

1. Title:

Psychological Disadvantage and a Welfarist Approach to Psychiatry: An Alternative to the DSM Paradigm

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Psychological Disadvantage and a Welfarist Approach to Psychiatry

Abstract: The American Psychiatric Association released the fifth edition of its *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)* in May 2013 amid criticism from the British Psychological Society and other eminent voices. Among DSM-5's problems are its over-emphasis on biological causes of mental distress and its classification of arguably normal states as disorders. We explain why these strategies are harmful and argue that the purpose of psychiatry—and of medicine generally—must be reconsidered if advances in medicine are to be effective in benefiting people. We advance an alternative framework in which medicine focuses not on disease but on psychological traits that, combined with other factors, reduce well-being. This 'welfarist' approach could avoid many problems encountered on the current model, bring order to those aspects of current medical practice that do not focus on curing disease, and target undesirable states regardless of whether they are symptomatic of disease. We call such states 'psychological disadvantage'.

Keywords: over-diagnosis, welfarism, disease, mental health, mental illness, nosology, enhancement, psychiatric classification, goals of medicine.

1. An explosion of mental illness

There is an apparent epidemic of mental illness. At the end of 2011, untreated mental disorders accounted for 13% of the total global burden of disease, and for 25.3% and 33.5% of all years lived with a disability in low- and middle-income countries, respectively (World Health Organization 2011: 1). Depression affects 350 million people globally and is the leading cause of disability (World Health Organization 2012). One in five US adults takes psychiatric medication (Frances 2013: xiv). One study found that by age 32, 50% of people surveyed qualified for an anxiety disorder, over 40% for a mood disorder, and over 30% for substance dependence (Moffitt et al. 2010). Another study reported that, by age 21, over 80% of people qualified for a mental illness (Copeland et al. 2011). Over the fifteen-years to 2013, cases of ADHD in US children trebled, cases of autism increased twentyfold, and cases of childhood bipolar disorder increased fortyfold (Frances 2013: 104).

This rise in mental illness is due to at least three factors: increased willingness to diagnose mental disorders, relaxation of diagnostic criteria, and invention of new mental disorders. Increasingly, psychiatry is expanding to include conditions that, whilst undesirable, are not intuitively symptomatic of mental disorder. For example, DSM-5 includes the following conditions: fear of speaking in front of an audience (social anxiety disorder), depressive symptoms experienced two weeks after the death of a loved one (major depressive disorder), irritability and episodes of extreme behavioural dyscontrol in children (disruptive mood dysregulation disorder), a difficult-to-resist urge to bite the nails (body-focused repetitive behavior disorder), and smoking tobacco when

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one both craves to do so and persistently desires not to do so (tobacco use disorder) (APA 2013a, APA 2013b).

This ‘pathologisation’ of normal human traits has raised concerns from—among others—Professor Allen Frances, chair of the Task Force responsible for producing DSM-IV in 1994 (Frances 2013), the British Psychological Society (BPS 2011, BPS 2013), and the medical sociologist Professor Peter Conrad (Conrad 2007).

2. Diagnosis as a route to treatment

This pathologisation is not all bad, since it helps people alleviate undesirable conditions. For example, whilst intuitively it may seem possible to have poor impulse control without thereby being diseased, children with poor impulse control are more likely—among other disadvantages—to have problems at school (Tobiessen et al. 1971), to suffer social and cognitive problems as adolescents (Mischel et al. 1989), to suffer from antisocial personality disorder and to be involved in crime as adults (Caspi et al. 1996), and to exhibit externalising problems (Caspi et al. 1995). Many children most able to benefit from improved impulse control are among those diagnosed with attention-deficit/hyperactivity disorder (ADHD), and the resulting treatment helps them.

Pathologisation is motivated by the assumption that, in order to be medically improved, a condition must be symptomatic of disease. DSM-5’s definition of mental disorder is flexible enough to enable pathologisation:

A mental disorder is a syndrome characterized by clinically significant disturbance in an individual’s cognition, emotion regulation, or behavior that reflects a dysfunction

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in the psychological, biological, or developmental processes underlying mental functioning. Mental disorders are usually associated with significant distress or disability in social, occupational, or other important activities. An expectable or culturally approved response to a common stressor or loss, such as the death of a loved one, is not a mental disorder. Socially deviant behavior (e.g., political, religious, or sexual) and conflicts that are primarily between the individual and society are not mental disorders unless the deviance or conflict results from a dysfunction in the individual, as described above. (APA 2013: 20)

This definition builds on that of previous DSM editions. As in previous editions, the definition is preceded by a disclaimer: 'Although no definition can capture all aspects of all disorders in the range contained in DSM-5, the following elements are required'. The definition, then, identifies *necessary* conditions for mental disorder, but not *sufficient* conditions. As a result it does not demarcate the pathological from the non-pathological. This opens the door for pathologisation.

That science is increasingly able to improve undesirable traits is, *ceteris paribus*, a good thing. So why is pathologisation objectionable?

3. *The problem with pathologisation*

Frances calls pathologisation 'diagnostic inflation'. He blames DSM-IV's conception of mental disorder for recent 'false epidemics' (Frances 2013: xiv) of childhood ADHD, bipolar disorder, and autism, and he views DSM-5 as likely to exacerbate this situation. He identifies two main negative effects of the current approach to mental health in the US: too many people are being wrongly

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diagnosed with mental disorders and prescribed unnecessary medications, and too many people with genuine mental disorders are not receiving the treatment they need. (Frances 2013, The Diane Rehm Show 2013).

Frances is not alone in his concerns. BPS's Division of Clinical Psychology argued that DSM-5's 'disease model' of 'distress and behaviour' over-emphasises biological factors at the expense of social and psychological factors (BPS 2013: 2-3). BPS views this approach as having the following drawbacks: it encourages the view that psychiatric diagnosis is 'an objective statement of fact' rather than 'a clinical judgement ... subject to variation and bias' (BPS 2013: 3); it encourages the view that medication is the best treatment; and it is 'embedded in a Western worldview' and is therefore 'discriminatory to a diverse range of groups and neglectful of areas such as ethnicity, sexuality, gender, class, spirituality and culture' (BPS 2013: 4).

Without an account of what distinguishes pathology from non-pathology, psychiatric diagnosis is open to abuse for political or ideological ends. There are many historical cases of this. In 1851, the American physician Samuel A. Cartwright described a new psychiatric disease, 'drapetomania', on which he blamed black slaves fleeing captivity (Cartwright 1851). Psychiatric diagnosis was used to control political dissidents in the Soviet Union, Romania and China, and elsewhere (van Voren 2010). In 1940s and 1950s Canada, thousands of orphans were misdiagnosed as mentally ill and transferred from orphanages to psychiatric hospitals, which received more generous federal funding. The surviving 'Duplessis orphans' report that they were neglected and abused (Clément, Undated; Quebec Ombudsman 1997). More recently, homosexuality was classed as a disorder by the APA until 1973, when it was omitted from DSM-

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II. The pathologisation of homosexuality meant that many homosexuals underwent humiliating and traumatic ‘conversion therapies’.

As neuroscience advances, the scope for such abuse increases. The emerging possibility of using neuroscientific techniques to change beliefs has recently led one neuroscientist to speculate that harmful beliefs—such as those associated with religious fundamentalism, and the belief that it is acceptable to beat one’s children—may one day be viewed as mental illness (Nelson 2013). To guard against the abuse of psychiatric diagnosis, we need a firmer account of the conditions under which a condition warrants psychiatric treatment.

Finally, pathologising normality perpetuates a harmful belief in the significance of the difference between disease and normality. Whilst DSM-5 does not draw a clear line between mental disorder and normality, the lives of some people depend on whether they are deemed mentally ill. Under US law, anyone with an intellectual disability—a category that includes everyone with an IQ below 71—avoids the death penalty (Ellis, Undated; Death Penalty Information Center 2011). As a result, some US citizens whose IQs fall close to the threshold have been executed despite the fact that their cognitive capacities are practically the same as those of people deemed intellectually disabled. An example is Teresa Lewis, who had an IQ of 72 (Mann 2010, Guihaire 2010). Whilst the difference between health and illness may not correspond to any clear, scientifically, medically, or ethically significant difference, the cultural importance of this distinction means that whether one is deemed healthy or ill may be literally a life-or-death issue.

There are two reasons why the definition of a psychiatric disorder should be more tightly constrained. The first is that no pathology has been clearly

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identified with psychiatric disorder. Whereas there is a clear diagnostic pathological difference between the brain scan and tissue biopsy of a person with a brain tumour or multiple sclerosis and that of a normal person, there is no such clear pathological difference between the brain of a normal person and the brain of someone with even a 'hard' psychiatric disorder such as schizophrenia.

Secondly, psychiatric disorders invite coercive treatment. The extreme is involuntary treatment but there are strong reasons to persuade people with disorders of the mind to accept therapy just because their mind is affected, including their rationality. Both of these factors open the door to excessive intervention into the minds of people without real pathology.

4. Rethinking mental health and illness

How might these problems be overcome? To reverse the pathologising trend of labelling any psychological dysfunction as a psychiatric disorder, we must reconsider the purpose of psychiatry, and of medicine in general. Historically, the purpose of medicine has been to treat and prevent disease, where diseases are conditions defined by clear pathologies: the presence of a malignant tumour, or a virus, for example. The basic ethical principle governing the practice of medicine is that treatment is offered in the best interests of the patient, who must consent to treatment before it begins.

A new approach requires restricting the term 'psychiatric disorder' to a subset of 'hard' psychiatric diseases. We cannot here outline the criteria for such a redescription. Our focus is the other end of the spectrum: identifying disadvantageous traits that are amenable to medical interventions, yet which should not be considered (in the absence of further pathological information) as

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diseases. We will call this new class *psychological disadvantage*. In this section, we outline its place in medicine.

Medicine is not simply about treating disease

Treating disease—where disease is typically characterized by biological pathology—is widely taken to be the primary focus of medicine. We contend that in deciding whether or not to use medicine to treat a condition, whether that condition is characterized by biological pathology, or otherwise classifiable as a disease, are irrelevant.

Rejecting a disease-focused conception of medicine may sound radical, but in fact much of medicine operates without this conception. For example, the field of obstetrics is not characterised with reference to disease. Much of optometry is concerned with correcting problems that are characterised in terms of their negative effect on patients' lives rather than with identifying and treating diseases. And in many cases what differentiates someone with a medical condition from someone without a medical condition is a matter of arbitrary convention rather than clear biological difference: for example, a person is diagnosed with hypertension if their systolic blood pressure is 140mmHg but not if it is 139mmHg, despite the fact that there is no significant relevant biological difference between the two.

Rejecting the belief that medicine must be concerned with disease deprives pathologisation of its main motivation. If we accept that human traits may be medically improved even when they are not symptomatic of disease, there is no reason to pathologise them. This amounts to endorsing *enhancement*: the improvement of human traits and capacities above and beyond what may be

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considered healthy or normal—as opposed to *therapy*, which restores normality by improving sub-normal traits and capacities.

Even so, endorsing enhancement is controversial, and many object that it is unethical.¹ We have each elsewhere defended the ethical permissibility of enhancement.² Ethical objections to enhancement presuppose some clear, ethically significant conception of normality at which it is acceptable for medicine to aim but unacceptable to exceed. Such a conception does not exist, for reasons we will not rehearse here;³ and the difference between normal and sub-normal is often one of (small) degree rather than kind.

Rather than viewing the primary purpose of medicine as raising the sub-normal up to the level of normality (or ‘health’), we should conceive medicine’s purpose as alleviating biological or psychological disadvantage.

The welfarist account

One of us has argued elsewhere for a welfarist account of disability (Savulescu and Kahane 2011, Kahane and Savulescu 2009). According to this account, a person has a disability if they have some stable psychological or biological state that makes it likely that their life will get worse, in terms of their own well-being, in the social and environmental context they inhabit. This conception of disability makes no reference to normality; as such it does not invite a distinction between treatments that count as therapy and those that count as enhancement. In addition, it makes no recommendation about what is the best way to treat

¹ For example, Fukuyama 2002, Kass 2003, Sandel 2004, Sandel 2007.

² For example, Savulescu and Bostrom 2009, Savulescu 2010, Savulescu et al. 2011, Roache 2008, Roache and Clarke 2009, Bostrom and Roache 2007.

³ For a detailed account, see Kahane and Savulescu 2012; Kahane and Savulescu, Forthcoming.

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disability. The biological, psychological, social, cultural and other factors that contribute to a person's having a disability are relevant only in so far as they negatively impact that person's well-being. The disability may be treated by addressing any one or more of these factors. Whilst it may be appropriate to treat disability by addressing the biological factors that contribute to it—by prescribing medication or surgery, for example—it may also be appropriate, instead, to address non-biological factors. Imagine someone whose leg has been amputated, and who counts as disabled solely because the amputation makes it difficult for her to negotiate the stairs to the second-floor flat where she lives. This combination of factors reduces her well-being. Her well-being will improve if she is fitted with a prosthetic limb; alternatively, it will improve if a lift is installed in the building where she lives. The medical route to treating disability is not the only route; nor is it always the most obvious or appropriate.

We believe that the current approach to mental health and illness should be replaced with a welfarist approach. According to this approach, a person has a mental disability if they have some stable psychological trait (or set of such traits) that makes it likely that their life will get worse, in terms of their own well-being, in the social and environmental context they inhabit. Being diagnosed with a mental disability on this account would not involve an assumption that the patient is sub-normal. Since what counts as a mental disability depends on individual circumstances, a trait could count as a disability for one person but not for another. For example, the tendency to experience unusually high levels of social anxiety is a mental disability for someone—like a politician—whose lifestyle involves many stressful social encounters; but not for someone easily able to avoid such encounters, such as a forest worker. On the welfarist view,

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mental disorders can be reclassified as mental disabilities, where ‘disability’ is understood in welfarist terms. However, to distance ourselves from more familiar models of disability, let us adopt a new, more neutral term: *psychological disadvantage* (PD).

Existing accounts of disease can, for the most part, be divided into naturalist and normative accounts. The welfarist view differs significantly from both. The most influential defender of the naturalist conception is Christopher Boorse (1975, 1976). He defines disease (including mental disease) as an unnatural impediment to normal species functioning. Illnesses are diseases that are, *inter alia*, undesirable for their bearers. Advocates of the normative view—notably, Joseph Margolis (1976, 1980) and H. Tristram Engelhardt, Jr. (1974, 1976)—also view illness as (roughly) unpleasantly experienced disease,⁴ and like the naturalist they define disease with reference normal species functioning. Unlike the naturalist, they contend that the idea of normal species functioning contributes usefully to our conceptions of disease and illness only when viewed through the lens of our social (and other) values. In the context specifically of mental health, Jerome Wakefield’s ‘harmful dysfunction’ account is a normative approach that takes mental disorder to consist in the failure of a natural selection-designed mechanism to perform its function, along with the value judgment that this dysfunction is undesirable (Wakefield 1992a, 1992b, 1999).

Welfarism differs from both naturalism and normativism in that it makes no reference to normal species functioning. PDs are defined instead by their impact on well-being, and even traits associated with normal species functioning

⁴ There are, of course, differences in the details of the distinctions between disease and illness drawn by Boorse, Margolis and Engelhardt that we gloss over here.

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may qualify as PDs in certain conditions. For example, an IQ of 100 may constitute a PD in a culture where the only available jobs are either so boring that they leave all but the least intelligent people frustrated, or so difficult that they are unavailable to all but the most intelligent. Further, both the naturalist and the normativist characterise the badness of illness for the patient in inescapably subjective terms: for Boorse, an illness is 'undesirable for its bearer' (1975: 61), for Margolis it is 'a diseased state that a patient might complain about or that might make him ail' (1976: 241), for Engelhardt it involves 'some form of suffering or pathos' (1976: 259). According to these accounts, then, the patient has the final word on whether she is ill.

By contrast, welfarism characterises PDs in terms of measurable negative impact on well-being. What is involved in promoting well-being differs between patients, depending as it does on each patient's values and interests. But once what is involved in promoting a particular patient's well-being is established, the extent to which her traits and environment impact negatively on her well-being can be assessed and measured independently of her assertions about her suffering. Indeed, the patient can be mistaken about the impact of a trait on her well-being, and on whether a trait qualifies as a PD. For example, a dyspraxic student may mistakenly believe that her dyspraxia reduces her chances of entering university. Accordingly, she over-estimates the negative impact of her dyspraxia on her well-being, and views it as a PD. It may be that, given her lifestyle and environment, her dyspraxia has no negative impact at all on her well-being, in which case her dyspraxia does not constitute a PD. On the welfarist account, then, the final word on whether someone has a PD is not merely the patient's.

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Well-being

There are various views about what constitutes well-being. Derek Parfit and James Griffin both describe three theories of well-being: hedonistic, desire fulfilment and objective list theories. Parfit defines objective list theories in the following way:

[C]ertain things are good or bad for people, whether or not these people want to have the good things or avoid the bad things. The good things might include moral goodness, rational activity, the development of one's abilities, having children and being a good parent, knowledge and the awareness of true beauty. The bad things might include being betrayed, manipulated, slandered, deceived, being deprived of liberty and dignity, and enjoying either sadistic pleasure, or aesthetic pleasure in what is in fact ugly. (Parfit 1984, p.499)

Objective list theorists include Aristotle, Plato, Aquinas, Leibniz, Adam Smith, Hegel, Marx, and Nietzsche.

Purely objective accounts of well-being are controversial, but there is good reason to take well-being to include an objective element. Amartya Sen has argued that taking well-being to consist solely in subjective assessments (that is, in people's assessments of their own happiness) makes subjective accounts of well-being vulnerable to adaptive preferences: the phenomenon that people adjust their expectations to their circumstances, so that someone in deprived circumstances will expect less from life than someone in wealthier circumstances, and the two may give roughly similar subjective assessments of

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their well-being. Assuming that we believe that it is bad for people to live in deprived circumstances, this indicates that we should take into account more than people's subjective assessments when assessing their level of well-being.

Another reason not to rely solely on subjective considerations when assessing well-being is that subjective well-being (that is, people's own assessments of how well-off they are) tends not to be permanently affected either by catastrophe or good fortune, as some well-known studies attest. For example, people who become paraplegic suffer an initial decrease in happiness, but after a period of adaptation they report themselves to be about as happy as they were before becoming paraplegic (Kahneman and Varey 1991); and winning the lottery increases winners' happiness only temporarily (Brickman et al. 1978).

Within our conception of well-being, we want to allow for the possibility that in the long term becoming paraplegic can be bad for a person and that winning the lottery can be good for a person. Allowing for this possibility requires factoring objective elements into our conception of well-being; for example, allowing that loss of independence, loss of mobility, and increased financial security can affect a person's well-being in a way that does not depend entirely on how an individual responds emotionally to these things. This conception fits with some plausible moral intuitions. For example, there are few who would not strongly condemn a surgeon who, in the absence of reasons making it very difficult or impossible to do so, failed to perform a procedure that could reverse a patient's paraplegia following an accident, and who defended this decision by observing that the patient will, in time, adapt to paraplegia.

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Recognising that there are problems with taking well-being to consist solely in subjective considerations does not entail that subjective considerations are irrelevant to well-being, and their value is recognized by many philosophers who take objective factors to be necessary components of well-being. Contemporary such philosophers include Parfit, Griffin (1986), Sen (1999), and Nussbaum (2010). Our goal in this paper is not to set out a comprehensive solution to assessment of the objective component of well-being but to show how it is important and provide a suggestive approach.

There is good reason to hope that adopting welfarism would help us address at least some of the serious problems with the current approach that we have described here relating to diagnosing mental illness. Let us reconsider these problems from a welfarist perspective.

5. Why the welfarist account is better

Moving away from the biology-focused disease model, and considering instead the entire range of factors that combine with psychological factors to reduce well-being, would reduce the current emphasis on medication as a means of treating PDs. The person, described above, whose high social anxiety qualifies as a PD would be 'diagnosed' as such by considering his high social anxiety in the context of his lifestyle, society, culture, and so on. (For simplicity, let us subsume all non-biopsychological factors that may contribute to a PD under the term 'environment'.) It seems likely that, by attending to these environmental factors, both patients and doctors would be led to consider ways to treat PDs that do not target biopsychological factors. Someone whose high social anxiety qualifies as a PD could be helped by medication, talking therapy, or a career or other lifestyle

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change; none of which, in the absence of further information about the patient and his preferences, stands out as the best or most obvious option. That welfarism would widen the range of possible treatments for PDs would be a positive step for patient choice and autonomy.

If well-being has partly subjective (desire-fulfilment and hedonistic) as well as objective components, then welfarism could also help discourage the view, ascribed by BPS to DSM-5's disease model, that a psychiatric diagnosis is always an objective statement of medical fact. This is because the patient's own evaluation of how her well-being can best be promoted plays a key role in the diagnosis of a PD, and in the choice of treatment. Given this increased patient involvement, we might also expect welfarism to help address the shortcomings of the current model, identified by the BPS, relating to marginalisation of patients' views, experiences, and cultural context.

Removing the prescription of medication as the knee-jerk response to psychiatric diagnosis may also help address a problem identified by Frances: that many people in need of psychiatric assessment are currently not getting it because doctors are too quick to offer medication on the basis of brief consultations. On the model we propose, diagnosing a PD would simply not be possible without attending to the individual context of the patient. Doctors would be forced to look beyond the biological aspects of a psychological trait; indeed, in many cases the biological factors may be irrelevant or among the least relevant. The welfarist approach encourages doctors to get to know patients, which would be a step towards ensuring that those most in need of expert psychiatric assessment get the attention they require.

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To the extent that there would be far fewer universally-applicable diagnoses of PDs, we may hope to reduce discrimination and stigmatisation of those in receipt of a diagnosis. This is partly because there would be fewer accurate generalisations about what those diagnosed with PDs are like; and partly because all of us suffer some PDs. We all have psychological traits that, to a greater or lesser extent, make our lives worse given the environments we inhabit and which limit the realisation of our potential. These may be as debilitating as severe depression or as mild as a tendency to procrastinate. There would not, then, be a well-defined group of ‘mentally ill’ people to stigmatise. Whilst this is unlikely to eliminate stigmatisation and discrimination—these attitudes hardly require accurate generalisations about those at whom they are directed—emphasising that PDs affect us all would be a step towards breaking down the perceived divide between the mentally ill and the normal.

We also saw that whether or not someone may be deemed mentally ill may have life-or-death consequences, as when a prisoner’s IQ is taken into account when deciding whether or not they are eligible for execution in the US. That our proposed model challenges the idea that there is a neat, objective divide between the normal and the ill may discourage placing such great weight on judgments about people’s mental health. For legal purposes, it may sometimes be necessary to draw sharp dividing lines: between the ill and the healthy, the guilty and the not guilty, those who must be punished by imprisonment and those not, and so on. However, adopting welfarism would help discourage the belief that such lines correspond to ethically or medically significant divisions. Ethical concerns about the relevance of IQ to decisions about the execution of prisoners are dwarfed by ethical concerns about the justifiability of the death penalty; but

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until these bigger ethical concerns are addressed, a move towards welfarism may provide a basis on which to argue for decisions about the fate of prisoners to be made on a case-by-case basis of decisional competence and capacity for responsibility rather on judgments about mental health that are taken to be universally applicable.

There are, then, at least *prima facie* plausible reasons to believe that welfarism would help solve some of the serious problems plaguing the current model of mental health. The extent to which it would indeed solve these problems is impossible to predict: it depends not only on the details of the welfarist account but on the way in which it is implemented in practice, and the smoothness of the transfer from the current model. That it addresses many of the most serious *theoretical* concerns about the current model is a promising start, however.

There is one concern mentioned above that we are yet to address: the problem of the abuse of psychiatric diagnosis. This sort of abuse—which occurs, for example, when political dissidents are deemed mentally ill and incarcerated as a means to control them—involves providing psychiatric treatment for reasons other than to promote the best interests of the patient. There are many, less controversial, examples of this practice. For example, providing psychiatric treatment to paedophiles and psychopaths for their conditions is motivated by a desire to prevent them from harming others rather as much as a desire to promote their interests. This raises the question of whether, and under what circumstances, it is ever permissible to provide psychiatric treatment to a person for reasons other than to promote their interests. We consider in the next section how this question might be addressed on the welfarist view. In doing so, it will

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be helpful to look beyond the field of mental health medicine, and consider the purpose of medicine more generally.

6. Medical practice: its purpose and goals

Consider the following table, which will be useful for comparing welfarism with the more familiar conception of medicine.

		<i>Medical purposes</i>	<i>Non-medical purposes</i>
<i>Personal welfare enhancement</i>	<i>Direct</i>	E.g. surgery to remove malignant tumour	E.g. vasectomy, abortion, tubal ligation, contraception
	<i>Indirect</i>	E.g. live organ donation to a loved one	E.g. cognitive enhancement to improve parenting skills
<i>Social welfare enhancement</i>		E.g. rubella vaccination to protect a future foetus	E.g. psychiatric treatment of paedophiles and psychopaths
<i>Personal autonomy enhancement</i>	<i>Direct</i>	No possible treatments	E.g. gender reassignment surgery, amputation of BIID patient's healthy limb, 'conversion' therapy for homosexuals
	<i>Indirect</i>	No possible	E.g. circumcision of

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		treatments	children for religious reasons
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We have already noted that, currently, the purpose of medicine is taken to be treating disease according to the best interests of the patient. This conception is captured by only one box in the table above: that representing direct personal welfare enhancement for medical purposes. What does this mean? Well, surgery to remove a malignant tumour is for *medical purposes* (as currently conceived) in that it aims to treat a disease—or, in more general terms, to restore a state of sub-normal health to normality, as opposed to improving a normal state beyond what is considered normal. The treatment is an example of *personal welfare enhancement* in that it aims to improve the welfare of the patient, rather than that of someone else. And this personal welfare enhancement is *direct* in that the treatment attempts to intervene in the body or mind of the patient in a way that is supposed to improve her welfare: a factor that will become clearer when we compare it to indirect enhancements below.

A quick glance at the table reveals that the category of direct personal welfare enhancement for medical purposes does not exhaust the procedures currently undertaken by contemporary medicine: every treatment mentioned in the table (except for cognitive enhancement to improve parenting skills) is part of medicine. The view that medicine is about treating disease in the interests of the patient, then, does not even capture all of what goes on in contemporary medical practice. All the more reason, then, to make explicit the full range of what medicine does involve.

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In addition to direct personal welfare enhancement for medical purposes, there is direct personal welfare enhancement for *non-medical purposes*. As we have noted, non-medical purposes aim not at treating disease, but at improving on what is considered healthy or normal. Examples of such interventions are given in the table; these examples are widespread in modern medical practice.

Would the welfarist approach dictate that we prescribe cognitive enhancers for students who declare they need them (or desire them) for their well-being? And if we have to prescribe them, do we say, only 10 mg daily of Adderall for each student? And for the student who insists he needs 60 mg? We have elsewhere considered the ethics of enhancement (Savulescu 2007c, Savulescu *et al.* 2011, Bostrom and Roache 2007, Roache 2008, Roache and Clarke 2009) The only reasons to limit prescription of cognitive enhancers are the safety of the intervention for the user; the potential of the use of the intervention to cause harm to others (as might happen if it had a side-effect of uncontrollable aggression, or if it placed others at an unfair competitive disadvantage); and distributive justice. In the case of parents requesting interventions for their children, we can add that the parent's choices should be based on a plausible conception of well-being and a better life for the child, and that prescription of the intervention should be consistent with development of the child's autonomy and with a reasonable range of future life plans (Savulescu 2007).

Do the prescription of cognitive enhancers constitute gaining unfair advantage? Cognitive enhancement of low normal may be necessary to correct natural inequality (Savulescu 2006, Dunlop and Savulescu 2014), but even within the normal range it is not clear that cognitive enhancement poses a

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greater threat to equality than many familiar methods of improving academic performance (Roache 2008).

Another difficult issue is that, in some cases, patients and doctors may disagree about whether and how to treat a particular condition. This can happen, for example, with some psychiatric conditions like schizophrenia, and it illustrates that identifying a particular condition as a disease is sometimes not the final word about whether to treat it. In such cases, consideration must be given to the patient's welfare, broadly conceived to include factors other than health. The advantage of welfarism over the current medical model is that it focuses on the central issue of welfare and asks: what is a mixed subjective/objective account of well-being in this person's case and what is the evidence that potential interventions (including biological, psychological, environmental) will have a favourable effect on that?⁵

Indirect personal welfare enhancement occurs when a patient undergoes treatment primarily to benefit a loved one, as in cases where a healthy parent donates a kidney to his child, who is in need of transplantation. The patient's welfare is enhanced as a result of the satisfaction derived from seeing a loved one benefit.

What of *social welfare enhancement*? Sometimes, people are treated primarily for the benefit of others. The patient, in such cases, may even be harmed. An example of social welfare enhancement for medical purposes is rubella vaccination. Rubella is a relatively mild illness; however, babies of pregnant women with rubella may suffer congenital rubella syndrome, a far more serious and disabling condition. People receive rubella vaccinations, then,

⁵ We are grateful to an anonymous reviewer for drawing our attention to these challenges.

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not primarily for their own benefit, but for the benefit of others (the as-yet unborn). Because of this, rubella vaccination is a social welfare enhancement. Moreover, it is a social welfare enhancement for medical purposes, since it aims to prevent a disease.

Social welfare enhancement can also aim at non-medical purposes. Consider paedophilia and psychopathy. Under the terms ‘pedophilic disorder’ and ‘antisocial personality disorder’, these conditions are classed as mental disorders in DSM-5—but why? It is relatively easy to see why paedophiles and psychopaths—for brevity, we will continue to use these terms, rather than DSM-5’s terminology—who are distressed by their condition might be said to suffer from a disorder. But what of paedophiles and psychopaths who are happy with the way they are?

For those reflecting on how best to define and classify diseases, happy paedophiles and psychopaths present an interesting case, and they have been discussed elsewhere in the disease literature. For example, Robert Spitzer argues that paedophilia and psychopathy plausibly result from the dysfunction of a natural selection-designed mechanism, and that, since this dysfunction is harmful to others, even happy paedophiles and psychopaths count as mentally disordered on Wakefield’s harmful dysfunction account (Spitzer 1999). There are other evolutionary explanations for the persistence of psychopathy in the population (Raine 2013). According to Rachel Cooper’s conception of disease, ‘[a] condition can only be a disease if it is a bad thing for the potential patient’; thus, whilst paedophiles and psychopaths who have second-order desires (desires about desires) to be rid of their harmful first-order desires do count as diseased, paedophiles and psychopaths who are happy with their harmful first-

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order desires are not diseased, on this conception. Cooper observes that '[o]bviously, claiming that paedophilia need not be a disease is fully consistent with claiming that it is a bad thing for other reasons' (Cooper 2002: 276).

DSM-5's diagnostic criteria for pedophilic disorder and antisocial personality disorder do not require the patient to be distressed by her condition, so happy paedophiles and psychopaths are considered disordered alongside unhappy ones (although, of course, the unhappy ones can be expected to be more likely to seek psychiatric help, and thus more likely to receive a diagnosis). In both cases, the disorder is characterised in terms of the subject's (potential) harm to others. Treating paedophiles and psychopaths, then, aims primarily at social welfare enhancement. Is such enhancement for medical or for non-medical purposes? That these conditions are characterised in DSM-5 as mental disorders suggests that we should class their treatment as medical. Yet the reasons for classifying them as disorders are exhausted by concerns about the patient's (potential) harm to others, which is captured by classing their treatment as social welfare enhancement, independent of specifying further whether such treatment aims at medical or non-medical purposes.

Welfarism enables a more nuanced account of paedophilia and psychopathy. As we have outlined it so far, welfarism about mental health characterises PDs with reference to the well-being of the patient. In objective terms, such lives are deficient—Parfit mentions 'moral goodness' as an element of well-being, and neither paedophiles and psychopaths are morally good, at least assuming they act on their harmful desires. Since the account of well-being that we endorse here includes objective elements, then, paedophilia and

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psychopathy count as PDs in cases where the subject acts on their harmful desires, regardless of whether or not the subject is happy to have the condition.

In considering a welfarist approach to paedophilia and psychopathy, we have so far been taking into account only the impact of these conditions on the subject's own well-being. However, the main problem with paedophilia and psychopathy is, of course, their potential to cause significant harm to others. Welfarism can accommodate this intuition by recognising that in deciding whether or not a given condition can be deemed a PD, it is relevant to take into account social welfare as well as the welfare of the subject. In most cases where people seek out medical interventions, social welfare is not an important consideration, because most of the conditions we wish to treat do not have a significant impact on the welfare of others. But in a few cases, like paedophilia and psychopathy, a person's condition can have a very significant impact on social welfare, to the extent that social welfare is the main consideration when classing the condition as a PD.⁶ Because of this, treatment of paedophiles and psychopaths is classed in the table above as a social welfare enhancement for non-medical purposes.

Whilst there is undoubtedly a societal need to prevent paedophiles and psychopaths from harming others, should we be disturbed by the welfare approach's concession that social welfare may sometimes trump personal welfare? Might this concession pave the way for personal welfare to be cast aside

⁶ Whilst we endorse a conception of well-being that has both subjective and objective elements, it is worth noting that recognising the importance of social welfare to the question whether a given condition constitutes a PD would enable even a brand of welfarism based on a purely subjective account of well-being to class paedophilia and psychopathy as PDs. Without taking into account the importance of social welfare, happy paedophiles and psychopaths would raise a problem for welfarists who are subjectivists about well-being, because they would be unable to explain what is bad about these conditions.

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in favour of morally dubious political ends? We might, for example, imagine an immoral government appealing to a need to promote 'political welfare' in order to justify diagnosing political dissidents as mentally ill. How do we guard against this sort of eventuality?

Those who abuse psychiatric diagnosis are undoubtedly willing to ignore the personal welfare of the patient; however, it would be hasty to view the concession that other considerations can sometimes trump patient welfare as dangerous in itself. The current approach to mental health—and to medicine in general—seldom involves explicit discussion of the goal of any given medical intervention in terms of whose welfare is being promoted, and in what way. The lack of rational, open debate about this seems more likely to facilitate abuse of psychiatric diagnosis than the observation that society's welfare may sometimes be more important than a patient's welfare. After all, in non-medical settings a similar observation is commonplace, and is hardly viewed as sinister: social welfare is placed above personal welfare when smoking is banned in public places, when people are prevented from parking their cars on busy streets, when people are prevented from playing loud music late at night in residential areas, and when infectious people are quarantined. On the other hand, in the absence of discussion about the permissible goals of medicine, unethical uses of medicine may pass undetected and unchallenged under the guise of 'treating disease'. As a result, categorising the various possible goals of medicine, considering the circumstances under which it is appropriate to pursue them, and promoting the importance of these issues to clinical practice, would be steps towards ensuring that medicine is not used for illicit ends.

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Autonomy enhancements are medically unnecessary treatments that either do not promote the welfare of the patient or anyone else, or where it is unclear whether they will promote the patient or anyone else's welfare and the main reason for providing the treatment is that the patient has requested it. Doctors should—and, indeed, do—accede to such requests in some circumstances (Savulescu 2007a). Examples of personal autonomy enhancements include gender reassignment surgery and the removal of healthy limbs in people with body identity integrity disorder (BIID), a condition in which people strongly desire amputation. Whilst, in some cases, these surgeries arguably constitute personal welfare enhancements, in other cases it will be less clear. Since some gender reassignment patients come to regret having surgery (Smith et al. 2005), it is difficult to predict antecedently the extent to which the surgery will promote the patient's welfare; and in the case of BIID, we might wonder at the capacity of a sufferer to weigh his desire for amputation against the difficulties he will face coming to terms with life as an amputee. In any case, however, in deciding whether or not to proceed with surgery, what plausibly matters most is not whether the treatment will be successful at promoting the patient's welfare, but that—unless we have reason to regard them as incompetent to make certain important decisions—people are allowed a say in what happens to their own bodies.

The examples of autonomy enhancements just given are all examples of *direct personal autonomy enhancement*: they involve medical intervention in the body or mind of the patient in order to promote the autonomy of that patient. There are, in addition, examples of *indirect personal autonomy enhancement*, which involves medical intervention in the body or mind of a patient in order to

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promote somebody else's autonomy.⁷ Examples include the circumcision of male or female children, at the request of their parents or wider community, for religious or cultural reasons.

Here ends our overview of the categories of medical treatment that appear in our table. What is most important is not that all medical treatments can be unambiguously classified using the framework we have proposed, but that the question of how they might be classified is openly debated. Routine consideration of whose interests are being promoted and how, whether the purpose of the treatment is medical or non-medical, and which historical or hypothetical treatments are relevantly similar may be expected to help unearth any proposed treatments that aim at immoral or imprudent ends, and to flag up unusual treatments for further, in-depth discussion.

One perhaps surprising point highlighted by this consideration of medicine's purposes is that, whilst the primary purpose of medicine may seem *prima facie* to be to restore health, this purpose—captured in the table above in the 'medical purposes' column—guides only part of current medical practice. It is the more general aim of improving the lives of patients and others via welfare and autonomy enhancement that unites medical practice. Of course, at this level of generality, medical practice resembles many other fields: education, politics, and law are all motivated (at least in theory) by the general aim of improving people's lives. What distinguishes medical practice from such other fields is,

⁷ Indirect personal autonomy enhancement should not be viewed as analogous to indirect personal welfare enhancement. The former involves treating one person to benefit another at the request of the beneficiary, whilst the latter involves treating one person to benefit that person via a benefit enjoyed by another at the request of the person who undergoes treatment.

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then, not its aims, but its employment of medical knowledge, techniques, and tools to achieve its aims.⁸

7. *Limits on the goals of medicine*

What considerations should be taken into account when deciding whether or not a given treatment is acceptable? Are there limits to the ends that medicine can serve?

With unlimited resources, medical practice could work to promote the welfare and autonomy of everyone who could potentially benefit from its assistance. In reality, however, resources are limited; consequently, considerations of distributive justice place limits on the uses to which we may justifiably put medicine. Current medical practice often struggles to meet the needs of patients with the resources available—there are more people in need of organ transplantation than there are available organs, for example—meaning that it is necessary to rank people’s needs in order of priority. Doing so is sometimes straightforward: most of us would agree that it is preferable to provide life-saving treatment than to cure a minor ailment, if we can only do one of these. However, it can be hopelessly complicated: how, for example, should we rank personal welfare enhancement against social welfare enhancement? Is it more important to medicate a dangerous paedophile to prevent him from harming others, or to provide counselling for disturbed children whom he has already harmed? How much weight should be given to irrational desires for treatment with unclear benefits, such as strong desires for the amputation of

⁸ To avoid circularity in the definition of ‘medical’ here, we can understand ‘medical knowledge, techniques, and tools’ in the sort of sociological terms described in Cooper 2002.

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healthy limbs? To ensure that the best use is made of the resources available, questions like these must be openly and rationally debated.

Potential harm to others must also be considered when deciding whether a treatment can be justified. The principle of non-maleficence—*primum non nocere* (first, do no harm)—is central to medical practice. Most medical treatments involve some level of harm—a vaccination is mildly painful and carries a risk of side-effects, for example—but this should be small relative to the expected benefits of the treatment. When both the harm and the benefit of a proposed treatment will accrue to the patient, the decision whether to proceed can be made relatively easily by the patient with the guidance of doctors. Matters are more complicated when a patient is treated for reasons of social welfare enhancement. Under what circumstances is it permissible to provide a medical treatment that harms one person so that another person (or group of people) may benefit? It is clearly permissible when the patient provides informed consent to proceed, but what if he does not? In some cases, it may be permissible to treat the patient without his consent. Indeed, treatment without consent is relatively common: pregnant women are sometimes forced to deliver by caesarean section to prevent harm to the baby, and psychiatric patients are treated against their will if they are deemed potentially harmful to others. One of us has argued that whether it is permissible to treat someone against their consent for the benefit of another person depends on how great the harm to the patient is, how great the benefit to the intended beneficiary is, whether the patient can be considered to have an obligation to the beneficiary, and whether the patient also stands to benefit from the proposed treatment (Savulescu 2007b). Such treatment may be justified by appeal to a duty of ‘easy rescue’,

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according to which we have a duty to help prevent significant harm to others in cases where the costs to us of helping are small.

As with the other issues we have discussed, it is less important to arrive at a simple formula for answering these sorts of difficult questions than it is to recognise the issues at stake and to debate them openly and rationally. Such debate does not, of course, guarantee that a consensus can be reached on these issues; however, it offers a better chance at reaching a satisfactory practical resolution than does operating within a system that fails to identify and consider the important issues at stake.

8. Conclusion

Psychiatry in particular, and medicine in general, are not merely about treating and preventing disease. This, as we have seen, becomes clear when we reflect on the breadth of treatments that medicine currently offers. DSM-5 demonstrates the failure of the disease model to capture all of the appropriate goals of medicine. Medicine and psychiatry should both aim at using medical and psychiatric knowledge, techniques and tools to change the biology, psychology and/or environment of patients in order to promote their well-being or autonomy, or—where appropriate—the well-being or autonomy of others. Broadly speaking, medicine is a form of life enhancement.

There are several limits to the proper use of medicine and the development of medical interventions. First, they are broadly constrained by people's interests—construed widely, not narrowly as medical interests. Second, they are constrained by people's autonomous desires: the desires people express for treatments should be fully autonomous. Third, they are constrained by

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resource limitations and considerations of distributive justice. Finally, they are constrained by the public interest, security, and safety.

By considering the permissible uses and limitations of medicine on an ongoing basis, more and more people will benefit from the advances of the biomedical sciences.

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