Philosophy's Territorialism: Scientists Can Talk About Values Too

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Philosophy's Territorialism
Scientists Can Talk About Values Too

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Tamara Browne proposes a provocative idea: She argues that philosophers, sociologists, and bioethicists should act as an independent editorial panel for future editions of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM). Her paper depends on some well-versed claims in philosophy of psychiatry: She argues that psychiatric classifications are inherently value laden and philosophers, sociologists, and ethicists are best placed to discern (i) the values are that embedded within scientific descriptions of mental disorders, and (ii) to speculate on the effects of any such classifications on individuals and the populace at large as a result of these classifications.

I agree with Browne that the DSM (and indeed, medicine in general) requires outsiders—among them philosophers (including medical ethicists) and sociologists—to help influence diagnostic systems. My criticism is that Browne delimits the role of outsiders in medicine to the above academics, whom she sees as some category of elite experts in values. In what follows, I argue that the motivation for her proposal rests on a problematic interpretation of the fact–value distinction (one, I argue, that is prevalent in philosophy of psychiatry and does not see facts and values as fully entwined). Building on these comments, I conclude that although an ethics review panel composed of philosophers and sociologists might have (a few) teeth it would have a lot more bite if it also comprised a composite of academics drawn from the rest of the human sciences (including social psychology, evolutionary psychology, cognitive science, and anthropology).

Browne (2017, p. 187) claims that, "there are certain questions that science cannot answer authoritatively where there may be clashes between different scientific groups and decisions made for non-scientific reasons." Following an established tradition of philosophical commentary on the value ladenness of psychiatry she argues that, "there are value judgements inherent in psychiatric classification which are unavoidable and cannot be answered by evaluating scientific evidence alone." In respect of this Browne echoes Sadler (2005) and Radden (1994), the latter of whom argues that "the question of where to draw the boundary between mental health and mental disorder will rest on decisions, not mere discoveries" (p. 198).

First, some preliminary observations impel me to recommend that Browne be explicit about her own views in regard to the following matter: Does

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she consider that values are a product of subjective preferences (taste, or whim)? Rejecting the fact–value dichotomy need not oblige us to side with social constructionism and the idea an objective reality (out there in the world, so to speak) is naive; by extension it ought not to compel us to construe reality as wholly socially constructed and socially determined. Is there evidence that Browne supports this extreme value-drenched perspective? Although I would emphasize that Browne does not explicitly attach her views to this framework her paper is consistent with it—and this is troubling. Browne (2017, p. 189) uncritically cites Foucault in support of the claim that "value judgments are inherent in psychiatric classification," and she endorses the view that sociologists (as well as philosophers) are uniquely equipped to discern the values that are embedded in science. Which brand of sociologist does she have in mind? Social constructionists? And, if this is not her stance, why *only* committee roles for sociologists among human scientists? To embrace a postmodernist agenda (or to fail to distinguish one's position from it) is a mistake.

Certainly, we can agree with the standard wisdom in the philosophy of psychiatry that the fact–value dichotomy is a dogma and one to be rejected; indeed, key developments in post-positivist philosophy of science have taught us that values are deeply entwined with facts (cf. Kuhn, 1962; Polyani, 1962). Cutting to the chase, however, the epistemological problem with social constructionism is that it creates a theoretical void: as Barkow rhetorically asks, "Where do social constructions come from, what are they made of, how do we know them?" (2001, p. 129). Rejecting the fact–value distinction cannot amount to the claim that science is not, thereby, objective. Indeed, as has often been argued, epistemic values (such as simplicity, coherence, and explanatory consilience), for example, guide scientific judgment about the plausibility of theories, including decisions about whether to abandon them: in this way, epistemic values are embedded in the scientific determination of facts and can even be said to be truth tropic. Equally, as Putnam argues, "value disputes [are not mere social conflicts but are] *rational disagreements calling for a decision as to where the better reasons lie*" (2002, p. 121). In summary, values (like facts) can be subject to reasoning. In the remainder of the commentary, I point out two ways in which Browne's paper failed to appreciate this important point, and expand on why this lies at the heart of my criticism of her thought-provoking paper.

First is the assumption that sociologists and philosophers have privileged access to the values and assumptions that scientists make in their psychiatric classifications. Browne fails to notice that there are facts (and values) inherent in the very determination of the value judgments that will form the products of her committee's ruminations. Who shall probe their values? Browne (2017, p. 196) argues that "including a variety of philosophers... [will increase] the likelihood that an informed, balanced view will prevail." What is her evidence for this assumption? Indeed, what *evidence* (if any) informs the evaluations that might underlie the speculative predictions of this assemblage? How do they determine the "untoward consequences of proposed revisions" and how do they arrive at "a harm–benefit analysis" of every condition in the DSM? Upon what information and intuitions are these analyses based? And why should we be persuaded by the view that philosophers have a royal road to the truth about "the broader social impact" and "potential harms and benefits" of treatments (as Browne alleges)? Take one example: It has freely been assumed by philosophers and sociologists that public education campaigns about depression will alleviate its stigmatization. This is an optimistic *armchair* assumption; yet unfortunately there is no evidence (so far) that the tendency to stigmatize individuals who are depressed has diminished despite expensive international campaigns to educate the public (Blease, 2012). The lessons from cognitive science are that our common sense intuitions can all too easily be overextended leading to errors and biases (Kahneman, Slovic, & Tversky, 1982): Working around (in full knowledge of) these biases is our best hope of overcoming them, but this requires scientifically sensitive policies, not a rush to moralizing judgment (nor, indeed, denial of the facts).

This brings me to the second point: the *is–ought* distinction. The philosophical dogma that 'one

cannot derive an *ought* from an *is*' is said to commit that well-known cardinal sin: the so-called naturalistic fallacy. The naturalistic fallacy is the claim that moral philosophers (and nobody else) should be in the ethics business: It is tantamount to the signage 'Philosophers Only' on the highfalutin door to moral decision making. The origins and formulation of this fallacy are alleged to be located in Hume's (1738/1985) *Treatise on Human Nature* (Book III, part 1). However, this fallacy (as traditionally conceived) may be a misreading of Hume as Patricia Churchland has argued. Churchland argues that (contra conventional philosophical wisdom) Hume was a naturalist about morality:

> So whence the warning about *ought* and *is*? The answer is that precisely because he was a naturalist, Hume had to make it clear that the sophisticated naturalist has no truck with simple, sloppy inferences going from *what is* to *what ought to be*. He challenged those who took moral understanding to be the preserve of the elite, especially the clergy, who tended to make dimwitted inferences between descriptions and prescriptions. (Churchland, 2011, p. 5)

Churchland's point is that moral inferences are not simple *deductive* inferences that can be represented by formally valid argumentation. Rather, she argues, "In a much broader sense of "infer" than *derive* you can infer (*figure out*) what you ought to do, drawing on knowledge, perception, emotions, and understanding, and balancing considerations against each other" (p. 6). This, according to Churchland is what Hume was arguing for, and what moral philosophers have overlooked: Moral judgments are a form of abductive reasoning and the quality of the judgments depends on a range of knowledge, including empirical information.

Browne insists that the evaluation of values should be set apart from scientific descriptions. In the paper, she tabulates the division of psychiatric labor with two separate columns: one column furnishes us with scientific descriptions of psychiatric nosology and a second provides the philosopher's discernment of the value judgments embedded therein. Browne is quite right: There will be value judgments that are inherent in these classifications, but (in light of Churchland's interpretation of Hume) this does not license philosophers to run away with them. In other words, inferences about values will be dependent on the quality of the descriptors provided. The upshot is that the philosopher's task is continuous with the scientist's; it is not an unbounded, distinctive evaluative task, as Browne perceives it.

Take the example of major depressive disorder and the value issues that Brown asserts are embedded within its classification but which (she urges) science cannot explicitly address: She says, "The view that the context of one's depression is irrelevant to whether it qualifies as a mental illness or not is itself a value judgment" (Browne, 2017, p. 190). On the contrary, science *can* inform this value judgement (and I would urge that it *must* do so). Consider the following: Evolutionary theories of depression hypothesize that depressive symptomatology was selected for because it was adaptive—it solved some set of problems faced by our ancestors. The questions then arise—Is depression functional today (either in its mild, moderate, or major forms) and what triggers might have occurred in the ancestral environment to elicit depressive responses? Consider one evolutionary theory of depression: the analytical rumination hypothesis (Andrews & Thomson, 2009). This theory proposes that a suite of behavioral and cognitive responses associated with depression facilitated sustained analysis of analytically challenging social problems (Andrews & Thomson, 2009); in short, it is hypothesized that being depressed helped the individual to focus on and solve some intricate social challenges. (Indeed, there is social psychological evidence, for example, that people with depression have more realistic perceptions of their own abilities, how they are perceived by others, and their control over the world [this is dubbed 'depressive realism']). We do not have to embrace this particular theory (and all it contains) to see how theories such as this one (counterintuitive as they may be) can be instructive. The take home message is that part of the answer as to whether depression is a contextual issue, and whether it should be treated as a disorder, and indeed, how it ought to be treated, are issues that might be usefully influenced by further scientific research: In this case, part of

that answer lies in the extent to which there is a contextual overlap between ancestral and modern environments. Similarly, to take another example, Browne argues that, premenstrual dysophoric disorder involves value judgements. But notice that she brings scientific evidence to bear on this example: namely, she states (p. 190), the *value issue* "*Ignores evidence* linking premenstrual anger and distress with abuse, stressful environments, and issues with partner communication." In short, she undermines her own thesis that there are certain questions that science cannot address, and that we should restrict ourselves to a committee of philosophers to address them.

In conclusion, I unreservedly agree with Browne that there should be a panel of outsiders—experts who might help to assess the whys and wherefores of psychiatric nosology—but that panel must include researchers whose theories, findings, and methods inform psychiatric classification decisions including their consequences. In the best interests of the patient, any such panel—should we choose to deploy it—would not be restricted to philosophers.

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