honour any demands that we respect these beings. Secondly, the derivation of respect from sentience seems wrong: the adoption of this criterion prevents Downie and Tefler from differentiating between children, the insane, and animals within the class of sentient but non-rational creatures in their discussion. It does not seem to me, however, that our respect for children and our respect for animals derive from the same source, or manifests themselves in the same ways; moreover, to say, as Downie and Tefler do, that

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<sup>223</sup> R.S. Downie and Elizabeth Tefler, *Respect for Persons* (Condon: George Allen and Unwin Ltd., 1969), p. 34.

<sup>224</sup> Downie and Tefler, p. 35.

it is not a matter of indifference how we treat “children, the senile, lunatics and animals”<sup>225</sup> and then go on to discuss them as a class obscures the differences between these cases. The mainstream conception of respect for animals requires that we not treat them cruelly; but surely this minimal requirement is not what we have in mind when we say that we have respect for children or those with Alzheimer’s Disease.

The attempt to ground respect in the trait of rationality is problematic because it cannot accommodate respect for many living beings that are not considered rational, but whom our intuitions tell us deserve respect. While Downie and Tefler try to stretch the Kantian ethical tradition to cover these exceptional cases, others find it more fruitful to abandon altogether the search for a justifying trait. Margalit, for example, thinks that “the case of the retarded seems...to constitute a serious reason not to base the attitude of respect for humans on a Kantian justifying trait such as rationality, moral capacity, or the like.”<sup>226</sup>

We are left with the original question: why respect human beings? Is there any solid reason for not abusing or humiliating human beings aside from asserting that abstaining from cruelty is just “*what we do*”? I think the best answer to this question can be found in Margalit’s “negative justification” for respecting human beings. Margalit says that the negative justification “means not aspiring to provide a justification for respecting people, but only for not humiliating them.”<sup>227</sup> His account, then, departs from the Kantian moral tradition’s search for justifying traits, but does not pursue the dubious strategy of grounding respect in our often less-than-perfect everyday practices.

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<sup>225</sup> Downie and Tefler, p. 34.

<sup>226</sup> Margalit, p. 81.

<sup>227</sup> Margalit, p. 84.

Margalit's argument hinges on an understanding of humiliation as a kind of cruelty.

Cruelty is the ultimate evil. Preventing cruelty is the supreme moral commandment. Humiliation is the extension of cruelty from the physical to the psychological realm of suffering. Humiliation is mental cruelty. A decent society must be committed not only to the eradication of physical cruelty in its institutions but also to the elimination of mental cruelty caused by these institutions.<sup>228</sup>

It is self-evident that cruelty is wrong, says Margalit; moreover, "psychological abuse is part of the meaning of cruelty."<sup>229</sup> On these grounds we can demand respectful (i.e. non-humiliating) treatment from others and from society's institutions without having to justify such treatment by appeal to a trait such as rationality, which, as we have seen, in Chapter One and above, is not unproblematic. But since even "irrational" human beings are capable of feeling humiliated, any society that aspires to decency has an obligation to avoid humiliating them. Margalit's theory, then, gives us a more compelling reason for respecting the non-rational than the reason Downie and Tefler suggest.

The advantage of Margalit's account over those that are situated within the Kantian tradition is that it places emphasis on the individual's experience of humiliation. His account can suggest moral reasons why mental patients should not be treated as children, incarcerated or drugged against their will, or stigmatized by labels – even when their behaviour does not seem rational to everyone else. In short, Margalit's theory provides a basis for saying that the ascription of irrationality does not in itself justify any kind of treatment whatsoever; and further, it does so without having to resort to rather

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<sup>228</sup> Margalit, p. 85.

<sup>229</sup> Margalit, p. 87.



Procrustean efforts to make Kantian ethics say something meaningful about the  
“exceptions.”

## CONCLUSION

I have tried to show that the issue of humiliation – which is front and centre in the writings of psychiatric survivors – rarely arises in the literature on psychiatric ethics. This is a serious oversight, since humiliation can be understood as a form of cruelty, and avoiding all cruelty (physical or psychological) is the quintessential moral commandment. Systematic neglect of the patient's point of view allows psychiatric ethicists to remove issues of humiliation to the sidelines. By ignoring the patient's point of view, psychiatric ethicists can proceed as though humiliation at the hands of psychiatry is a thing of the past, despite protestations from psychiatric survivors that humiliation continues even now.

My focus on the experience of the patient is meant as a corrective to the standard attitude in psychiatric ethics. Considering the first-person accounts of people who have been hospitalized invites us to see them as human beings, and makes it harder to dismiss the "mentally ill" as gibbering, dangerous individuals who lie outside the human commonwealth due to their irrationality and non-responsibility. Though no psychiatric ethicists I have considered explicitly draws the conclusion that it is a matter of moral indifference how society treats mental patients, there is precious little in these ethicists' writings to support the notions that mental patients have dignity and that they ought to be treated with respect. I have tried to suggest a philosophical basis for these notions, deriving not from Kantian ethics, but from Margalit's idea of a negative justification for respect for human beings.

As for the question of why scant attention is paid to the perspective of the patient: I suggested that the “objective attitude” as described by P.F. Strawson can help us understand certain phenomena arising from the clinical psychiatric encounter and, correspondingly, the reluctance of psychiatric ethics to admit that many people feel that psychiatric intervention has harmed them. We will remember that when we adopt the objective attitude toward someone, we see her as a problem to be solved or as something to be controlled, studied, cured or trained,<sup>230</sup> and that the objective attitude is incompatible with normal reactive emotions such as gratitude and resentment. This is not to say that the objective attitude is never appropriate. Strawson says that we can adopt the objective attitude in particular situations, for example, as a response to extraordinary stresses and strains that might arise in our relationships with others. Objectivity of attitude is also appropriate, on his view, in cases where study, policy or treatment demand it. For these reasons, Strawson thinks that the objective attitude is the only civilized attitude to take toward those who are psychologically abnormal.<sup>231</sup>

Though I concede that the objective attitude is sometimes appropriate, I do not think that our dealings with the “psychologically abnormal” ought to be characterized by a thoroughgoing objectivity of attitude, for two main reasons. First, as we saw in Chapter Two, Habermas describes the objective attitude as an epistemological stance that understands phenomena from a detached, third-person perspective; as such, it cannot address the normative claims internal to the phenomena to be understood. Psychiatrists (and the ethicists who legitimize psychiatric practice) tend to explain patient behaviour solely as the result of particular causes and do not endeavour to take on the second-

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<sup>230</sup> Strawson, p. 9.

<sup>231</sup> Strawson, p. 11.

person stance of an interlocutor who tries to understand the *meaning* of the behaviour, or the normative claims that might be embedded in their behaviour. As a result, psychiatrists' explanations are often reductionist (for example, in seeing distress as a purely, or even predominantly, bio-chemical problem requiring a bio-chemical solution) or insensitive to the reasonableness of a patient's behaviour in reaction to extraordinary social or family circumstances. The effectiveness of psychiatry in alleviating distress is diminished when doctors strive to be good psychiatrists at the expense of being good psychologists (in the lay sense).

Secondly, the objective attitude can be equated with a crude sort of instrumental, utilitarian view of human beings that I do not think is appropriate as a general policy for dealing with the so-called "mentally ill." Seeing a person as a thing to be controlled or taken account of might be unavoidable or necessary in limited circumstances, but we ought never to forget that treating a person in this way can efface that person's dignity and humanity. Still, psychiatric ethicists often do forget it. The article by Grisso and Appelbaum discussed in Chapter Three illustrates this point. Their discussion of "dangerousness" takes for granted the idea that protecting society at large by locking up certain "mentally ill" individuals (though the overall efficacy of such interventions have not been and probably cannot be established) overrides the right of the individual to be punished only for deeds she has committed and not those which statistics say she will *probably* commit. In a similar vein, Reznek's utilitarian calculation of the benefits and risks of treating children with Ritalin prioritizes social control and docility at the expense of the health of the child (for drugs such as Ritalin have side effects) – not to mention that

widespread psychiatric labeling, especially at such an early age, might be something many of us might not approve of.

While we might criticize these authors' views as particularly gross examples of the objective attitude, is it reasonable or realistic to expect psychiatrists as a whole to abandon the objective attitude towards their patients in favour of the participant attitude? This is a very difficult question to answer. Certainly there are individual psychiatrists (Dr. Peter Breggin, for example) who do pride themselves on helping their patients not by prescribing drugs but by listening patiently and providing sensitive input. Whether psychiatrists can learn such an attitude as part of their training is dubious, and whether the participant attitude is compatible with the bureaucratic imperatives of a state-regulated institution is even more dubious. Unquestionably, improvements can be made in the treatment given to patients so that it is less humiliating. But I am inclined to agree with the activists quoted toward the end of Chapter Three that many people, in order to heal, need meaningful work, decent housing and love, and that psychiatry cannot provide these.

Nevertheless, promising alternatives to psychiatry do exist. Peer support organizations, drop-in centres staffed by ex-patients, and political engagement with the psychiatric survivors' movement are all embryonic (because they are relatively new and not particularly widespread) alternatives to medical intervention. In addition, crisis centres like Toronto's Gerstein Centre show that it is possible to treat those in severe psychological distress as autonomous individuals deserving of respect – guests are able to come and go as they please, wear their own clothes, and they do not have to share a bedroom with others; moreover, guests are not required to participate in talk sessions

with staff, but when they do need to talk to someone they do not wait more than ten minutes for a staff member to become available.

Of course, expecting psychiatric institutions to give way to patient-directed alternatives would be utopian. Nevertheless, it is important that such alternatives exist not only as a resource for people who need them, but also as a moral example which shows that there are alternatives to treating the so-called “mentally ill” as objects.

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