

Editorial

The moral content of psychiatric treatment

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**Summary**

Psychiatric treatment can enhance human morality. It can promote the emergence of moral motives and intentions, aid in the acquisition of skills essential to moral action, and help to develop the ability to apply moral understanding and skills in particular circumstances. Good psychiatric

practice demands an honest appraisal of its moral dimension.

Declaration of interest

None.

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Psychiatric treatment can enhance human morality. One way it does so is via pharmacological interventions.¹ Medication can increase the likelihood that moral states of mind remain stable and lead to action. Another is via psychological interventions. Psychological interventions can lead to the acquisition and development of moral motives, skills and understanding. We illustrate how psychological interventions produce these results and argue that helping patients to be more virtuous is a proper concern of psychiatry.

Moral effects of psychiatric treatment

Psychological interventions can foster moral growth in three ways. First, they can lead to the emergence of new moral motives and intentions. Second, they can lead to the acquisition or development of cognitive skills such as empathy, which are central planks of moral action. Third, they can enhance the ability to apply moral understanding and skills in particular circumstances.

Let us consider these in turn, starting with a vignette demonstrating the emergence of new moral motives and intentions. A man attends therapy as a condition of his parole. He drinks to excess and has a number of convictions for offences committed while drunk. Although he acknowledges the causal link between drinking and the offences, he expresses no intention to stop drinking. During the course of therapy, he becomes more aware of the consequences of his drinking and less hopeless about the possibility of giving up. He develops a new resolve to stop drinking.

Our next vignette exemplifies the acquisition and development of moral skills. A man attends therapy because of angry and jealous feelings towards his ex-partner. He regards his violent outbursts, which are witnessed by his young son, as justified and inconsequential. During the course of therapy, he explores childhood experiences of witnessing his father's angry outbursts and becomes aware of the effect of his own outbursts on his son. He begins to perceive the similarities between his behaviour towards those around him and the ways he experienced his caregivers during his own

childhood, and is able to identify with his son's distress at his outbursts. He has developed his capacity for empathy.

Our final vignette shows enhancement of the ability to apply moral understanding and skills in particular circumstances. A man attends therapy at his wife's urging. He is routinely depressed and resentful at the family demands placed on him; he takes no interest in his children and shows them no love. The man is morally sensitive and insightful about others, but he does not know why he fails his wife and children in this way. Over the course of therapy he explores his mother's failure to meet his needs and his father's failure to show him love, and he acknowledges his envy of his children. He comes to see that, in truth, he does not want the responsibility of his children and that this is wrong. Despite the shame, he becomes able to apply his moral sensitivity and insight to himself. This recognition launches him on the path to taking responsibility within his family and showing his children love.

Each of these vignettes illustrate one way that psychological treatment can foster moral growth. This purpose is in fact explicit in several psychological methods. Motivational interviewing is defined as 'a directive, client-centred counselling style for eliciting behaviour change by helping clients to explore and resolve ambivalence'.² Its purpose is to encourage the emergence of motives and intentions which we recognise as having moral value, for instance, resolving to give up harmful use of alcohol or drugs (first vignette above), or harmful behaviour in the treatment of bulimia.³ Mentalisation-based therapy has as its express purpose the development of the capacity to mentalise, an ability closely related to empathy (second vignette). Lack of this capacity is postulated as a core deficit in borderline personality disorder.⁴

We take it as given that interventions that foster moral growth occur routinely within psychiatric settings. One obvious example comes from the treatment of personality disorders. It is now widely accepted that psychotherapy is the most effective treatment for personality disorder.⁵ However, DSM-IV diagnostic criteria for personality disorders clearly include traits that involve failings of morality or virtue.^{6,7} Narcissistic personality disorder is partly defined by a lack of empathy; borderline personality disorder is partly defined by uncontrolled anger and impulsivity, which inevitably have negative impacts on others; histrionic personality disorder involves sexual behaviour that has the potential to exploit and abuse; and antisocial personality disorder involves lying, violence and criminal behaviour.⁸ If recovery from these conditions by means of psychiatric treatment is possible, then it must be effecting specifically moral changes for the better.

Note that this does not mean that psychiatric disorders are not diseases, or that psychiatric treatment is not a form of medical

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treatment. Szasz famously argues that mental illness is a 'myth'.⁹ By this he means that mental disorders are not properly conceived of as scientifically validated categories of disease, but instead involve deviations from moral and other norms. But Szasz is wrong to hold that a disorder cannot be both moral and medical.⁷ On the one hand, efforts to remove reference to value from psychiatric definitions cannot succeed¹⁰ – as well illustrated by personality disorders. On the other hand, many psychiatric disorders may prove to be properly conceived of as *bona fide* diseases – as distinct and naturally occurring types of dysfunction, open to multi-level scientific explanation and correlated interventions. Theoretically, there need be no tension between these claims. When the dysfunction involves a trait that counts as a moral failing or vice, then that is part of what medical science must seek to explain, and medical interventions must seek to change.

Moral content of psychiatric treatment

If it is correct that psychiatric treatment can foster moral growth, then the question that remains is why this is not generally acknowledged. Presumably, part of the explanation is historical. We now recognise that in the past, psychiatry practised coercion and abuse under the guise of moral conformity and righteousness. However, a more salient part of the explanation may be the embrace of a blanket and pervasive moral relativism. This makes it difficult for psychiatry, a medical science, to acknowledge the role of value within it.¹¹ We are uncomfortable with the idea that the purpose and effect of psychiatric interventions can be moral growth and betterment, or that clinicians might harbour moral hopes or intentions for their patients. For who gets to decide what morality is? Worries about relativism may not seem pressing when considering the criminal law and the domain of rights and obligations. However, they are pressing when one considers the more basic and ancient moral question, which has exercised philosophers since Aristotle, of how one should live.¹² Aristotle believed that happiness – *eudaimonia* – is only possible through living a life of virtue.¹³ He held that virtuous traits such as moderation, kindness, fairness, generosity, humility, trust, patience, productivity, and love and respect for self and others are the building blocks of a happy life – a life of flourishing and fulfilment. Of course, philosophers have offered moral theories that rival Aristotelian virtue ethics.^{14,15} Whatever the correct moral theory proves to be, it is hard to deny Aristotle's basic insight – namely, the importance of the connection between happiness and virtue.

Recent research underlines this connection: eudaemonic well-being measures are increasingly used alongside or in place of hedonic measures in assessing quality of life.¹⁶ For instance, individuals found to be 'flourishing' are less likely to miss days at work, use health services or suffer impairments to psychosocial functioning¹⁷ compared with those who suffer mental disorder, those who are 'languishing', and those in moderate mental health.

The purpose of psychiatry, and medicine in general, is to alleviate suffering and, ideally, to maximise well-being. It should therefore be self-evident that psychiatry should aim to encourage human flourishing and virtue – never mind that, in fact, it does. Given psychiatry's influence on the lives of individual patients, it is unacceptable to fail to acknowledge this role. Such failure makes a self-reflective and self-critical examination of the moral content of psychiatric practice impossible. It is not easy to think clearly

and conscientiously about virtues and values – about how we should live and how we should not. Equally, it is important to recognise that different virtues have a different value for different people at different times. However, these difficulties do not warrant a retreat into a blanket moral relativism, nor do they license a convenient blindness to the moral content of psychiatric practice. We suggest that this avoidance is immoral, in the sense that failure to recognise and think seriously about the inevitable moral content of psychiatric practice invites abuses. We need to face the hard questions about the role of morality within psychiatry.

Of course, there is never any guarantee that abuse will not occur. Our best defence against it is honesty and ever-vigilant self-reflection. Psychiatry is both a moral and a medical science. We do ourselves and our patients no favours by ignoring this fact.

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