CASE STUDY

Mental health reform

In 1974, the American Psychological Association (APA) began to discuss plans for a revision of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM), a book that serves as the definitive guide for psychologists and psychiatrists in understanding and diagnosing pathology. Mental health professionals were using the second significant revision of the manual, as they had been since its publication in 1968. The push for a third significant revision of the manual came in reaction to a vocal social and political movement that began in the LGBTQ community.

Soon after the revision of the DSM-II in 1968, LGBTQ rights activists began to demonstrate publicly against the APA for the inclusion of homosexuality as a mental disorder. Many in this community viewed this inclusion as simply bigotry, or an attack on deviant 'lifestyles,' fueled by stigma. Activists drew analogies to the civil rights movement of the 1950s and 1960s and claimed that the view of homosexuality as a disorder was an effort toward marginalizing those who were viewed as inferior and stripped them of their liberties.

This movement was called the anti-psychiatry movement, and it was remarkably successful. Without clear boundaries between normal and pathological, and reflecting a mostly psychodynamic, rather than biological, framework of mental health, the APA faced challenges to the legitimacy of mental health diagnoses. Quickly, the APA worked to deflect criticism, and in 1974 the 7th printing of the DSM-II replaced homosexuality as a category of disorder with the title, 'sexual orientation disturbance.'[26] This new category allowed for a more flexible view of homosexuality. If a person's sexual orientation caused a 'disturbance' to his or her well-being, it was treated as a disorder, but the *disturbance* and not the *orientation* was said to be the basis for a diagnosis.

This amendment to the DSM-II was intended by the APA as a short-term remedy to pacify demonstrators, but the APA knew that their manual had to be transformed. Immediately, the APA put together a task force and began to develop the DSM-III. Robert Spitzer, a psychiatrist from Columbia University, was elected chairman of the new DSM task force. Spitzer's goal was clear: bring the DSM in line with the International Classification of Diseases (ICD), the World Health Organization's diagnostic tool for epidemiology and disease.[27]

For Spitzer and his committee, the stakes were high. In addition to the anti-psychiatry protests, the diagnostic methods for mental disorders had come under fire from within. A year earlier, David Rosenhan, a psychologist at Stanford's law school, had published a paper titled 'On Being Sane in Insane Places' in the journal *Science*.[28] Rosenhan had conducted a two-part experiment on the reliability of psychiatric diagnosis. In the first part, Rosenhan and seven 'pseudo-patients' feign psychiatric symptoms in an attempt to gain admission to various psychiatric hospitals. Rosenhan and his pseudo-patients were each admitted to psychiatric hospitals in five different states and diagnosed with mental disorders. Once admitted, they began acting normally again, but were forced to take anti-psychotic drugs

CASE STUDY *(continued)*

and remain in the facilities under treatment. The pseudo-patients described the conditions in the facilities as 'dehumanizing' and unethical. After hearing of these initial results, a well-respected psychiatric hospital contacted Rosenhan and asked him to send pseudo-patients to them, claiming that their diagnostic procedure was so fine-tuned that they would be able to detect them. In the months that followed, the facility admitted 193 new patients. Of these, 42 were identified as Rosenhan's pseudo-patients by hospital staff and psychiatrists. In reality, Rosenhan had not sent a single pseudo-patient to the facility. Rosenhan's experiment was, and is, controversial. Some in the social sciences question whether it can rightly be called an experiment, while others claim that it raises important questions about psychiatric diagnosis.

Rosenhan's work and the ongoing scrutiny by LGBTQ rights activists weighed heavily on Spitzer and his colleagues. How could they develop a diagnostic tool that would identify mental illness without bias or subjectivity? The task force's goal was to address this skepticism by bringing psychiatric diagnosis in line with the kinds of clinical diagnostic procedures used by physicians and epidemiologists.

The DSM-III was drafted within a year and was the subject of trials and debates for five additional years before it was published in 1980. Abundant revisions were made to the DSM-II and the new manual, the DSM-III, was barely recognizable. The DSM-II was 134 pages long and listed 182 disorders. It had two main branches: neurosis, which consisted of anxiety and depressive disorders where no break from reality was detected, and psychosis, where hallucinations or delusions were detected. The new DSM-III was 494 pages long and included 265 separate diagnoses.[29]

In an attempt to align psychiatric diagnosis with medical diagnoses, where Spitzer and his task force believed that they rightly belonged, each disorder was placed on an axis with disorders that shared similar characteristics. This new multi-axial system replaced the branches in the DSM-II and was believed to organize disorders in such a way that each disorder was part of an axis that was defined by clinically significant and measurable attributes. Variations within each axis were defined by essential qualities and symptoms as particular disorders.

Mental health reform and justice as fairness

Spitzer's revision revolutionized psychiatry and the process of psychiatric diagnosis. His axial model is still used, and the architecture of the DSM remains the same. A major revision of the manual was published in 1994, fourteen years after the DSM-III, and the newest revision, the DSM-V, was released in 2013.[30] Each of these revisions has been controversial in its own right based on the classification, addition, and deletion of particular disorders. Still, the axial system is widely credited for the medicalization and professionalization of psychiatry.

Though there has been a great deal of progress in psychiatry since Spitzer and his committee drafted the DSM-III, the stigma surrounding mental health, and the scarcity

CASE STUDY *(continued)*

of resources is still one of the most pressing issues in our society. Debates over the medication of pediatric attention deficit disorders, the provision of special education, the accommodation and support of adults with mental illness and cognitive disability, the efficacy of therapeutic practice, and the involuntary admission of individuals into psychiatric facilities are all related to the scope of mental experience: 'What is within the normal range, and what is not?' It is clear that mental experience varies differently from person to person, but it is much less clear how we ought to make sense of this variation. When does a different way of processing, understanding, feeling, or reacting become pathological or disordered? Should all differences be tolerated? In the absence of any harm to another person, is it ethical for variations to be singled out for eradication?

Questions of justice arise in many different contexts when mental health is concerned. For example, most universities now have an office of student or disability services. Educational and mental health professionals in this office often make recommendations as to reasonable adjustments that might be made for students with learning, cognitive, or mental disabilities.

These accommodations often include things that help the student learn, such as note-taking, extra time on tests, or different forms of assessment. It is unclear, however, when these accommodations move from being a reasonable adaptation to an unreasonable advantage because our understanding of mental experience is, to this point, as crude as our understanding of justice.

Five component analysis

Rawls' theory of justice as fairness focuses on two central concerns: equality of resources and consideration of capabilities. Equal access to the resources necessary for citizenship allows for reasonable accommodations to be made in order for individuals to secure employment, participate in the political process, and access public institutions. Wheelchair ramps, minimal federal assistance, free public records, and accessible locations for voting are all artifacts of this view.

While this approach has been relatively successful in consideration of physical disabilities, it falls short in addressing neurodiversity because of its reliance on rationality as an ultimate moral power, as explained earlier in this chapter. Responding to this, care ethicists proposed an alternative approach to understanding human differences based on capability alone, and not the equality of resources. This view has been successful in addressing cognitive disability, but mental illness still poses a challenge, because capabilities might be intact and even intensified, while goal-driven action or the ability to reason are diminished.

Of course, the history of psychiatry and its relationship with contemporary debates over justice and mental health is not without its own controversies, and this further complicates mental health reform. Psychiatry, like all other disciplines, has a history of prevailing theories and naysayers, debates and innovations. Yet it seems as if other areas of medicine have a much less vexed history and a much clearer trajectory of progress.

CASE STUDY *(continued)*

Edward Shorter, a historian of psychiatry, claims that it is the nature of psychiatry itself that makes it a minefield.[31] Shorter writes:

> To an extent unimaginable for other areas of the history of medicine, zealot-researchers have seized the history of psychiatry to illustrate how their pet bugaboos – be they capitalism, patriarchy, or psychiatry itself – have converted protest into illness, locking into asylums those who otherwise would be challenging the established order. Although these trendy notions have attained great currency among intellectuals, they are incorrect, in that they do not correspond to what actually happened. Psychiatry is, to be sure, the ultimate rule maker of acceptable behavior through its ability to specify what counts as 'crazy.' Yet there is such a thing as mental illness. It has a reality independent of conventions of gender and class, and this reality can be mapped, understood, and treated in a systematic and scientific way.[32]

In other words, humanity is so tangled up with mental activity that it is often hard to distinguish ideas, opinions, and volition from delusion or mood. While historically various political motives, sexual preferences, and philosophical positions have been pathologized, making psychiatry a powerful 'rule maker,' not all mental illness is constructed socially in this way. Shorter's 'zealot-researchers' still exist in debates over autism, Ritalin, gun control, homosexuality, atheism, and in the knotted fragments of almost all other issues over which there is the potential for controversy.

How would a leader apply Rawls' theory of justice as fairness to work toward mental health reform? Rawls' work would say that leaders and followers must work together toward a goal of justice. This does not simply mean the just distribution of goods among the membership of the leader/follower community, but also the addressing of issues of justice within the context of this community. But how does this work in practical terms? Rawls' two principles actually offer some guidance in this. Rawls' principle of equal liberties outlines the basis of the goal for the leader. The goal that the leader and followers work toward is to guarantee a wholly adequate set of basic liberties to all citizens. For mental health reform this means safeguarding those with mental health challenges so that their basic liberties remain intact, but if we accept the modification to justice as fairness as put forward by the care ethicists, it also means developing resources and adaptations to existing social institutions so that dignity is preserved and the social goods being distributed are distributed with an eye toward varying capabilities.

The context of leadership in mental health reform necessitates the acceptance of the care ethicists' emphasis on capability. Leadership in mental health reform must recognize diversity within an organization or society because there have been too many cases in this history of mental health where failing to do so has led to drastic consequences. The pathologizing of those on the LGBTQ spectrum outlined above is one example, but throughout history, there have been numerous examples such as the witch trials, the idea of hysteria, and more. Distributing the same set of social goods to all fails to recognize this diversity and promotes equality in a way that is not sensitive to difference.

CASE STUDY *(continued)*

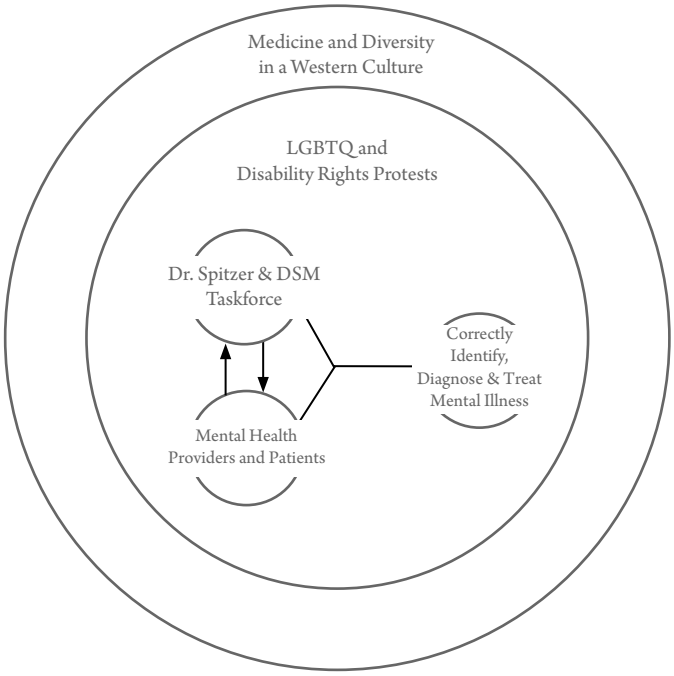

Figure 10.3 The Five Components of Leadership Model applied to the mental health reform case study

Rawls' second principle of justice, the difference principle, also emphasizes the importance of the leader and followers' recognition of this diversity in their interactions. The second principle that serves to protect the right inequality insofar as it allows citizens to pursue their own conception of the good is based on a foundation of equal opportunity and overall leads to a better life for all, not only those who are privileged.

This means that it is the leader's role to ensure that those with mental illnesses are able to pursue their conception of the good. This defines the leader's responsibility as two-fold: distributing the material and social goods that the community needs, but also providing the social and political protections that are necessary for the flourishing of the group. This is a challenge, as the citizens we are discussing in this chapter often do not, or are not able to, engage politically. Further, because mental health is a spectrum, there is no clear way to represent those who cannot engage politically. They may all have very different experiences and needs. The leader and the follower in Rawls' theory of justice will have to work together to make sure that the perspectives of those who cannot engage politically are considered in the distribution of social goods.

For Rawls, this does not mean that each citizen's experience must be maximized in some way. The goal is not to raise everyone to the level of the privileged, but instead to afford them all basic liberties and equality of opportunity. The care ethics modification of this theory asserts the need to focus on dignity as the benchmark. Are these individuals able to live a dignified life? Political philosopher Elizabeth Anderson says it this way:

CASE STUDY *(continued)*

> Once all citizens enjoy a decent set of freedoms sufficient for functioning as an equal in society, income inequalities beyond that point do not seem so troubling in themselves.[33]

To ensure that all citizens 'enjoy a decent set of freedoms,' the leader and the followers have to work together to make sure institutions and practices are also accessible so as not to restrict citizens of varying capabilities from using them. In *Frontiers of Justice*, Martha Nussbaum wrote 'no matter how much money we give the person in the wheelchair, he will still not have adequate access to public space unless public space itself is redesigned.'[34] For mental health reform, the adaptations that institutions have to make may not be adaptations to physical space but rather adaptations to legislation, policy, and the availability of community resources. The role of the follower, then, is to become a strong and willing advocate, while the role of the leader is to protect basic liberties and to facilitate democratic debate.

Rawls' second principle also emphasizes the right of all citizens to pursue their own version of the good. Moreover, the theory of justice as fairness asserts that it is not the role of democratic institutions to make value judgments about these conceptions of the good, only to protect basic liberties so that citizens have the freedom to pursue the good. For leadership, this means that the leader must remain neutral to the variations of the good that citizens pursue. Again, this reinforces the assertion that the diversity within the environmental context needs to be recognized and protected.

Spitzer and his colleagues did just that with the revision of the DSM in reaction to protests and advocacy from the LGBTQ community. They realized that pathologizing diversity in sexual orientation did not adequately address difference, and fully ignored the capabilities and dignity of individuals. Basing mental health diagnosis and treatment on the experience of the individual and his or her own ability to flourish and live a dignified life in pursuit of the good respected these differences as well as the individual's right to freedom. The revision of the DSM-II was an act of leadership: leaders (Spitzer and his team of mental health professionals) and followers (advocates, allies, and protestors) working together toward a goal (a fair and accurate method for diagnosing mental illness without pathologizing difference) while considering the environmental context, and also the cultural values and norms that influence the institution of psychiatry.

From this evaluation of the case study, there are a few important points to take away. The first is that Rawls' theory of justice as fairness is an appropriate approach to ethical leadership. Rawls does a thorough job of providing guidance to leaders who want to implement his approach, and his two principles make the approach both concrete and realizable. The second is that a contemporary leader working in a diverse society or organization might want to consider also using the care ethics addendum to the theory of justice as fairness. This approach helps to address the challenge and opportunity of diversity by making the theory more inclusive, and also tailoring it to the individual, rather than broadly prescribing a method of distributing social goods. The Five Components Model used to analyze the mental health reform case takes Rawls' theory and translates it into a practical guide that is applicable to contemporary leadership situations.