Bug-eyed and breathless: emerging crises involving values

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One might expect support from a long-time colleague and friend of Fulford, Broome and Stanghellini. Indeed, there is little in their thoughtful and definitive essay that I would want to challenge, other than perhaps its relative lack of urgency. I would like to provoke a sense of urgency in my comments through sketching some potential emerging crises driven by value issues in mental disorder classification.

Genetic and molecular-biology-informed classification and diagnosis. The simplicity of a classification agnostic about etiology will become untenable as we accumulate knowledge about the molecular and genetic mechanisms of mental disorders. Unfortunately, it appears that the phenotypes associated with these scientific insights will bear limited resemblance to current diagnostic categories (1-4). The values questions will involve how, or if, to assimilate biological etiology into a descriptive classification used by clinicians in an existing "medical-industrial complex". Equally complex will be to establish the role of non-biological (psychological, sociocultural) etiological factors. We should not overlook the latter's hierarchical (or not) relationship to biological etiological factors! How will war-trauma related mental disorders look in DSM-VI? How will we weight etiological factors vis a vis diagnosis?

Diagnosis and crime. With "both eyes open", weird paradoxes concerning the relation between crime and mental disorder can be recognized in our current classifications. For instance, in DSM-IV-TR and ICD-10, we have a diagnostic category (pedophilia) largely defined in terms of a criminal behavior (child molestation) and impoverished with regard to associated clinical features (4). If this is an exemplar model for crime-related mental disorder classification, why are we not classifying serial murder, serial rape, terrorism, and other patterned criminal behaviors as mental disorders? How are the victimizing paraphilias different from repetitive crime? Appreciation of this paradox leads to tough values questions like: Should we classify (all, some) crimes as mental disorders? Should no crime be classified as a mental disorder? On what evaluative criteria will we parse out criminal behavior from mental illness? Should we parse out criminal behavior from mental illness?

Gender norms. In the absence of a generally agreed-upon, non-ideological account of gender norms (5,6), how can deviation from gender norms be the basis for a psychopathological diagnosis? This and related questions will continue to be an issue for diagnoses like DSM-IV-TR's premenstrual dysphoric disorder and gender identity disorder, and the ICD-10's excessive sexual drive, among others. What should be the normative image of sex and gender that shapes our conception of psychopathology (4)?

Cross-cultural validity. Because of the ICD-10's and DSM-IV's accumulating awareness of cross-cultural variation in psychopathology, cross-cultural validity will continue to be a critical values-related problem for upcoming classifications. If the DSM and ICD categories are not empirically established as universally valid (a practical impossibility), then what should the criteria be for ethically-justified use of DSM/ICD diagnoses in a culturally distinct society? Should all societies be subject to a prevailing Western biomedical model of psychopathology? Should endemic notions of psychopathology be respected? How?

The problems posed by value conflicts in psychiatric diagnosis and classification are real, and will not be solved by scientific advances. Indeed, they will be compounded by scientific advances as we increasingly diversify choices about mental health. We have a lot of evaluative work to do.

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Keeping an eye on clinical utility

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Fulford et al's efforts to raise awareness of the interplay between value judgments and scientific facts will undoubtedly be helpful in framing many of the discussions about how to define particular mental disorders during the next revision of the DSM. While consideration of value diversity was a factor in a number of the DSM-IV discussions (for example, adjusting the criteria set for gender identity disorder so that it did not inappropriately capture tomboys), such considerations were not explicitly and systemat-

ically part of the DSM-IV process.

Beyond that, it is difficult to comment on the practical aspects of Fulford et al's arguments since they neglect to explain with any clarity precisely what their proposal for values-based practice (or "values-based diagnostic assessment") actually entails. Fulford et al appear to be suggesting that patient values be given center stage in the clinical diagnostic assessment process itself. I see at least two problems with this suggestion, in terms of its potential for compromising the clinical utility of DSM-IV and the inevitable interaction of psychopathology with value-determination.

The most important goal of the DSM diagnostic system is to facilitate clinical communication between mental health professionals and to help guide clinical practice. By employing operationalized, standardized, and descriptive criteria, DSM diagnoses allow the clinician to reliably summarize patients' patterns of psychopathology and make evidence-based treatment decisions. The success of this enterprise, however, depends on a reliable application of the diagnostic criteria. Idiosyncratic application of the diagnostic criteria can result in inaccurate diagnoses that can mislead other clinicians who may be part of the treatment team and invalidate the applicability of empirically based treatment guidelines. For example, consider a clinician evaluating a severely depressed patient who believes that having severe depressed mood is a normal fact of life, resulting in no diagnosis of major depressive disorder despite the fact that the full syndromal criteria are met. Consultants reviewing the diagnosis will be operating under the mistaken assumption that the patient's symptoms are much less severe than they actually are, resulting in clinical confusion rather than clinical communication. Furthermore, the clinician is likely to make inappropriate treatment decisions if he or she assumes that treatments that have been empirically demonstrated to be effective only for mild depressive symptoms (such as supportive psychotherapy) will also work for this severely depressed patient.

A second problem concerns Fulford et al's proposal for having the patient's values about what is pathological "be on an equal footing with the professionals". For many mental disorders, the psychopathology itself may involve distortions in the patient's value system. Take, for example, the diagnosis of pedophilia. Many pedophiles believe that there is nothing pathological about having sex with children. Should the diagnosis of pedophilia depend on an equal consideration of the patient's value system? If it did, it would be impossible to make a diagnosis of pedophilia for most individuals whose arousal patterns involve having sex with children. Although pedophilia might seem like an extreme example, in fact this problem applies to all disorders in which the symptoms are essentially ego-syntonic, i.e., those disorders in which the person does not appreciate his or her psychopathology as being symptomatic of a disorder. DSM-IV avoids this insight problem by having the clinician's value judgments supercede the patients' in such cases.

Perhaps the best way to integrate values into psychiatric practice is to separate the process of *making* a diagnosis from the process of *applying* the diagnosis for the purposes of clinical management. I agree with Fulford et al's statement that "Symptom control… is often less important than professionals tend to assume. People often have other priorities (a home, a job, etc.) that may actually be prejudiced by over-enthusiastic efforts to control symptoms". It is crucial for clinicians to place their patient's values front-and-center when formulating a treatment plan – otherwise, treatment adherence will inevitably be compromised.

On winking at the facts, and losing one's Hare: value pluralism and the harmful dysfunction analysis

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Disorder is partly a value concept; conditions that do not cause harm (e.g., benign angiomas, dyslexic dysfunction in a preliterate society where reading is neither taught nor valued) are not disorders. However, disorders are not merely disvalued conditions. Most negative conditions, from ignorance and lack of talent to shortness in an aspiring basketball player, are not disorders. Nor does need for treatment imply disorder, as in abortion and delinquency (1).

What is the factual criterion that distinguishes disorders from other disvalued conditions? Fulford et al never address this question. By merely winking at the facts in disorder judgments rather than opening their eyes to them, the authors fail to correctly apply Hare's analysis. According to Hare, a value concept like "good strawberry" has three elements: first, a factual domain to which the value is applied ("strawberry"); second, a value term ("good"); and third, a factual basis for the value (e.g., taste and color), which may vary. The authors, focusing on values, ignore the domain specification.

I analyze disorder as harmful dysfunction (HD), with "harmful" a value term based on social judgments, and "dysfunction" a factual term meaning failure of biologically designed functioning (2). The HD analysis fits Hare's model well. Dysfunction is the factual domain, harm is the value applied to the domain, and there are implicit cri-

teria for harm (e.g., suffering, disability) that may vary from culture to culture.

However, "harmful" reflects social, not individual, values. For example, in a literate society, a person who does not value reading still has a dyslexic disorder if incapable of learning to read due to a brain dysfunction; and, in a society valuing reproductive capacity, a sterile individual has a disorder even if he or she does not want children.

The authors argue that values are more diverse regarding mental than physical conditions, so mental disorder is more value-laden. They propose that diagnosis be negotiated with the patient based on the patient's values. In effect, they make "harm" relative to individual rather than social values in response to growing value pluralism that casts doubt on the very notion of social values.

The proposal inflates the value ladenness of mental disorder and mischaracterizes its consequences. Once the factual domain of disorder is specified as dysfunction, value divergence narrows considerably. For example, people may differ in how much they value joy or hate sadness in response to life's vicissitudes or as philosophical attitudes, but there is much less difference in how they feel about true depressive disorder in which something has gone wrong with the mind so as to continually generate painful sadness unrelated to actual losses or philosophical insights.

Moreover, the effects of value variation on diagnosis are severely limited because of the dysfunction requirement. Values can disqualify a dysfunction from being a disorder, but values cannot make a non-dysfunction into a disorder.

The authors' proposal erodes the distinction between disorder, anchored in biological facts, and disvalued conditions in general. The HD analysis suggests an alternative approach. First, limit diagnosis to dysfunctions based on facts, setting aside values to the extent possible. Second, further refine the current approach of using individual values in treatment decisions. Patient values may dictate not treating a dysfunction or treating a non-dysfunction (e.g., cosmetic surgery, abortion).

Mental medicine faces a dilemma. As society becomes more pluralistic, the assumption of shared social values underlying disorder's "harm" component becomes problematic; yet adopting the authors' individual – values approach to harm undermines the distinctiveness and usefulness of the concept of disorder. The answer to pluralism, I suggest, is to make diagnosis more scientific and make treatment decisions more explicitly value laden. Helpfully, the value ladenness of disorder turns out to be much less than the authors suggest once its factual component is understood.

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Recipe for disaster: professional and patient equally sharing responsibility for developing psychiatric diagnosis

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Fulford et al are, of course, correct in asserting that psychiatric diagnosis involves not only facts, but values. They are also correct in emphasizing the stake that patients – and the community – have in how psychiatric diagnosis is developed and applied. No one can doubt that, for example, certain terms that have been used in psychiatric classification, such as "psychopath" and "addict", have had a stigmatizing effect. It is partly for these reasons that such terms have been avoided in more recent psychiatric classifications. However, Fulford et al have not provided the reader with examples from the current DSM in which the classification would have been better, had more attention been given to examining the implicit values of various diagnoses or the way in which diagnostic criteria were formulated.

What is most remarkable about Fulford et al's proposal is their assertion that "it requires a decisive shift from the standard model of diagnosis, as a process that is essentially professional-led, to a model of diagnosis as a project of shared understanding in which patient and professional have equal roles to play". They do not discuss what this means in practical terms, but I can only assume that they are recommending that an equal number of patients and professionals would be members of the work group that develops future revisions of the DSM. The criteria for professionals on the DSM work groups have been some demonstrated (or assumed) clinical or research expertise in psychiatric diagnosis. What would be the criteria for selecting appropriate psychiatric patients on the DSM work group? Would it include psychiatric patients only if they were sympathetic to the concept of psychiatric diagnosis and believed that psychiatric treatment is often helpful? What about psychotic patients who believe that they are being persecuted by psychiatry? Assuming that appropriate patients could be selected, how would they contribute to technical discussions of classification and diagnostic criteria?

Fulford et al fail to note that, beginning with DSM-III, non-professional groups, often led by psychiatric patients, have had input into developing the

DSM manual. Such groups have been sent drafts of the developing DSM and asked to comment and make suggestions or indicate concerns. Why is this kind of non-professional patient input not sufficient?

Yes, psychiatric diagnosis involves values as well as facts, but Fulford et al's proposal that psychiatric patients and professionals equally share the task of developing psychiatric diagnosis is neither practical nor necessary. If actually implemented, it would be a recipe for nosologic disaster.

Recognizing that values matter

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I found the paper by Fulford et al thought provoking, novel in approach and interesting. I regretted however that the paper: a) makes such a sharp distinction between mental disorders and other medical conditions; b) does not discuss the role of culture and the differences in value systems that exist between cultures (and between social class groups within populations of the same cultural background) and c) separates the making of diagnoses from the process of the encounter between a health professional and a patient, a process that includes the definition of problems, their labelling and action to resolve them.

Psychiatrists are probably somewhat more inclined to accept that values and cultural factors in general affect their thinking and their actions than are their colleagues in other medical disciplines: this however does not mean that the impact of culture on "non-psychiatric" medical conditions is not just as powerful in the vast majority of states of ill health. It is therefore to be hoped that the valuable work done by Fulford and others interested in this matter will be brought to the attention of the wider medical world rather than stay cantoned in the field of psychiatry.

Cultures are the scaffolding embedding value systems and their differences are often difficult to capture in quantitative terms. In qualitative terms, however, this is possible and of direct practical importance. The "good process", Fulford et al say, depends critically on models of service delivery that are patient centred and on the use of multidisciplinary approaches in medicine. Patient-centredness, however, is by no means a universally accepted way of proceeding in dealing with illness or other matters concerning human life. In some cultures, care has been family centred and public health doctrines of the mid-20th century emphasised the usefulness of that model, since the survival of the community depends on the essential functions of families rather than on the functioning of any individual member of the family. The dependence on family function and the value given to it grow with environmental pressures and the lack of essential support to the community – a situation that is unfortunately turning from an endemic to an epidemic problem in many parts of the developing world.

This brings up another point: a difficulty in the education of new health workers about value-related medical practice. Values change with time (and unevenly) and have to be assessed and re-assessed in a continual fashion in order to offer information that will be useful in dealing with illness – a task that takes time which health systems do not have at their disposal. The fact that medical practitioners and their patients are in modern times moving from place to place and from one cultural setting to another more than ever before adds another obstacle to the application of the excellent notion of value based practice. The use of value and evidence-based practice (rather than evidence-based practice) requires more education, possibly also more time and effort by the practitioner: in order to make it popular and generally used, it will be necessary to show that value and evidence-based practice improves the patients' and doctors' quality of life more than evidence-based practice.

The third point mentioned above – about the impact and importance of values in all stages of the medical encounter – is implied in the article: it would have been useful to bring it up more forcibly, because of its importance for the whole of medicine and its role in dealing with illnesses.

In all, I see the effort of Bill Fulford et al as a very useful invitation to rethink medicine and psychiatry and to remain aware of the fact that values influence all of medicine – including the process of treating an illness. This notion might be of particular importance in the training of medical students and students of other health professions, but has its application in other fields as well – perhaps more so in health policy-making than in basic research.

Eyes and ears wide open: values in the clinical setting

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The acknowledgement of its inherent complexity and the question on how to best deal with it have become lately the order of the day in psychiatry (1). Actually, when it comes to mental illnesses, few would dispute that rock-bottom scientific givens are hardly the whole story. Bill Fulford and colleagues take a further step in

the direction of complexity by recognizing the role of values in diagnostic theory and practice and, accordingly, by proposing a sophisticated two-fold approach to psychiatric diagnosis in which values, alongside facts, are seriously considered. In this commentary, we aim at briefly discussing certain far-reaching consequences, in terms of clinical practice, of adopting the approach suggested.

The blurred and ever-shifting medical-moral boundaries in psychiatry result from the Janus-like character of such discipline. There is an agonistic tension at the core of psychiatry (where values play a key role) that cannot be eliminated or bypassed. This is easily noticed in the everyday clinical activity. Thus, it is crucial to realize the extent to which our diagnostic concepts and tools actually mirror such tension and happen to constrain the clinical encounter. The strategy of simply targeting symptoms, within the framework of a supposedly *neat* nosologic system, gives us a fair example.

Even though general goals of patients and clinicians often coincide, this is not always the case. Dissent is particularly likely to take place in matters that are less related to symptom control. One may ask then "which are the legitimate patient's expectations" or "what should count as a return to normalcy". This point underscores the need for values disclosure regarding the most basic assumptions of the discipline. As John Sadler has aptly stated: "Psychiatrists work toward helping people with all manner of maladies, from problems-in-living to chronic, debilitating diseases; but what the profession, and its practitioners, believe about the best way to live is their best-kept secret" (2).

It is against such background that human *pathos* should be somehow apprehended in the clinical encounter. Subjective experience of illness is necessarily framed and expressed in language. Thus, one cannot identify any evaluative elements embedded in language unless notions like "meaning" and "understanding" fully come back into play. First-person narrative and idiographic formulation have a fundamental role here (3). Accordingly, listening becomes the cornerstone of clinical work, which is in complete agreement with the broad definition of respect for the diversity of values within mental health provided by the policy implications of the National Institute for Mental Health in England (NIMHE) Values Framework. However, notwithstanding foreseeable gains for decision-making in healthcare that such patient and process-centered approach may engender, one must be aware that there are other issues at stake that go far beyond a rational value-conflict between patients and clinicians, such as, for instance, the human dividedness and the problem of akrasia (acting in a way that is contrary to one's own best interest). Choice making (about rivalrous goods, evils and forms of life) is the basis of ever-evolving self-creation. Besides, it may well be that the ends and goals a given person pursues in life may not prove reconcilable at all.

The clinical enterprise takes place inevitably within the realm of practical reasoning. Therefore, we think that notions such as clinical significance, clinical judgement and clinical utility should be brought to the forefront of conceptual and empirical research in psychiatry. Values-based practice seemingly offers a good starting point for such a move.

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Values and comprehensive diagnosis

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As recognized, but not discussed, by Fulford et al in their paper, there is consonance between attention to values in clinical diagnosis and care and what may be termed the comprehensive diagnostic model. The undeniable importance of values for a science and practice of psychiatry, which Fulford et al are compellingly articulating, is relevant to both the structure and the purposes of comprehensive diagnosis in psychiatry as well as in medicine at large.

The emerging comprehensive diagnostic model (1, 2) aims at understanding and formulating what is important in the mind, the body and the context of the person who presents for care. This is attempted by addressing the various aspects of ill- and positive- health, by interactively engaging clinicians, patient and family, and by employing categorical, dimensional and narrative descriptive approaches in multilevel schemas. Illustrations of such a comprehensive diagnostic model are at the core of the International Guidelines for Diagnostic Assessment (IGDA) produced by the WPA (3) and the Latin American Guide for Psychiatric Diagnosis (GLADP) produced by the Latin American Psychiatric Association (4).

Fulford et al's discussion of values in psychiatric diagnosis focuses on their relevance to classification of mental disorders, which corresponds to Axis I of the ICD-10 mental disorders chapter (5) and Axes I and II of DSM-IV (6). It can be pointed out that values are at least equally relevant to the axes in the above diagnostic systems involving functioning/disabilities and contextual factors (psychosocial environmental and personal problems). Issues of meaning, contextualization, and interpretability are quite germane to these axes.

Values are also of substantial importance in the case of Axis IV (quality of life) in IGDA (3) and GLADP (4). It is

widely accepted that the assessment of quality of life should be principally based on the own perspectives of the patient or subject of evaluation. The full range of contents involved, from physical well-being to spiritual fulfillment, are to be addressed in such an axis in a personally- and culturally-informed manner. Attending with such centrality to the person's perspectives attests to and reflects the importance of values for the scientific assessment of a topic increasingly relevant to understanding health and planning health care.

The above considerations on values and the assessment of health speak additionally to the ethical exigencies of diagnosis and care (7). The fundamental purposes of comprehensive diagnosis are treatment and health promotion focused on the needs and goals of the patient or consulting person.

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Bridging the gap between fact and values

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The Declaration of Geneva (1), enacted in 1948, enunciates the role and duties of the doctor and views medicine as a vocation. This declaration is rife with value-laden constructs such as consecration, respect, dignity and honour, and draws attention to the implicit value-based constructs defining the fundamental role of the medical profession and its status in society.

The last decade has seen the rise to power of the "evidence-based medicine" movement, where large-scale randomised controlled trials are held up as the gold standard for medical research paradigms (2). A hierarchy of credibility is assigned to various study designs by the Cochrane Library (3), which in turn drives assessments of what constitutes good evidence for different treatment modalities. In the UK, this hierarchy of "best" evidence strongly determines the recommendations of good clinical practice (4). These recommendations in turn determine what treatments are funded within the National Health Service, thus marginalising other approaches which may not be as amenable to "evidence-based" research inquiry (2). This illustrates the power and influence of this biomedical model on patient treatment, and also the practical importance of this debate.

The ascendance of "fact" in medicine is not new. As early as 1973, Foucault saw the development of modern medicine as a progressive abstraction of illness away from the whole person, to the current focus on cellular or tissue pathology, with a depersonalisation of both the patient and doctor, associated with an increasing reliance on laboratory tests (5). There are interesting ramifications of the "factual" medical model. This emphasis on "evidence-based" treatments, with organisations and professionals dictating what should be made available to patients, contradicts the concurrent movement towards patient-centred care, user involvement in research, and patient choice (6).

There is, however, a danger of going too far in the opposite direction. If only relativistic "values" are seen as valid, then only the person who experiences the phenomenon has the privilege of determining whether he has a problem that requires help, which reduces medicine to an encounter where the customer is always right. A collapse into the totally relativistic realm would be particularly problematic in psychiatry, where insight and ability to make decisions, and even the authentic self, can be lost in certain stages of certain mental disorders (7-10).

So how do we avoid these equal and opposite errors? Fulford et al suggest a middle path, which allows the consideration of both "fact" and "values". This is an extremely attractive proposition, as it promises to bridge this yawning gap. The main difficulties with this are the academic credibility and practical implementation of this model, not least the re-education of the professionals involved. Fulford et al have clearly made inroads into the latter task, and are able to point to practical resources which are currently available or being developed.

There is a clear need for more research and development in this area, both in order to win more widespread recognition and use, and also to provide a rigorous grounding for the exploration of values. The evidence-based movement did an immense favour to medicine by moving clinical practice away from the realm of the arbitrary and establishing clear methods of investigation (3). In a similar way, the study and discussion of values in medicine in general, and psychiatry in particular, should be amenable to a differently-framed but equally rigorous process of empirical investigation and formulation. Experience is showing

that this is possible, and can prove very fruitful (11, 12). Using Fulford et al's model, this type of research would complement "factual" evidence-based medicine, rather than aim to replace it. This would re-integrate meaning into the research evidence base by taking into account the perspectives and experiences of patients and individual variation, which are stripped from evidence in large-scale randomised controlled trials. This empirical research and development enterprise would probably be a greater challenge for the issue of values than it has been for the domain of facts, but this should not deter us from trying. After all, this cannot be harder than trying to adhere to the Geneva declaration itself.

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Looking with both the eyes and heart open: the meaning of life in psychiatric diagnosis

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The definition and classification of mental disorders have long been based on considerations in the realm of cognition. Symptoms and signs, however measured, are described in cognitive terms. Fulford et al argue that we have to be aware of the fact that psychiatric diagnosis is based on both facts and values.

The value systems of individuals are what they can recognize and describe in cognitive terms. For example, "a good strawberry – a strawberry that is good to eat" (or "mental disorder – a mind that is disordered") is a value-laden term that can be rephrased as "a strawberry that is red and juicy" (or a mind that is sad or mad). These qualities – redness and juiciness – are evaluative terms with cognitively-described qualities. Fulford et al further note that, if evaluative elements differ widely, the judgement will be disputed; that is, whether the strawberry is good or the mind is disordered.

Why, then, do judgements about mental disorders differ from one person to another, depending on their values, in contrast to judgements on bodily disorders? For example, sadness may be recognized as pathological in some individuals but considered normal (physiological) in others. The DSM-IV defines major depressive disorder as a constellation of a certain number of symptoms of "sadness", excluding general medical conditions or the effects of chemical agents. This may occur following "any" type of life event. There is, however, one exception: grief, the "sadness" occurring after bereavement. The DSM-IV excludes from the diagnosis of major depressive episode people with symptoms of "sadness" if they have recently lost a loved one. Only when bereaved people showed psychotic symptoms or suicidality (for whom treatment is imperative) does the DSM-IV allow the diagnosis of a major depressive episode. This may be because the authors of the DSM-IV believed that bereavement is recognized by both professionals and lay people as a situation that generally causes sadness, and is therefore non-pathological – an evaluative judgement.

In the case of grief, who should be included as a "loved one" is entirely subjective, and clinicians heavily rely on the assessment of the extent to which the grieving person has been attached to the lost person. Psychodynamic theory dictates that the bereaved person is unable to withdraw libidinal attachment from the lost person (1). Important here is the meaning of the existence of the lost person to the life of the grieving person. Thus, the values on which psychiatric diagnosis is based are tightly bound to the specific meaning of the event, situation, and people related to a specific person.

Grief "involves the transformation of the meanings and affects associated with one's relationship to the lost person, the goal of which is to permit one's survival without the other while at the same time ensuring a continuing experience of relationship with the deceased" (2). Therefore, the "diagnosability" of such experience largely depends on what the person has found in the event or situation.

I agree that recognizing the values-based view – both facts- and values-eyes open – gives psychiatric diagnosis further richness rather than an imped-

iment. In addition, psychiatrists should open their hearts toward the meanings and affects related to events that individuals experience in relation to their mental disorders. The endeavour of diagnosticians to make their hearts consonant with those of clients will make psychiatric diagnosis an even more fertile ground to understand the human mind.

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The need for trained eyes to see facts and values in psychiatric diagnosis

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Twentieth century education and training in medical diagnostics produced physicians who could see the facts and recognize the facts in what they saw. We need now a sophistication that not only opens our "values-eye" but also spares us from a "visual agnosia" for values in medical diagnosis and practice. The paper by Fulford et al provides a pathway to this sophistication for the 21st century.

Attaining sophistication in our theoretical and practical knowledge of values in psychiatric diagnosis poses, I believe, profound and exciting clinical, research and educational challenges, of which I shall highlight a couple here.

To see and recognize the kinds and the scope of values in psychiatric diagnosis. The trained eye will have a wide-ranging view on the kinds and the scope of values. It would see more than mere bio-ethical values, prescriptive values, normative values and even quasi-legal values. It would see more than principles, virtues, ideals, personal values and religious values. It would also see medical, psychiatric, societal, cultural and aesthetic values. It would see values of good/bad, right/wrong, and of duties, obligations, responsibility, etc. Too narrow a view, in contrast, on the kinds and the scope of values would preclude their recognition, and preclude determining as to whether a particular value should or should not play a role in making a psychiatric diagnosis. Fulford et al give convincing examples of values that pertain legitimately in making a diagnosis. They also give an example of values that should not have played a role, i.e. the abusive influence of political values on psychiatric diagnoses in the former USSR. There remains, however, a question about the (kinds of) values that should or should not pertain in making psychiatric diagnoses. This question is relevant in every clinical encounter, since all diagnostic decisions are based on values in addition to facts. This is also a question that should be researched. This question, whether in practice or research, would be approached best with a trained eye for the various kinds of values.

To identify and work with values in psychiatric diagnosis. The practical questions are: How do I identify and even uncover the (hidden) values that pertain in making a diagnosis? And, what do I do about them once identified? These multifaceted questions prompt us to realise that the knowledge and skills to identify and work with values in psychiatric diagnosis are lagging behind in comparison with the knowledge and skills that we have in the science of psychiatric diagnosis. Fulford et al describe the resources that could be drawn on fruitfully in addressing the need for sophistication about values, but much more development is required in training and research as well in the standard diagnostic practice of individual mental health practitioners.

The resources described by Fulford et al, however, stand on solid philosophical foundations and formidable developments are already evident in midstream psychiatry despite the relative early days. Several publications, also by renowned international leaders of psychiatry, have fully embraced the evaluative aspects of psychiatric diagnosis and are grappling courageously with the difficult implications for diagnosis and diagnostic classification systems in psychiatry (e.g., 1-6). These developments will also be taken forward, for example, at the 14th Biennial Conference of the South African Society of Psychiatrists in September 2006, with its theme being "Facts and Values in Psychiatric Practice".

Taking seriously these challenges amongst others would provide psychiatry with trained eyes for facts *and* values in diagnosis, leading the way for the general field of medicine.

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Coloring our eyes

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In reviewing Fulford et al's paper, I declare that I have to open both my mind and emotions as a black male, mental health survival and approved social worker with a doctorate in philosophy. I stress this position because one of the problems of the paper is that the writers fail to declare their identity (values), and how, in collaborations, friendships and professional associations on an informal or formal level, they apply their own values to keeping both eyes open. Consequently they are made absent, which is implicit to the ways science claims objectivity. Their failure to have a patient perspective from the beginning means that they advocate on their behalf, which undermines the whole premise behind their claim for equality in the relationship between the patient and the professional.

The power and persuasion of the paper is that it names the problems of social value judgments, and rescues seeing the dysfunction in the individual without really exploring how society values are politically influencing clinical judgements. For example, when using the metaphor of the strawberry in relation to the tensions between factual and evaluative elements, the paper hides the deeper problems when colour is used in relation to humans, particularly black young men who represent the major problems in relation to cultural values and misdiagnosis. So the issue of what is shared or divergent hides the implications of power, especially in relation to white men, which become politically neutral, similar to the presence of the writers throughout this paper.

The paper promotes a reality that value based practice is possible despite the failure to see the personal values that become explicit inside the diagnostic label. The failure to examine these values at the outset means that value based practice becomes reactionary as opposed to proactive, because in the process of looking at our values it may be too painful to admit that we corrupt science by personal labelling before the assessment takes place. This embarrassment to our own bias is not discussed in the paper nor is the loss for professionals to truly give to the patient real partnership in a political democracy in which the patient may reveal a perspective that highlights poor practice and injustice. So, whilst the Institute for Mental Health in England (NIMHE) values framework highlights the "respect" component to the patient, the political and economic pressures placed on the mental health team are not discussed, nor how these pressures influence the four key areas of clinical skills outlined in the paper: raised awareness of values and of value diversity, reasoning skills, knowledge of values and communication skills.

The problem implicit throughout the paper then becomes the absence of the writers, and how through their values they construct the imaginary stakeholders to respond to their pre-set questions. So the stakeholders' personal histories have also to be made irrelevant to why they ask the questions and how race, class, gender and other personal variables may be operating in the complexity of values and facts in the assessment process. This enables the authors to reinforce as opposed to refute and retest their position about the real complexity of values and facts from a professional-centred approach.

The question by the carer facilitates this defence of romanticising, whilst avoiding to examine the radical personal changes needed to truly move towards a value based practice and to provide evidence of this transition, or to give the accountability to the carer and patient to measure this change. The question on ethical relativism is crucial to the pretence of suggesting that all human values are given equal consideration, which negates the importance of legal considerations when conflicts between the values of patient and psychiatric profession emerge.

In conclusion, a delusion is again in practice in that professionals can share their understanding, but not how in their internal worlds they are really assessing and making value judgements about the patient. By using philosophical theories, none of which reflects a non-European/American heritage, this paper gives licence to opening our eyes to values and facts, whilst we may not need to open our hearts and minds.

Erratum – The first reference in the commentary "Looking back and ahead. Suicidology and suicide prevention: do we have perspectives?", by J.P. Soubrier, which appeared in World Psychiatry, 3: 159-160, 2004, has been submitted and published in an incorrect form. The correct reference is: Soubrier JP. Suicide prevention as a mission. Opening lecture at the 19th Congress of the International Association for Suicide Prevention, Adelaide, March 1997.