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Valid ethics versus probable histories

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Tamara Kayali Browne's proposal for a DSM Ethics Review Panel (hereafter, "the Panel") conceives of a state-sponsored panel of academic experts – philosophers, sociologists and bioethicists – dealing in a reflective, systematic, and standardized manner with the "value judgements" that are an "integral and unavoidable part of psychiatric nosology" (Browne 2015, 6). The Panel would consider existing and new diagnostic categories, and issue authoritative vetoes and/or modifications as appropriate. Browne asserts that "it should not be necessary to have protests and political activism, such as that involved in removing homosexuality from the DSM, in order for the status quo to be reassessed" (Browne 2015, 13). The Panel, in other words, is intended to do via expert deliberation what has been done previously via the apparently lesser methods of "protests and political activism".

My criticism of Browne's article concerns its historiographic argumentation. To exemplify the Panel's work, she offers a counterfactual history of Premenstrual Dysphoric Disorder (PMDD). The selection of PMDD – rather than, say, Homosexuality – is unhelpful to her case, and her narrative of a counterfactual deliberation on PMDD does not sufficiently distinguish, nor defend, its historical probability.

Browne lists three areas which the Panel of philosophers, sociologists, and bioethicists would respectively address: value judgements; societal consequences; and harm/benefit analysis (Browne 2015, 14-16). She concretely illustrates these debates in her account of a hypothetical Panel discussion of PMDD. The diagnosis is a DSM-5 category which Browne believes *should* be discontinued, and which she argues *would* have been vetoed by the Panel, had it existed: "it is most likely that a panel of philosophers, sociologists and bioethicists would have rejected the proposal to list PMDD as a diagnosis in DSM-5" (Browne 2015, 23). Note the counterfactual conditional: an important, concrete element in Browne's case for the Panel is the inference that, had the Panel existed, it would have rejected PMDD for valid reasons. While I concur with analysis that regards counterfactual

reasoning as essential, though often implicit, to historiography (e.g. Bunzl 2004), I believe that there are least two problems in Browne's argument by counterfactual history.

The first problem is the selection of PMDD. It is not explained why PMDD should be particularly useful for her historical argument. This is a significant omission because the history of Homosexuality in DSM, and a corresponding counterfactual history, would seem a better-informed alternative. There is a growing body of material that refers specifically to Homosexuality in DSM (e.g. Bayer 1981, Drescher and Merlino 2007), beyond the brief intra-professional historiography that Browne cites (Zachar and Kendler 2012), and an indefinitely large hinterland of social and cultural histories of gay rights and activism. In particular, a discussion of Homosexuality would have allowed Browne to identify what functions of "protests and political activism" could have been taken on by the Panel. Since there is, for instance, no well-known equivalent of the Stonewall riots for PMDD, Browne's counterfactual history leaves unclear precisely what the Panel would be taking over from the political and public spheres. The suspicion therefore arises that Browne's choice of PMDD stacks the deck in her favor: since no substantive actual (i.e. non-counterfactual) history of PMDD is provided by Browne, one cannot readily discern, for instance, whether the Panel's deliberations are an unlikely or improper substitute for "protests and political activism". Moreover, Browne's selection of a currently contentious diagnostic category poses a problem to readers who disagree with her conclusions on PMDD's validity. Those who have come (as they see it rationally) to a different (e.g. biomedical) conclusion about PMDD are confronted with a counterfactual history in which the Panel comes to precisely the wrong conclusion. If they accept Browne's historiography, but reject her nosology, then they will oppose her proposal. Choosing an uncontentious invalid category such as Homosexuality would have circumvented this obstacle.

The second problem is that Browne's discussion of the Panel's hypothetical deliberations simultaneously presents her case for the removal of PMDD from DSM-5. Two kinds of argumentative validity are therefore mixed indiscriminately. In one strand of argument, Browne contends that PMDD should not have been included in DSM-5. This is most apparent when she seems at points to be writing in her own voice, rather than constructing a valid historical argument. Consider a statement such as: "The PMDD label thus has the potential to stigmatise not only those women given the label but, given the social biases that exist regarding gender worldwide, there is the risk that it may stigmatise and harm all women" (Browne 2015, 23). Regardless of Browne's intentions, this sentence is easily (and perhaps correctly) apprehended in context as her inference about PMDD, rather than her inference about the course of a hypothetical Panel debate on PMDD. The unfortunate rhetorical effect is to muddle the validity of her views on PMDD with the validity of her historical argument. I found much that was convincing in Browne's feminist argument that PMDD is something like a highly contingent, culturally specific Western idiom of distress, "a normal and understandable reaction to stressful circumstances", rather than a "medical problem" (Browne 2015, 22). But I also found myself at first persuaded, then dissuaded and irritated, by the halo effect that emanates from this argument, and which colored my initial reading of her historiography.

Browne's counterfactual history is tacit at the beginning of her discussion of PMDD, since she writes initially in the second conditional (i.e. "if there were a Panel, it would …"), and seems to be offering a prediction about what the Panel *would* do if implemented in the present: "If a proposal to upgrade PMDD to a full category was put to the Panel, the Panel would then set to work identifying and examining the value judgements inherent to the proposal and predicting possible consequences" (Browne 2015, 21). But by the concluding paragraph, it is evident that Browne regards these predictions as equivalent to a

counterfactual history of the recent past. Browne offers a number of significant statements in the third conditional (i.e. “if there had been a Panel, it would have …”): “Those trained in philosophy, sociology and bioethics would have raised the issues and potential harms of the PMDD diagnosis highlighted above. These would have been weighed against the potential benefits”; “On this analysis it is most likely that a panel of philosophers, sociologists and bioethicists would have rejected the proposal to list PMDD as a diagnosis in DSM-5” (Browne 2015, 23). Browne’s historiographical vacillation presumably relies upon a silent inference that the present and the recent past are sufficiently similar historical contexts for her argument. For the sake of simplicity, I will accept this equivalence, and treat her discussion as an exercise consistently in the counterfactual history provided in her final paragraph.

Because Browne tends to confound historical and ethical validity claims, her presentation and rebuttal of counter-arguments is limited to her conclusions about PMDD, and nowhere extends to her historical conclusions about the deliberations of the Panel. Nosology is dignified with argument, but history receives only assertions about what is “likely”. Thus, with respect to biomedical rather than psychosocial explanation of PMDD, Browne writes: “Given the absence of verified associated biomarkers […], I would not think it likely that the Panel would be convinced on this point” (Browne 2015, 21). Browne assumes that the counterfactual events would be determined purely by the rationality (as she sees it) of the actors. Even if we accept for the sake of argument the validity of Browne’s case regarding PMDD, it is a *non sequitur* to suppose that the deliberations of any actual Panel would be as rational. Browne has to show that the (putative) rational structure of the Panel discussion would also be historically probable. At an abstract level, Browne proposes various safeguards to maximize rationality, such as state sponsorship to ensure that the public are the primary stakeholder, an appointment process that favors expert heterogeneity, and the capacity to invite external specialists when dealing with particularly recondite issues (Browne

2015, 17-19). However, none of these mechanisms are specified in the concrete counterfactual history of PMDD, which invites suspicion that they lack credibility when applied in particular contexts (for instance, one might wonder what would prevent the Panel selecting experts that confirmed its biases, or what would happen if the heterogeneous experts ended up in deadlock, unable to give a majority view) – and this is to say nothing of new "what ifs" that might be generated in a concrete, closely argued and counter-argued counterfactual account of the Panel deliberating PMDD.

There is, though, one sense in which Browne's counterfactual history sets the bar too high for her overall argument. Browne needn't show the historical probability of a Panel rejecting PMDD for good reasons. She merely has to show that, all in all, the Panel is an improvement upon things as they stand. But this means something more than merely showing the problems within the APA's current measures (Browne 2015, 24-26). It brings me back to the mystery that I noted in the beginning of this commentary. Browne states that "it should not be necessary to have protests and political activism, such as that involved in removing homosexuality from the DSM, in order for the status quo to be reassessed" (Browne 2015, 13). Browne may indeed be correct, but she needs to establish in greater detail what she takes to be deficient in protests and political activism as a means of exerting pressure on the DSM. Without clarity on this premise, it is unclear why the Panel is better overall. Otherwise, the Panel seems perhaps not an improvement, but merely the kind of thing that appeals to philosophers, sociologists, bioethicists, and others who find the seminar room congenial.

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