CHAPTER 4

CHARACTER

Moral Treatment and the Personality Disorders

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One interesting philosophical question about personality disorders is whether people diagnosed with such conditions should be held morally responsible for their actions (Elliott 1996). Another philosophical point of interest lies in the fact that these disorders usually involve deviations from social rather than physiological norms, meaning that they are evaluative and not simply descriptive diagnostic categories (Agich 1994). But what really are personality disorders? There are standard clinical answers to this question, of course, but philosophically the answer is far from obvious.

The argument advanced here is that the conditions we now call “personality disorders” actually constitute two very different kinds of theoretical entities. In particular, several core personality disorders are actually really moral, and not medical, conditions. Accordingly, the categories that are held to represent them are really moral, and not medical, theoretical kinds. Strategically, the idea is to work back from the possibility of treatment to the nature of the kinds that are allegedly treated. Along the way, we will revisit the eighteenth-century idea of moral treatment. The discussion closes with a reflection on how the ambiguous medical status of personality disorders and their treatment today is reminiscent of the ideological tug of war that pits alienist “mad doctors” like Pinel against their lay counterparts such as Tuke as they battled over who should be in charge of treating the mad.
BRIEF HISTORY OF THE PERSONALITY DISORDERS

Personality disorders have proven to be rather transient theoretical kinds. To understand this aspect of their nature and the arguments to come, it is important to appreciate their history. For our purposes, that history starts with publication of the third edition of the Diagnostic and Statistical Manual of Mental Disorders (APA 1980). Loosely understood, personality disorders have a history that arguably predates the publication of DSM-III by hundreds of years (Millon and Davis 1995). Some prefer to trace their origins to the late nineteenth century, when the modern concept of personality first appeared (Healy 2002: 14). But it is only with the publication of DSM-III that the personality disorders achieved widespread official recognition as a separate clinical diagnostic class of their own. Indeed, some researchers even distinguish between a "pre-" and "post"-DSM-III era in the study of personality disorders (Livesely 2000).

The publication of DSM-III marked a turning point in the evolution of personality disorders and, indeed, the DSM itself. The chief factor responsible for this change was the introduction of a multiaxial system of classification. Prior to DSM-III, by default all mental disorders were located on a single diagnostic axis. The move to a multiaxial system of classification has been compared to something like a Kuhnian "paradigm shift" (Millon and Davis 1995: 17). In that shift, personality disorders were placed on a separate axis, namely, Axis II. Axis I was reserved for the more serious clinical "mental" disorders such as schizophrenia and depression. Axis II was the domain of "personality" disorders and mental retardation, both enduring conditions with a relatively early onset. Finally, Axes III, IV, and V were left for more general medical and psychosocial factors relevant to treatment and diagnosis (APA 1994: 25–31).

Scientific experts in the area of personality disorders do not hesitate to say that the classification of personality disorders proposed in DSM-III was just as much a political compromise as was their classification in DSM-I (APA 1952) and DSM-II (APA 1968). In all cases, the guiding methodological principle has been to systematize and codify trends in current diagnostic practice using surveys and special committees and workgroups. As might be expected, this has meant that DSM classifications are highly vulnerable to political and economic influences and interests, a fact that even sympathetic insiders freely admit. Personality disorders have proven especially vulnerable to these forces. As Lee Ann Clark states, "it is no secret that the official classification of personality disorders...embodied in the DSMs represents a compromise among the often competing interests of clinicians, researchers, educators, and statisticians with various training backgrounds and orientations (1995: 482). Others are even more critical, stating that "in many ways, the DSM-IV classification of personality disorders is more like a political or philosophical statement than a sci-
entific classification” (Livesley 1995: 500). These criticisms by sympathetic “insiders” are significant and not very far removed from the more polemical criticisms by “outsiders” (Caplan 1995; Kirk and Kutchins 1992).

In DSM-IV, a personality disorder is defined as “an enduring pattern of inner experience and behavior that departs markedly from the individual’s culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress and impairment” (APA 1994: 629). Personality disorders are defined as collections of personality traits that have passed a certain “threshold” and “cause significant functional impairment or subjective distress” (633). More specifically, “only when personality traits are inflexible and maladaptive and cause significant distress do they constitute Personality Disorders” (630). Table 4.1 contains a list of the DSM-IV personality disorders and their predecessors. It nicely illustrates the transient nature of these peculiar theoretical kinds.

The placement of personality disorders on a separate axis represented a statement of faith in their empirical validity as important clinical conditions in their own right (Livesley 1995a: iv; Tyrer 1995: 29). It encouraged and eventually led to a large quantity of research devoted to the DSM personality disorders and their criteria sets (Livesley 1995; v; Shea 1995: 397). Recently, however, research in the area has been dwindling. Critics, even sympathetic insiders, are calling for change. The problem is that too many efforts have gone into measuring and defining the DSM criteria sets. Some have gone as far as calling this “an indictment of academia” (Tyrer 1995: 30).

The present categorical system itself has come under heavy fire. A categorical approach works best when “all the members of diagnostic class are homogenous, when there are clear boundaries between classes, and when the different classes are mutually exclusive” (APA 1994: xxii). Unfortunately, many mental disorders do not satisfy those conditions, and therefore categorization has to be more flexible. The solution has been to retain the categorical approach but with “polythetic” criteria sets (xxii). According to that method, one need not satisfy all the criteria for a disorder in order to have it. One need only satisfy “a subset of items from a longer list” (xxii).

DSM-IV contains a brief mention of the fact there is a dimensional alternative to the present categorical system (APA 1994: 633–34). There are now many commentators who believe that these efforts need to be put into developing a dimensional approach to classification (Blashfield and McElroy 1995; Clark 1995; Shea 1995; Widiger and Sanderson 1995). It is probably not an exaggeration to say that the adoption of a dimensional model of classification for personality disorders would signify a scientific revolution in the area. But why reject the categorical model? According to many experts, it poses vexing problems, particularly in the case of personality disorders. First, its adoption was based on committee consensus and not scientific merit. Second, according to many, it simply does not accord with the facts. In summarizing a large amount of research in the area, John Livesley flatly states that “the simple categorical model adopted by the DSM-IV is not supported by the facts” (Livesley 1995: 499). He argues that “the results of all relevant studies consistently support a dimensional model of phenotypic traits of personality disorders (Livesely 1995: 499).
Table 4.1. DSM Personality Disorder Classifications

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This of course makes the transient character of our current personality disorders even more shaky than it already is.

**PERSONALITY DISORDERS AS INTERACTIVE MORAL KINDS**

The preceding historical sketch is very hard to reconcile with the idea that personality disorders might be naturally occurring disease entities. In the language of philosophers, it makes it doubtful they are "natural kinds." The reason is that they are very transient and rest on a very weak empirical base. How then are we to understand their nature? This is an area where psychiatry can benefit from contemporary discussions in the philosophy of science.

Personality disorders may not be what philosophers call natural kinds. But they do appear to be distinct theoretical kinds nonetheless. In Ian Hacking’s terms, they are interactive kinds. The distinction between natural and interactive kinds is particularly helpful in trying to make sense of the transient character of personality disorders. Indeed, it helps explain why they are so transient. Hacking’s doctrine of interactive kinds provides a helpful way for understanding the ontology of personality disorders that at the same time acknowledges their transient character. Exploring this thesis will set the stage for the central argument of this essay, which is that several of the core personality disorders are really moral, and not medical, theoretical kinds.

According to Hacking, natural kinds are “a kind of event found in nature and hooked up to other events by laws of nature” (1995: 59). Typical examples include “water, sulphur, horse, tiger, lemon, multiple sclerosis, heat and the color yellow.”
(Hacking 1999: 107). Natural kinds are indifferent: they are simply there, unaware of being classified by the terms used to classify them. In that respect they are different from interactive kinds. Those are kinds “that, when known, by people or those around them, and put to work in institutions, change the ways in which individuals experience themselves—and may even lead people to evolve their feelings and behavior in part because they are so classified” (104). Thus, interactive kinds interact with what they classify. For example, consider plutonium: it is a natural, or indifferent, kind; it “does not interact with the idea of plutonium, in virtue of being aware that it is plutonium, or experiencing existence in plutonium institutions like reactors, bombs, and storage tanks” (105). In contrast, hyperactivity is an interactive kind: a hyperactive child can be aware of the fact that he is classified as such and this can shape his future behavior. In general, “terms for interactive kinds apply to human beings and their behavior” (123). What makes them interactive as opposed to indifferent is that “they interact with the people classified by them” (123). Interactive kinds thus have a characteristic looping effect that connects what is classified with what does the classifying (105, 121).

Asking the question what personality disorders are using Hacking’s distinction between natural and interactive kinds has interesting consequences for the debate whether the current categorical system should be retained or replaced with a dimensional alternative. On the one hand, the notion of an interactive kind fits nicely with the transient character of some of the personality disorders generated by the current categorical approach. On the other hand, speaking of personality disorders as natural kinds seems to make more sense in the context of a dimensional approach, particularly where the suggested dimensions are held to be measurable biological variables. On a biological dimensional approach, the idea is to work “bottom-up” from biological mechanisms to disorders, rather than “top-down” from folk psychological descriptions determined by clinical practice. Cloninger’s (1986, 1987) hypothesis that personality disorders are heritable dispositions that derive from malfunctions in monoaminergic pathways is a good example of a “bottom-up” biological dimensional approach. If that hypothesis is sound, there is an important sense in which personality disorder categories might turn out to be genuine disease conditions, or natural kinds.

On Hacking’s view, some mental disorders look very much like genuine natural kinds; schizophrenia and mental retardation are the examples he cites. Alternatively, he says, anorexia and hyperactivity look more like interactive kinds (Hacking 1999: 101–2). Note that it is also possible for a kind to be both natural and interactive. Schizophrenia and depression are probably like this. But before we try to sort personality disorders into their respective kind status, we need to look at another element in how this talk of “kinds” relates to them. The connection lies in the fact that natural kinds can be of different sorts. They can be geological, chemical—or medical. Diseases like multiple sclerosis and tuberculosis are examples of medical conditions that are natural kinds. Is the same true of personality disorders?

On his side, Carl Elliott is skeptical about construing personality disorders as medical kinds, noting that “the idea that personality disorders are illnesses should give us pause” (1996: 62). However, unlike Thomas Szasz, who argues that mental illness is a myth.

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illness is a myth, Elliott does not say that the DSM personality disorders are mythical. Nor is what he says consistent with this. He appears to take their existence seriously, at least enough to inquire into their implications for questions of moral responsibility. His view appears to be that, despite their ambiguous nature, we can and do generalize about the different "kinds" of personality disorders nonetheless. In other words, there is something to the general category and its putative individual kinds. In sum, personality disorders may not be medical kinds, but they are "kinds" of some sort. They do exhibit some theoretical uniformity, provide some explanatory and predictive power, and enable us to capture a modest amount of generalizations.

**Problems with Treatment**

Treatment plays a central role in Elliott's argument that the medical status of personality disorders is doubtful. In that argument, he asserts that "for personality disorders there is often no effective treatment" (Elliott 1996: 62). However, if we are to believe the most recent edition of *Treatments of Psychiatric Disorders*, this situation is changing. In the introduction to that volume, the claim is made that "advances in the diagnostic understanding and treatment of the personality disorders have been substantial" (APA 2001: 2223). Indeed, some personality disorders are now held to be "eminently treatable with psychotherapy" (2223). This suggests that at least some personality disorders may be illnesses after all. In turn, that suggests that they may, in fact, be medical conditions. The controversial premise here is nicely captured by Bill Fulford's claim that "medical interventions require medical grounds" (Fulford 1999: 164, 182). If a condition is a medical condition, then it is no surprise that it requires medical intervention. In the case of personality disorders, successful medical treatment would then be confirmation of the fact that these constitute conditions of a medical sort; that they are medical kinds.

The treatments for personality disorders referred to in *Treatments of Psychiatric Disorders* include both pharmacological and psychological therapies. Sometimes pharmacological therapies are recommended because of concurrent Axis I comorbid conditions. In practice, pharmacological treatments might also be administered even though they are not therapeutically specific to the conditions they are applied to (APA 2001: 2225). For example, antidepressants and neuroleptics might form part of the recommended treatment for some personality disorders even though there is no full-fledged Axis I indication for them (Healy 2002: 346). In that respect, such treatments resemble and function like the pharmacological tonics of earlier eras (Healy 1997: 257; 2002: 65–67). On the psychotherapeutic side, a variety of approaches are possible. Virtually all them are said to require the establishment of a "therapeutic alliance" and "empathy." Pharmacological and psychotherapeutic treatment recommendations are not divided equally across the different personality disorders. As might
be expected, pharmacotherapies tend to be favored in the case of disorders that are suspected to have strong biological determinants; for example, the schizotypal and avoidant types (APA 2001: 2223). In other cases, pharmacological interventions are prescribed on a "creative" basis, depending on the individual details of the case (2223).

Let us grant there now exists a widespread variety of therapies that are more or less effective in treating some of the personality disorders. Let us also grant that the pharmacological therapies involved sometimes target genuine Axis I conditions and so are clearly medically indicated. What I want to suggest is that this leaves an important subset of personality disorders out of the medical loop, beyond the boundaries of medical intervention, strictly speaking. The disorders I have in mind are the antisocial, borderline, histrionic, and narcissistic types. These, I suggest, are not genuine medical kinds; they are really moral kinds. As we shall see, this goes beyond merely suggesting that they are evaluative in nature (Agich 1994).

The central thesis of this discussion is that historically the DSM personality disorders tend to fall into two groups: a moral group and a nonmoral group. Part of the inspiration for this distinction is the division of personality disorders into clusters found in DSM-IV (APA 1994: 629–30). There personality disorders are divided into three classes. Cluster A consists of paranoid, schizoid, and schizotypal; this is referred to as the "eccentric" group of personality disorders. Cluster B consists of antisocial, borderline, histrionic, and narcissistic; this is referred to as the "dramatic" or "theatrical" group. Finally, Cluster C consists of avoidant, dependent, and obsessive-compulsive; this is the "anxious" or "fearful" group. This division of personality disorders into clusters is based on "descriptive similarities" (629). We are also told it has not yet been "consistently validated" (630).

In fact, the division of personality disorders into clusters is on the right track but does not go far enough. It cannot go far enough because the criteria for clustering are supposed to be limited to purely descriptive, factual terms. This is understandable, since the DSM professes to be a descriptive, objective scientific text. Terms with strong or even weak moral or evaluative connotations are to be avoided as much as possible. Psychiatry is part of medicine, and medicine is supposed to be based on science. And science, of course, is supposed to be based on fact, not value. The point is to identify and describe mental categories and conditions that are of "clinical" relevance, not to morally evaluate those conditions and the persons who suffer from them.

However laudable this might be as a general statement of ideological commitment and priority, the DSM fails to live up to its pledge to fact and objectivity. The general point that many of the DSM categories and criteria are heavily evaluative is well known and has been ably defended from a variety of different points of view (Agich 1994; Fulford 1999; Szasz 1961). The evaluative nature of the personality disorders is particularly transparent (Elliott 1996: 57–67). Even the notion of a mental "disorder" is evaluative. As Hacking notes, "disorder' often suggests something bad, unhealthy, and undesirable" (Hacking 1995: 17). On the other hand, "order" typically means something good—what is healthy and desirable. This precisely is how the concept of a personality disorder appears to function in psychiatric diagnosis and treatment. Pe
treatment. Personality disorders are undesirable and unhealthy traits of character that medical specialists hope to alleviate or cure through treatment. Therefore, the concept of a personality disorder is inherently evaluative. It is based largely on value and not simply on fact.

**TREATMENT AS MORAL CONVERSION**

To say that personality disorders are evaluative and not simply descriptive categories is not the same as stating they are specifically moral categories; the moral is only one subdomain of the evaluative. Thus the thesis that some of the central personality disorders are really moral categories requires a separate argument. The disorders in question are those in Cluster B: antisocial, borderline, histrionic, and narcissistic. Those Cluster B conditions are fundamentally moral in nature, while Cluster A and C conditions are not. The thesis that the Cluster B disorders are moral and not medical can be defended on the basis of the kind of treatment required for their “cure.” Call this the “Argument from Treatment.”

It is impossible to imagine a successful “treatment” for the Cluster B disorders that does not involve a moral commitment to therapy. The central issue is whether there exists a moral willingness to change together with a sustained readiness to make the moral effort to make and sustain that change. Thus it is impossible to imagine a successful “treatment” or “cure” for those conditions that does not involve some sort of conversion or change in moral character. On this basis, it can be argued that these are fundamentally moral conditions and, consequently, that their treatment requires a sort of moral treatment. None of this should be taken to imply that Cluster B disorders cannot or do not admit of treatment using other means. Rather, the point is simply that those other treatment interventions can never be sufficient for complete treatment or recovery. A full cure requires moral willingness, moral change, and moral effort. Of course, these moral desiderata are not mentioned in most standard psychotherapeutic interventions recommended for the treatment of personality disorders. Scientific objectivity does not permit it. But the point is that those desiderata are ultimately required for successful treatment and cure.

To see why, consider very briefly the nature of the individual Cluster B disorders. Antisocial personality disorder is said to involve a “pervasive pattern of disregard for and violation of the rights of others” (APA 1994: 649). Narcissistic personality disorder is said to involve a “lack of empathy” (661). The moral nature of histrionic personality disorder is more implied than explicit but is clear nonetheless. Here the “excessive attention seeking” and “inappropriate sexually seductive and provocative behavior” referred to is flatly inconsistent with a pattern of empathy and regard for others (657–58). Finally, the “inappropriate, intense anger” and “instability in interpersonal relationships” cited in the diagnostic criteria for borderline personality disorder again
imply clear moral deficits in empathy and regard for others. There is therefore no escaping the conclusion that, either by explicit mention or by implication, persons diagnosed with Cluster B personality disorders exhibit morally objectionable and reprehensible behavior toward others.

Clearly, moral shortcomings of some sort appear to be necessary conditions of the DSM Cluster B personality disorders. It follows that unless those moral problems can be overcome or eliminated, successful treatment and cure are impossible. Someone who is empathic and caring of others cannot logically be said to suffer from antisocial or narcissistic personality disorder in the way these are presently characterized in the DSM. Likewise, someone who has reached the point of being morally committed to being more respectful and considerate of others can plausibly be said to be improving and recovering from histrionic personality disorder. The case of borderline disorder is more difficult, but here as well it is plausible to imagine that a moral commitment to being patient and loving with both others and oneself is an essential ingredient of any serious treatment and cure. Note that the same cannot be said of psychotherapeutic interventions for many other sorts of conditions. There are no such moral presuppositions for desensitization behavioral therapy for phobias or even cognitive therapy for depression. Willingness, commitment, and effort are of course required for therapy to succeed in these and many other cases. But moral willingness, commitment, and effort of the sort we have been discussing are not required. In addition, successful pharmacological interventions to reduce conditions like depression and anxiety for the Cluster B disorders may well help foster positive growth and development, but without a moral commitment to change, those interventions are doomed to remain insufficient and will elude any thorough cure.

WHAT PERSONALITY DISORDERS ARE

We are now in a position to answer our opening question about what personality disorders are. Keeping in mind the distinction between the Cluster B personality disorders and their moral presuppositions, which are absent from the Cluster A and C disorders, the answer is this.

First, Cluster B disorders are not natural kinds in any plausible sense. They are a species of interactive kinds that are simply too transient to count as genuine natural disease entities. In fact, precisely because they are interactive, their transient character should be no surprise. It is a predictable consequence of the fact that as social and political conditions change, so do the boundaries of deviant moral behavioral syndromes that are thought to require special social attention and behavioral control. Nonetheless, despite their transient interactive character, Cluster B disorders still stand for genuine theoretical kinds. They represent behavioral syndromes that are

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nomologically uniform and distinct enough to permit various limited explanatory projects and activities.

Second, Cluster B disorders are moral and not medical kinds. Both their identification and treatment rest on and require articulation in moral terms and concepts. In particular, treatment requires a sort of moral willingness and commitment to change that is typically absent in consent to therapy for other sorts of mental and behavioral disorders. Willingness and commitment to developing the capacity for empathy is an important milestone in psychotherapeutic treatment for Cluster B disorders. So is the willingness and commitment to relate honestly in the therapeutic alliance. Any psychotherapeutic intervention directed at Cluster B disorders must pass these two milestones if it is to be successful. Moreover, this remains true even if the theoretical vocabulary in which that therapeutic theory is couched makes little or no explicit mention of any such notions. Two interesting contemporary therapeutic initiatives to consider here are Moral Reconation Therapy for antisocial personality disorder (Little and Robinson 1988) and Dialectical Behavioral Therapy for borderline individuals (Linehan 1993).

Third, turning to Cluster A and C disorders, we can say that these appear to be very different in kind from their Cluster B counterparts. Whether they constitute natural and independent disease entities is doubtful but remains to be seen. However, that they are not moral kinds seems much clearer. Consider the fact that the definition of the Cluster A and C disorders does not appear to employ or imply moral terms and notions, while the definition of Cluster B disorders does. In effect, most of the behaviors captured by the Cluster A and C groupings are morally neutral. Thus, the avoidant person simply avoids others but does not necessarily dislike or hate them. In other words, dislike and hate are not logically presupposed or implied by the diagnosis. Likewise, the dependent individual may annoy others but does not necessarily intend to annoy them for the sake of it. Again, the intention to annoy is not logically presupposed or implied by the diagnosis. Finally, the obsessive-compulsive individual may embarrass or ignore others as a result of that condition, but typically this is not because he intends to do so. Here again, there is nothing in the diagnosis that logically presupposes or implies the intention to embarrass or ignore others. Of course, cure and treatment for these three conditions do require willingness and effort—but not the sort of moral willingness and effort required by the Cluster B disorders. You can be fully cured of obsessive-compulsive, avoidant, or schizoid personality disorder but still have an evil character and intend to perform immoral actions. However, you cannot be fully “cured” of antisocial, borderline, histrionic, or narcissistic personality disorder and regularly intend to be systematically cruel, dishonest, and indifferent to the feelings of others. Successful treatment here requires a moral commitment and character change of a significant sort. This invites the question why treatment should be administered by medical professionals. The issues go to the heart of the professional status of psychiatry as a medical discipline and the conditions it claims to treat. The situation is also reminiscent of the ideological and professional disputes associated with the eighteenth-century practice of moral treatment.
Revisiting Moral Treatment

In its widest sense, moral treatment had to do with restoring inmates to orderly and socially appropriate conduct. For example, William Tuke's York Retreat was run according to a strict code of "moral management" defined by basic rules of housekeeping and personal conduct that included everything from regular dining and bedtime hours to leisure activities like gardening, games, and strolls in the countryside. Every effort was made to inspire and instill a family atmosphere, and intimacy with patients was paramount. The idea was to manage all aspects of inmates' lives in order to restore them to reason and emotional equilibrium. These general presuppositions of moral treatment were accompanied by moral interventions of a narrower sort. Intimacy with inmates was thought necessary to address these narrower, more immediate moral concerns (Scull 1993: 148). Therapy consisted of efforts to rouse and nurture inmates' moral feelings, as well as their sense of moral discipline. Appeal to the desire for self-esteem was held to be a central component of this task (Scull 1993: 101). Overall, this was a system supposed to be governed by "kindness" (Scull 1993: 102; Porter 2001: 291). Tuke repeatedly insisted on the nonmedical character of moral treatment and refused even to say that it was based on any theory. According to him, this was clearly not a professional intervention requiring special theoretical skills. And yet it proved surprisingly successful, if recent historical assessments of the official records are to be believed (Scull 1993: 102, 148–55; Porter 2002: 105–15; Whitaker 2002: 19–38).

The nonmedical character of moral treatment posed no problem for Tuke and his lay followers, but it did pose a problem of allegiance for medical proponents like Pinel. Why were medical professionals needed to administer nonmedical moral treatments? The same question is pertinent today. If the Cluster B disorders are fundamentally moral in nature, then it is unclear why their treatment should fall in the province of medicine or any other "scientific" form of treatment, including various psychotherapies. Strictly speaking, the moral treatment of the Cluster B disorders falls in the province of what psychiatrist David Healy calls the quest for authenticity (1990: 28–33, 200–204, 214–15). Standard psychotherapy may help and sometimes even be required for moral recovery, but it can never be sufficient on its own. It should be clear that, for the Cluster B disorders at least, moral treatment must form the core of any successful treatment and recovery (Borthwick et al. 2001; Deniker and Sempé, 2001). The fact that this recommendation might seem naïve and utopian just shows how far we have strayed from the ideals of hope and humanity that drove Tuke and Pinel to undertake their reforms.
REFERENCES