

## ***Scrupulosity and the Shady Morality of Psychiatry***

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Can you be too moral? Certainly, you can be too *moralistic* – a prude, a prig, a rigid stickler to rules, moral and otherwise. Equally, you can be too prone to perfectionism, irrational doubts, and anxiety, lacking the ability to cope well with these traits in various aspects of life – again, moral and otherwise. But is it possible either to have so much *care or concern for morality* or to have *moral standards* that are so high that you have a problem that may need psychiatric treatment? In their rich and nuanced paper, Jesse Summers and Walter Sinnott-Armstrong argue that, when a person has a condition called *scrupulosity*, it is appropriate to treat patients who exhibit too much moral care or concern, or whose moral standards are too high, even over their objections when certain conditions are met. This commentary aims to raise some questions about their characterisation of scrupulosity as a disorder involving, among other things, *too much care or concern for morality* or *too high moral standards*, and their arguments for the appropriateness of treatment over patients' objections. But, in so doing, it also considers some of the broader connections between morality and psychiatry, bringing the monsters that lurk in the shadows of psychiatry to light.

Scrupulosity is not a self-standing disorder according to the DSM-IV-TR. Rather, it seems to combine one of the traits characteristic of Axis II Obsessive-Compulsive Personality Disorder (OCPD) with some of the symptomatology of Axis I Obsessive-Compulsive Disorder (OCD). The personality trait in question is excessive conscientiousness, "scrupulosity", and inflexibility about matters of morality, which is out of keeping with a person's religious or wider moral community. The symptomatology in question is persistent and intrusive thoughts – particularly thoughts about real or possible failures to meet the demands of morality – which cause anxiety and distress and lead to compulsive and repetitive patterns of behaviour that aim, but ultimately fail, to cope with the underlying thoughts and emotions.

To give a flavour of the condition, Summers and Sinnott-Armstrong describe an Orthodox Jewish woman who feels compelled to recite a ritual blessing before eating 18 times; a religious man who obsessively cleans his orifices for at least 20 minutes before praying; and a waitress who checks that the containers of cleaning solvents are sealed before serving every order, in order to make sure she does not poison her customers. Certainly such behaviour and correspondingly its underlying motivation appears unusual. But do these people really have too much care or concern for morality or moral standards that are just too high?

Consider a non-religious and non-moral but otherwise comparable pathological example: a person who checks the lock on the door 22 times when leaving the house, in order to make sure it is secure. Would we say this person cares or is concerned too much about household security or has overly high security standards? I don't wish to deny that, speaking loosely,

we might put the problem this way. But on consideration, this characterisation does not seem apt, because it suggests that the behaviour in question *promotes household security*. We would certainly expect a person who cares about household security or has high security standards to ensure the door is locked before leaving. But, if indeed it is locked the first time they check, nothing security-wise is gained by a further 21 checks. Rather, when linked to a diagnosis of OCPD or OCD, this behaviour seems better characterised as a way of *coping with anxieties about household security*, which the person feels compelled to perform even though the repeated behaviour does nothing to decrease the likelihood of a break-in. This is not a person who *cares or is concerned too much* about household security or whose *standards* are too high, but a person who is *anxious* about household security and has developed an obsessive-compulsive coping strategy.

Let us return now to the religious and moral examples more characteristic of scrupulosity. Do these people have too much care or concern for morality or have moral standards that are too high? Again, this characterisation does not seem apt, because moral ends are not in fact served by such highly rigid, repetitive, and fixated behaviour. Of course, all things being equal, Orthodox Jews believe that they should recite a ritual blessing before eating; many religious people believe that they should not pray in a dirty, squalid state; and morally decent people believe that we should all take precautions to ensure we don't kill other people, which will involve responding appropriately to possible risks. But, just as household security is not promoted by checking the lock 22 times, morality would not seem to be promoted by saying the ritual blessing 18 times, cleaning orifices for at least 20 minutes before praying, or checking that the containers of cleaning solvents are sealed before serving every order. If the ritual blessing has been recited, the body normally cleaned, and there is no evidence of possible risk of poisoning, then 17 further blessings, extra time spent cleaning, and incessant checks on the containers, are neither morally required nor morally desirable. Rather, as Summers and Sinnott-Armstrong emphasise, these patterns of behaviour instead seem to be *aimed at coping with anxieties about morality*, which scrupulous people feel compelled to act on even though the behaviour arguably does nothing to increase the likelihood that moral ends are in fact promoted.

Indeed, morality may, in certain contexts, demand precisely that people *not* behave in such ways. This will be so whenever the behaviour – perhaps due to its rigidity, repetitiveness, and fixation – *interferes* with genuine moral demands and so bears a *moral cost*. This may happen, for example, if the compulsion to recite the blessing 18 times before dinner impedes attending to one's child at dinner; or if obsessive washing pre-prayer results in less time or focus on praying itself; or if incessantly checking the cleaning solvents means that food gets cold and goes to waste. In general (and among other things), acting morally requires the flexibility to adjust principles to particular contexts and circumstances; the capacity to balance multiple considerations as opposed to fixating on one thing in particular; and the ability to manage any unhelpful desires and emotions so that these interfere minimally with doing the right thing. The scrupulous people described by Summers and

Sinnott-Armstrong do not seem to evidence such qualities. Rather, their OCPD or OCD seems to *compromise* their capacity for morality, not make them *more* moral.<sup>1</sup>

Scrupulosity, then, is not well characterised as a disorder involving, among other things, *too much care or concern for morality or too high moral standards* in so far as that suggests that scrupulous behaviour *promotes* morality. The scrupulous people described by Summers and Sinnott-Armstrong are not more moral than their religious or wider community. Like others in their community, we can suppose, they want to do things right. The difference between them and others seems to be that, even when there is no reason whatsoever to doubt that they have done things right, they are extremely anxious about this, and have developed obsessive-compulsive ways of coping that repeat behaviour in a rigidly specified way, but that do not in fact serve moral ends.<sup>2</sup> So, as Summers and Sinnott-Armstrong describe, their problem is that, like others with OCPD and OCD, they are prone to rigidity, perfectionism, irrational doubts, and anxiety, and lack the ability to cope well with these.<sup>3</sup> But – and this is the crux – this does not make them more moral than ordinary even if the focus, in these cases, of the rigidity, perfectionism, irrational doubts, and anxiety, is on behaviour pertaining to religious and common morality.

Why does this matter? The answer is that it matters because there is only a distinctive puzzle and need to justify treatment for scrupulosity if it really does involve an extra dose of morality, as we might put it. Rigidity, perfectionism, irrational doubts, anxiety, and poor coping skills, are all problems that psychiatrists commonly treat. On the whole, we do not consider these traits good to have. Equally, they often and understandably cause clinically significant distress and dysfunction – a core marker of psychiatric disorder and one of the

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<sup>1</sup> In this respect, scrupulous patients appear more like the informal characterisation of scrupulosity that Summers and Sinnott-Armstrong quote but reject, as “seeing sin [or immorality] where there is none” or “focusing on minor details of the person’s religion, to the exclusion of more important areas”. Summers and Sinnott-Armstrong rightly emphasise the over-simplicity of this characterisation, due to its failure to understand scrupulosity in connection with OCPD or OCD. But this characterisation nonetheless emphasises the way scrupulositing *interferes with* morality, rather than seeing it, as Summers and Sinnott-Armstrong do, as *servicing* morality.

<sup>2</sup> It is a good question why scrupulous people are especially anxious and prone to irrational doubts *about morality in particular*. A psychodynamic explanation might posit unconscious, immoral impulses, which could be traced both to general features of our species and individual developmental trajectories, as the source. Scrupulosity could then be understood as a defence against these impulses. But such an account is not part of the standard conception of scrupulosity.

<sup>3</sup> Note that pathological perfectionism – the sort that warrants clinical attention – with respect to any domain does not in fact make patients ‘perfect’ or enable them to meet their expectations or achieve their goals – unlike our intuitive understanding of non-pathological perfectionism. Non-pathological perfectionists typically have high standards and push themselves very hard, but often meet (at least some of) their expectations and goals. Patients who struggle with pathological perfectionism typically have expectations and goals which they fail even to try to meet – or give up trying to meet very quickly – due to their intolerance of lapses, mistakes, and failures, and low self-esteem and self-efficacy. When I first started working clinically, I was often struck by the oddity of patients who describe themselves as perfectionists, yet were highly dysfunctional and very far from ‘perfect’. They often failed to meet ordinary expectations or achieve even the most ordinary goals. As I have come to understand it, such patients seem to feel that they are bound to fail no matter what, and in response opt to fail by not even trying, rather than to fail by trying but not succeeding. Pathological perfectionists are therefore typically far less ‘perfect’ than non-pathological non-perfectionists.

cornerstones for the justification of treatment. Morality, in contrast, is generally considered to be good to have. It comes as a surprise to hear it characterised as part of the cause of clinically significant distress and dysfunction. Of course, sometimes doing the right thing is hard and causes discomfort – for example, when it requires forsaking selfish pleasures for the sake of others. But how could doing the right thing cause clinically significant distress and dysfunction? And, if it did, would we really want psychiatrists to interfere in such cases, to help people do the right thing *less* and stop caring so much about morality or having such high moral standards?

If it is correct that scrupulosity is not rightly characterised as involving *too much care or concern for morality* or *too high moral standards*, then the puzzle and need for a special justification for treating scrupulosity, over and above the treatment considerations relevant to OCPD and OCD, collapses. However, treatment for scrupulosity may nonetheless require psychiatrists to challenge and try to change beliefs and behaviour that patients themselves view as morally important – for instance, by helping them to understand their obsessions and compulsions as unhelpful ways of coping with anxiety and distress, as opposed to morally required or desirable. And, even if this would not *in fact* make patients *less* moral – notwithstanding their own view of the matter – it is yet something that, at least instinctively, it may seem wrong for psychiatrists to do.

Summers and Sinnott-Armstrong state that: “The job of psychiatrists is presumably not to judge the moral views of their patients”. It is at this point that the monsters lurking in the shadows of psychiatry need to come to light. History reveals psychiatry to have been the perpetrator of terrible human rights abuses – a willing, coercive tool of tyrants and evil states, and an impressively systemic instrument for social control that has been used to violate and harm individuals whose beliefs or lifestyles do not conform to the norm.<sup>4</sup> Psychiatry is a branch of medicine. Its aim is to help and care for people, and alleviate suffering, not harm them. Summers and Sinnott-Armstrong are absolutely right that the job of psychiatrists is not to be *morally judgemental* any more than it is to serve tyranny, oppression and conformity. Yet, morality and psychiatry are intertwined, in the very nature of psychiatric disorder, diagnosis, and treatment. We cannot address this fact and protect people against the risk psychiatry poses unless we bring this monster out of the shadows, and face up to it in broad daylight.

Many of the personality disorders – including Obsessive-Compulsive Personality Disorder, to which scrupulosity is connected – are diagnosed via personality traits that link to immoral actions or display a lack of moral qualities. Lack of empathy, lack of remorse, cruelty and callousness, a willingness to exploit others and violate their rights, a history of criminal activity and violent behaviour, impulsivity, recklessness, extreme and inappropriate anger, a

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<sup>4</sup> Standard examples include the diagnosis of runaway slaves as suffering from drapetomania; homosexuals as suffering from a form of perversion and sexual deviance; and political dissidents as suffering from psychopathology and madness.

tendency towards unjustified suspicion and distrust, obedience to rules at the expense of the good of others, and a desire for interpersonal control – these are some of the traits by which some personality disorders are diagnosed. Hence, in order to make a diagnosis, psychiatrists must attribute traits to people which are not morally neutral, but which invite moral condemnation. In order to treat people for these traits, psychiatrists will in effect be offering a form of moral improvement – treatment ipso facto makes people *morally better*. Of course, psychiatrists do not typically view the process of diagnosis and treatment in these terms, especially outside of forensic contexts. These personality traits typically cause terrible distress to those who have them and create chaos and dysfunction in their lives, because of their impact on the possibility of stable and caring relationships with others, a sense of belonging to a community, employment and educational opportunities, and more. So the aim of helping and caring for people, and alleviating suffering, can be achieved by diagnosing and treating these traits, without any need to explicitly focus on their moral status. Yet, morality lurks in the shadows of this process, no doubt inviting psychiatrists to step out of the role of doctor and carer, and into the role of judge and oppressor.<sup>5</sup>

Hence psychiatrists may need to attribute and address morally relevant traits to people in order to do their job, even though the aim of their job is not to judge people morally. In principle, this is true whether the traits are morally negative or positive. Either way, psychiatrists need to act for the good of the people they treat, and be alive not only to individual differences and people's right to choose how to live, but also to the diversity of ways of living that are conducive to wellbeing. On the whole, and as a rule of thumb, psychiatric treatment is in practice seen as justified when the following conditions obtain: a psychiatric diagnosis can be made or the person in question has problems that fit within the domain of psychiatry well enough; they suffer from sufficient distress and dysfunction to warrant psychiatric intervention; a form of treatment is available that there is evidence or reason to think will help them; and, crucially, they want to be helped.

There is no question that many cases of scrupulosity will meet these conditions, with the form of treatment in question likely being an individually-tailored variety of intervention for Obsessive-Compulsive Disorder or Obsessive-Compulsive Personality Disorder. But Summers and Sinnott-Armstrong want to argue that treatment for scrupulosity may be justified even when people do not want to be helped. They state explicitly that they are interested in cases where treatment might be justified in particular “over objection” and “over moral objection”. The cases they have in mind appear to involve a person refusing treatment out of a conviction that it would result in them becoming *less* moral. I am unsure how common it is to find scrupulous people refusing treatment on precisely these grounds, when they are genuinely distressed and struggling to function due to their scrupulosity. When this is the case, psychiatrists who press treatment will indeed be (implicitly or explicitly) challenging and hoping to change beliefs and behaviour that patients view as morally important. But,

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<sup>5</sup> For further discussion of issues of morality within psychiatry and in relation to personality disorders in particular, see Pearce & Pickard (2009), Pickard (2011) and (2013).

however common such refusal is, it is extremely important to draw a very sharp distinction between two different kinds of action that psychiatrists can take when patients do not want to be treated, and that require correspondingly different forms of justification. The distinction is between the action of *offering* treatment over a patient's objection – and, perhaps, even more, endeavouring to persuade the patient to accept it – and the action of *forcing or otherwise coercing* a patient to undergo treatment.

In ordinary cases of scrupulosity, I can see no justification for a psychiatrist to force or otherwise coerce an unwilling patient to undergo treatment. There are two standard ethical and legal forms of justification for involuntary treatment. The first is when the patient lacks decision-making capacity to consent to treatment which is judged to be in their best interests. Given the standard criteria for assessing decision-making capacity, it seems unlikely that most scrupulous patients fail to have it in relation to a decision as to whether or not to undergo treatment for scrupulosity. The second is when there is a sufficient risk of serious harm to self or others if treatment is not forced to warrant the violation of patient autonomy that involuntary treatment constitutes. Again, it seems extremely unlikely that the average scrupulous patient poses such a risk to self or others. Of course, there may be particular cases where one or other of these two standard concerns arises, and a justification for involuntary treatment is therefore available in that particular case. But Summers and Sinnott-Armstrong do not discuss cases where scrupulous patients lack decision-making capacity or pose a sufficient risk of serious harm to self or others, and I cannot see how, in absence of such concerns, involuntary treatment for scrupulosity could ever be justified.<sup>6</sup>

Perhaps, then, Summers and Sinnott-Armstrong mean to focus not on whether a psychiatrist would be justified in forcing or coercing treatment for scrupulosity over objection, but rather on whether a psychiatrist would be justified simply in offering treatment – or trying to persuade a patient to be treated – over objection.

Well, why wouldn't they be justified in offering treatment? There are indeed circumstances where, even if a person has come to a psychiatrist for help and wants treatment, it should not be offered. For instance, if the person's distress and dysfunction, that core marker of psychiatric disorder and cornerstone for the justification of treatment, is not sufficient to warrant psychiatric intervention, or if no treatment exists which there is evidence or reason to think will help. But this is not the kind of issue Summers and Sinnott-Armstrong consider. Rather, they seem to be concerned, as suggested above, with the impropriety of a psychiatrist judging a patient's moral views or "imposing [their] own moral standards on the patient" merely in virtue of offering treatment for scrupulosity. I think we can here see how psychiatry's monsters are lurking in the shadows – the concern seems to be that psychiatry

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<sup>6</sup> It is also important to mention, as Summers and Sinnott-Armstrong equally note, that forced treatment for scrupulosity is very unlikely to be effective, since treatment outcomes typically depend on patient motivation and engagement.

should not be an instrument of oppression and conformity, “imposing” its own so-called “moral standards” on patients. Above, I claimed that moral ends are not served by 17 further blessings, extra time spent cleaning, and incessant checks on the containers. But people disagree about morality. So, one might wonder, how do I know my claims are right? And, if there is a possibility that I am wrong and scrupulous patients are right, how could a psychiatrist be justified in imposing this view on patients?

Both concerns –how to respond to moral disagreement, and how to protect against the risk of psychiatry being an instrument of oppression and conformity – are well-taken. But imposing a moral view on patients is not what *offering* treatment – as opposed to forcing or otherwise coercing treatment – for scrupulosity amounts to. If a person suffers distress and dysfunction due to rigidity, perfectionism, irrational doubts, anxiety, and poor coping skills – with respect to any matters, moral or otherwise – it is surely justifiable for psychiatrists to offer help and try to persuade the person to accept it. Psychiatrists do this all the time – with all forms of obsessions, compulsions, and irrational thinking processes. Indeed, arguably, offering treatment and aiming to persuade a person to accept it (while always acknowledging that the choice is theirs) can be a sign of respect for that person – a way of engaging with them as a rational and participant member of our shared social and moral community, developing a genuine relationship with them, and expressing care and concern. What would not be justified is to force or in some way coerce treatment – to violate a person’s autonomy and right to choose – because they suffer distress and dysfunction due to some combination of rigidity, perfectionism, irrational doubts, anxiety, and poor coping skills, in relation to any domain, moral or otherwise.

Summers and Sinnott-Armstrong argue in detail that treatment over objection – whether this is to be understood as forced treatment or the offer of treatment – is only justified when the person meets three conditions: they are in significant distress, their beliefs are internally incoherent and they cannot adequately justify them, and this incoherence is driven by anxiety or underlying emotional needs. Alongside dysfunction, significant distress is, as mentioned above, part of the rule of thumb justification for diagnosis and treatment, and rightly emphasised by Summers and Sinnott-Armstrong. Equally, their account of how and why scrupulosity can develop as a way of coping with anxiety or underlying emotional needs is insightful, and can be nicely linked to clinical practice. The conceptualisation of many of the behaviours that are diagnostic of or contributory to psychiatric disorders as unhelpful ways of coping with underlying emotions is both prevalent within psychiatric contexts and may straightforwardly contribute to the rationale for offering treatment. However, I am not convinced of the relevance of finding a person’s beliefs to be internally incoherent, and the person themselves being unable to justify their beliefs, to the justification of treatment. This seems to place a demand on people with scrupulosity that few of us without it ever meet. Do most of us really have internally coherent beliefs, especially as pertaining to religious or moral domains? And could most of us, even if our beliefs are coherent, justify them adequately to others, especially others who do not already

hold a similar set of beliefs? Honest reflection on our own shortcomings, together with the findings of social and cognitive psychology, suggest that we typically possess, alas, a mish-mash of poorly integrated beliefs which we may have limited access to, and which stem from different origins and which we have acquired via diverse processes.<sup>7</sup> It's not easy to sort through them, and, even if we manage to achieve this, we may yet lack the articulacy and argumentative skills to justify ourselves adequately to others. Unquestionably, the consistency and justification of our (religious, moral and other) beliefs is an ideal to which we may aspire. But if there is really a question as to whether (forced or merely offered) psychiatric treatment can be justified, I do not think it can be answered by pointing to the fact that a person fails to live up to this ideal.

So, does scrupulosity involve caring or being concerned about morality too much or having moral standards that are too high? No, it is a condition where people suffer from rigidity, perfectionism, irrational doubts, anxiety, and poor coping skills, particularly with respect to matters that pertain to religious and common morality. Is it scrupulous to treat scrupulosity? Absolutely, if the person suffers sufficient distress and dysfunction to warrant psychiatric intervention, and if they want treatment. If they don't, psychiatrists should yet go ahead and offer it, and explore with the person why it is at least possible, on the one hand, that they are mistaken if they genuinely believe their behaviour is morally required or desirable, and on the other, that their rigidity, perfectionism, irrational doubts, anxiety, and poor coping skills are getting in the way of a better life. But, presuming the person retains decision-making capacity and the risk of harm to self or others is not severe, there is no justification for forcing or coercing treatment over objection. This cannot be emphasised enough, because it's absolutely essential to controlling the monsters lurking in the shadows of psychiatry. When capacity is present and risk is not high, psychiatrists ought to talk to people openly about their assessment of their problems, and try to engage them in treatment if their best judgement – meaning their judgement when they have done all they can to be sensitive to the other person's (moral and other) perspective, and alive to their own biases and preconceptions – really is that the person would benefit from treatment despite their misgivings about having it. But when capacity is present and risk is not high, psychiatry cannot be granted the power forcefully or coercively to interfere in people's lives. Let's relegate the monsters to history.<sup>8</sup>

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<sup>7</sup> The literature on this topic is copious, but for two excellent books written for a general audience, see Khurzban (2012) and Wilson (2004).

<sup>8</sup> Thanks to Jesse Summers and Walter Sinnott-Armstrong for very generous and helpful comments on an earlier version of this commentary.

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