

**Paweł Łuków**

University of Warsaw  
Institute of Philosophy  
p.w.lukow@uw.edu.pl

**INTEGRATING ETHICS WITH PSYCHIATRY  
THE CASE OF ANTONI KĘPIŃSKI**

**Abstract**

This paper argues that in the case of mental illnesses whose somatic bases are not known or do not exist, a promising route to understand mental illness is to see it as the lack of a patient's engagement with some moral values that are necessary for a good human life. The paper explains how the first-person perspective, which is constitutive for mental illnesses, makes it impossible to provide an adequate, third-person explanation of the pathological. Because of its irreducible first-personal nature, mental illness must be understood (also) in terms of a moral harm to the patient, and so an integration of ethics and psychiatry (at least at the level of practice) is required. This view is further illustrated with A. Kępiński's idea of psychiatry as therapy with moral values.

**Keywords:**

Antoni Kępiński, ethics of medicine, moral values, psychiatry, patient-doctor-relation, epistemology in psychiatry

From their very beginnings, medicine and philosophy have been struggling with the concepts of the pathological and the normal. These difficulties grew even larger when the concept of mental illness – as different from madness, possession by demons, bewitchment and other forms of supra-natural activity – took hold. On the one hand, the concept of mental illness had a liberating power because it de-moralized the affliction and helped remove moral responsibility from the afflicted. On the other hand, however, mental illness often medicalized what was earlier seen as a misfortune or misbehaviour and moved psychiatric treatment into the clinic. De-moralization of mental illness resulted from the “discovery” of mental illness and its medicalization.<sup>1</sup>

---

<sup>1</sup> Roy Porter, *The greatest benefit to mankind: A medical history of humanity* (London: HarperCollins, 1997), chap. XVI; Michel Foucault, *History of madness* (New York: Routledge, 2006).

The de-moralization of mental illness is often applauded. It freed mental patients from the stigma of guilt and wrongdoing and made psychiatric care more human than before. But this process also led – especially in the 20<sup>th</sup> century – to the removal from psychiatric theory, or at least from the purview of its proponents, of a significant part of the moral dimension of psychiatric care. To be precise: the moral requirements for therapists have been strongly endorsed, as can be seen in codes of professional ethics and other forms of ethical and legal regulation of the profession, but the practice of therapy is mostly thought of as a value-neutral or value-nonspecific enterprise in that it does not allow the therapist to conceive of the goal of his or her intervention in moral terms. The point of the intervention is to restore the patient's psychological balance, self-fulfilment or social adjustment, not to educate him or her morally or help live a morally good life. In a way, the moral dimension of the goal is to be defined by the patient, not the therapist.

This approach to mental illness tends to ignore the specific nature of those mental disorders whose somatic causes remain unknown or do not exist.<sup>2</sup> In the case of such illnesses, which will be the focal point of this paper, both theoreticians and practitioners are left with an explanation of the illness process with limited or no relation to a rational approach to therapy, speculative theories of mental illness providing telling examples of it. I will argue that in the face of this absence, a promising route to an understanding of mental illness is by reference to morality. On this view, mental illness is not to be seen as a result or symptom of the patient's immorality but as a lack of his or her engagement with some moral values that are necessary for a good human life as well as for the patient's mental wellbeing. My argument will take three steps. First, I will try to show how the first-person perspective, which is constitutive for mental illnesses (especially for those which do not have somatic causes or whose somatic causes are not known), makes it impossible to provide an adequate explanation of the pathological both generally and in particular cases. Secondly, I will show that because of its first-personal nature, mental illness must be understood in terms of a moral harm to the patient. On this basis, an integration of ethics and psychiatry (at least at the level of practice) becomes required. Thirdly, I will present a brief account of what such an integration would involve in psychiatric practice. To illustrate this program, I will offer a short discussion of A. Kępiński's idea of psychiatry as therapy with moral values.

The concepts of health and pathology are general. They rely on a conceptual apparatus which of necessity leaves out some of the particulars of a normal or pathological state. When we say that the state of an individual is normal or

---

<sup>2</sup> See however David Papineau, "Mental Disorder, Illness and Biological Disfunction," *Royal Institute of Philosophy Supplements* 37 (1994).

pathological – whether it is purely descriptive or contains normative elements – we must abstract from particulars of a concrete and unique biography and put them in the mould of the abstract. Of course, abstraction is unavoidable in thinking because it partly constitutes it. It provides us with concepts with which we can organize the perceptual materials and draw both theoretical and practical conclusions. The worry about abstraction is not about it as such but about the degree of abstraction that exceeds the level of recognisability of the subject matter.

However, by organizing our thinking with concepts we change our view of the given. An individual patient is seen as a case of the normal or pathological. He or she is seen as one among many members of its kind or class. In this way the patient is put into a conceptual grid which invokes certain ideas and eliminates others because the conceptual apparatus applied is about selection of what is important from what can be legitimately left out. Being an object of such conceptual processing, the patient changes in the eyes of the practitioner who attempts to assist them. The patient is not perceived in their uniqueness and entirety, and is often taken out of the context that determines the patient's identity and uniqueness of their problem.

It is obvious that concepts are determined by various factors. Researchers who live in a particular time and place organize their observations in their own way. The classification of mental disorders offered by E. Kraepelin in his *Kompendium der Psychiatrie*, which had shaped later developments in psychiatry, is the product of a particular person with his special interests and perhaps idiosyncrasies. Kraepelin lived in the 19<sup>th</sup> century, which cultural milieu encouraged him to see illness where his predecessors saw madness or demons. Like other concepts, the normal and the pathological are human creations, and so descriptions and categorizations of mental disorders are applications of the creative inputs of researchers and practitioners.<sup>3</sup>

The fact that concepts are human creations does not imply that the normal and the pathological are necessarily arbitrary. Observation and scholarly criticism correct conceptual apparatuses when they prove inadequate or inconsistent. However, the concept of mental illness is special in that the phenomena referred to as mental illnesses reduce or perhaps even eliminate the corrective role of observation and criticism.

What is special about a mental illness whose somatic cause remains unknown or is non-existent is its first-personal perspective.<sup>4</sup> Although some mental illnesses are effected by organic disturbances, for example in the nervous

---

<sup>3</sup> German E. Berrios, *The history of mental symptoms : descriptive psychopathology since the nineteenth century* (Cambridge, New York: Cambridge University Press, 1996); Ludwik Fleck, *Genesis and development of a scientific fact* (Chicago: University of Chicago Press, 1979).

<sup>4</sup> Karl Jaspers, *General psychopathology* (Baltimore: Johns Hopkins University Press, 1997). Especially, the first chapter.

or endocrine systems, the majority of them cannot be clearly correlated with somatic changes. And if they can, it is often hard to say which of the two is the cause and which is the effect – the illness or the somatic change. For this reason the line between a pathological process and its symptoms is very often problematic in psychiatry, which is well-illustrated by the anti-psychiatric movement and the discussions it evoked.<sup>5</sup> As a result, psychiatrists tend to rely on observations of eccentric behaviour of some individuals or their experiences.

Although unusual or deviant behaviour can provide many clues about mental illness, the fact that what is considered unusual depends heavily on what is considered morally good or bad or on what is a sign of social adjustment or defect of it, makes diagnosis of mental illness extremely difficult in general and perhaps impossible in many particular cases.<sup>6</sup> What is more, standard or non-deviant behaviours are not necessarily signs of lack of mental illness because its central arena is the psyche of a person, usually associated with behaviour. Unlike most somatic diseases, only some mental illnesses have been clearly correlated with intersubjectively accessible changes in the patient's body. It remains to be seen whether this lack of correlation is necessary or a result of scientists' temporary ignorance. For the time being, however, the main source of evidence of mental illnesses is the experiences of those who suffer from them. And this makes mental illness special because in most cases it must be conceptualized and understood, if at all, by reference to the first-person perspective of the sufferer.

The first-person perspective of mental illness has several characteristics that make it much more difficult to conceptualize than somatic disease. First, apart from well-documented behavioural symptoms of many mental disorders, the first-personal perspective is irreducible to the third-person point of view, which can at best rely on descriptions of the person's reports or behaviour.<sup>7</sup> Such reports are not, however, equivalent to the experiences themselves. The experience of compulsion to wash one's hands every time one touches something cannot be translated into a description of this person's compulsive behaviour. Any description of such behaviour will leave out the central elements of the experience of mental illness.

---

<sup>5</sup> Thomas Szasz, *The myth of mental illness; foundations of a theory of personal conduct* (New York: Hoeber-Harper, 1961). Hans Jürgen Eysenck, "Classification and the problems of diagnosis," in *Handbook of Abnormal Psychology*, ed. Hans Jürgen Eysenck (London: Pitman Medical Publishing Company Ltd., 1960); David L. Rosenhan, "On being sane in insane places," *Science* 179, 4070 (1973).

<sup>6</sup> Derek Bolton, "Problems in the Definition of 'Mental Disorder'," *The Philosophical Quarterly* (1950–) 51, 203 (2001); Derek Bolton, *What is mental disorder?: an essay in philosophy, science, and values*, International Perspectives in Philosophy and Psychiatry (Oxford; New York: Oxford University Press, 2008).

<sup>7</sup> Thomas Nagel, *Mortal questions* (Cambridge, New York: Cambridge University Press, 1979), especially the chapter "Subjective and objective".

The first-person aspect of mental illness limits intersubjective access to the experience of the suffering person by a therapist. What a person experiences depends on, and shapes, that person's individuality, and so any attempt to envisage this experience by someone else will, of necessity, depend on the individuality of the person who makes that attempt. They will not be the same experiences. The experiences of the person afflicted with a psychiatric condition are co-constituted by that person's unique biography and personal traits and, reflexively, shaped by them. The view and feel of those experiences arrived at by the therapist will therefore be necessarily different from the experience of the suffering person. An attempt to envisage them will depend on the unique biography and personal traits of the therapist.

Secondly, a prominent characteristic of the experience of mental illness is the sense of *being unwell*. It is an experience of *being* ill, and not simply having an affliction or a problem that does not shape the very identity of the person in question. Mental illness is a mode of existence due to its constitutive first-personal perspective. Although analogous phenomena can be found in serious or life threatening somatic diseases, mental illness is characteristically constituted by the first-personal perspective. In such cases there is nothing (or little) more that constitutes it other than this perspective, and so mental illness is a mode of existence of a person rather than their characteristic or property. Delusions, even after illness, remain with the person for the rest of their life. Mental illness is therefore an intimate assault on the person, not simply something that happens to them.

Since mental illness affects the mode of a *person's* existence, it has a characteristically totalizing nature. It would be misleading to say merely that a part of a person suffers from mental illness; rather it is the whole person who is unwell. A person who is afflicted by mental illness may experience problems with self-control (e.g. mood swings), with their sense of self-identity (e.g. with personality disorders) or with self-directedness (e.g. delusional symptoms). Problems like these do not affect only a part of the person, leaving other aspects or functions unaffected, but due to the unitary character of a healthy mental life, they upset their whole person, as with the most dramatic cases of dissociative identity disorders.

Being *unwell* in mental illness is not just discomfort of different magnitudes or severities that makes patient's daily activities more difficult or inconvenient. It is an evil that affects the specifically human capacities for reasoning and action, including the capacities to plan action, make decisions, and execute them, and vulnerabilities to misinformation and deception.<sup>8</sup> A person who cannot focus on a practical problem and plan her future or act due to fear or

---

<sup>8</sup> Paweł Łuków, *Moralność medycyny. O sztuce dobrego życia i o sztuce leczenia* (Warszawa: Wydawnictwo Naukowe „Semper”, 2012), chap. 4.

anxiety is not simply inconvenienced. Similarly, when someone suffers from delusions, such a person cannot make plans and successfully execute them because of the false ideas about their environment. These human potentials and vulnerabilities expose a person who suffers from a mental illness to harms which are indistinguishable from those caused by lies, deception, fraud, confinement, imprisonment, or enslavement. They are all moral wrongs, not only inconveniences.

Thirdly, mental illness, like any other illness, is always uniquely contextualized. It comes in particular social and cultural circumstances which determine the nature and process of illness by providing the cues for mental disturbance and content of the experiences of the afflicted person. It is also contextualized by the unique biography of the suffering person. In a somatic disease the experience of illness is also unique at the level of experience but the process of somatic disease is “standardized” in a way which makes it a phenomenon that is not unique to a particular patient. The process of a somatic disease is usually generalized and differentiated from its symptoms, and so can be described in an objectivized way. As a result, somatic disease becomes more manageable conceptually and, often, therapeutically. In a mental illness that is not caused by a damage or dysfunction of the body the standardization of the illness process is often unmanageable conceptually because of its non-intersubjectivity. Any attempt to decontextualize a case of mental illness in order to describe it in an intersubjectively manageable way must rely on generalized ideas, which inevitably leads to the elimination of the first-personal, defining elements of the experience, and so deprives others of the possibility to adequately understand it. Mental illness often seems to be an *illness* with no identifiable disease.

The non-intersubjective, because first-personal, character of mental illness as opposed to somatic disease is salient in psychiatry textbooks where individual patient stories are standardly presented as illustrations of descriptions of mental conditions.<sup>9</sup> It seems as though authors of such textbooks find it impossible to describe a mental illness without recourse to a particular illness narrative. By contrast, in somatic medical textbooks, individual cases are usually presented when they are anomalous or non-standard. For cases that are standard and typical, standardized vocabulary is sufficient. The unique cases, so abundant in psychiatry, are needed probably because they provide the only practical way to at least superficially grasp a disorder. Paradoxically, the atypical, anomalous, and non-standard seems to be the typical, normal, and standard in psychiatry.

The non-reducibility of mental illness to the intersubjective, its moral dimension, totality, and uniqueness encourage the questioning of the distinction

---

<sup>9</sup> Robert E. Hales, Stuart C. Yudofsky, and Glen O. Gabbard, *The American Psychiatric Publishing textbook of psychiatry* (Washington, DC: American Psychiatric Pub., 2008).

between the normal and the pathological as doubtful. If the normal and the pathological rely on generalization, whereas the experience of illness is unique, how can it be described as pathology? In order to do so, one would need a standardized picture of mental pathology understood in terms of its sites and tangible or even measurable processes. And it is exactly this that is lacking because of the first-personal nature of many mental illnesses. Mental pathology seems therefore somehow defective. It resembles a search for the ultimate reality in places where there may be nothing more fundamental than the illness itself. Mental illness may be the process and the symptom in one, which is an idea foreign to all those who, like the pioneers of psychiatry of the 19<sup>th</sup>-century achievements of biomedical sciences, are under the spell of objectivity.

This is not to deny the reality of mental illness. Rather, the possibility that mental illness has no foundation in the physical reality of the patient's body suggests that an adequate view of mental illness should rely on a conceptual framework that is not analogous to the somatic pathology of disease process and its symptoms. Or, if the pathology is to be adopted it should be supplemented in a way that assimilates the first-personal and non-intersubjective character of *being unwell* in mental illness.

As mentioned above, the first-personal perspective of mental illness is largely defined by reference to moral values. Thus, an adequate account of it may require moral vocabulary and a moral engagement with the phenomenon of mental illness. This might call for inclusion of the sphere of the moral into an understanding of mental illness. Such an approach would involve a conception of what it is to be human and when human life goes well or unwell, i.e. when a person is ill.

This move would require a shift in the conception of psychiatry. In particular, it would be required to de-medicalize it in the areas in which there are no identifiable somatic causes of mental illness. If the moral dimensions of mental illness are appreciated the de-medicalized, psychiatry may require supplementation with a moral understanding of mental disease, and so a moral approach to both diagnosis and therapy.

The moral approach may have two layers. First is conceptualization of mental illness as also a moral crisis in the life of a patient which is defined by a lack of access to central moral goods. On such a view of mental illness, the moral crisis would require actions that will make the goods accessible to the patient by connecting their experiences to those goods. The second layer of the moral approach is the therapist's active engagement with moral goods. It would involve their active commitment to those goods and a view of a good human life, which would serve as both the basic tool of therapy and the source of guidance for the therapist.

The two layers are closely interconnected. The process of diagnosing a patient's problem would require the therapist's commitment to those goods as

important for humans. The therapeutic process would depend on the patient's recognition of and commitment to those goods, and their inclusion in the patient's self-perception. These two processes would only be the starting point of therapy and would further rely on a close interaction between the patient and the therapist. The therapeutic process would involve the therapist's engagement with the first-personal perspective of mental illness of a particular patient, constituted by his or her unique biography contextualized by his or her individual life experiences and culture. The result of such therapy would be a redefinition of the patient's experiences according to the requirements of the moral goods, which could result in the psychological balance, patient self-fulfilment or social adjustment.

The moral approach to mental illness sketched above has two central characteristics. First, contrary to the dominant view of the moral neutrality of the theoretical presuppositions of the psychological theory, it assumes a substantive view of a morally good life. It does not, therefore, assume that the therapeutic process must lead directly to a psychological equilibrium, the patient's self-fulfilment or social adjustment, which in turn might help the patient define the goods of their life. The relationship between the patient's psychological balance, self-fulfilment or social adjustment and the nature of the pursued goods is reversed here. The wellbeing of the patient is mediated by the moral goods that are necessary for a good human life. Secondly, the moral goods are integrated in the treatment in that they provide structure and determine the intermediate goals of treatment. The assumption is that psychological equilibrium, patient self-fulfilment or social adjustment can be achieved by the patient's contact with those moral goods.

The immediate result of such an approach is the integration of ethics in psychiatry. This integration is a response to the first-personal nature of the experience of mental illness in cases in which the somatic basis of the illness is not known or non-existent. This integration is not, therefore, a result of the discovery of the nature of mental illness. Rather, it is a consequence of the recognition of the limited conceptual resources and knowledge base that are available to psychiatry. Ethics provides a context for psychiatric diagnosis and treatment because of a lack of other resources.

To some extent the integration of ethics and psychiatry is similar to the old-fashioned approaches to psychiatric problems known from before the emergence of modern psychiatry. Both approaches rely on moral values. The key difference is that pre-modern views of psychiatric conditions saw the patient as a victim of his or her own or other's misbehaviour. The integration of ethics and psychiatry along the lines sketched above do not make the patient responsible for his or her fate. It sees the patient as a person who for biographical, social, and cultural reasons is deprived of access to the moral goods that are fundamental for human life. The goal of treatment is the



restoration or initiation of this contact by the therapist's commitment to those goods and a learning process in which the patient can recognize them and find guidance in them. The patient is not burdened with guilt for lack of connection with the goods but is seen as harmed by a disconnection from them.

A form of integration of ethics with psychiatry had been offered by A. Kępiński. As I explain elsewhere,<sup>10</sup> his theoretical approach relies on the idea of metabolisms of energy and information whose imbalances can result in psychiatric disorders. Kępiński argues that in the exchanges of energy and information between an organism and its environment there are two biological laws: of self-preservation and of reproduction. These two laws found what he metaphorically called "biological conscience". Following the laws results in pleasure. When action is not rewarded by pleasure due to imbalances in exchanges of energy and information, an organism becomes unable to continue its existence or to reproduce, and the two laws are violated. The violation is not necessarily caused by the patient. It may be caused in many different ways, which are not primary objects of Kępiński's interest. He is most interested in the situation of the suffering person, not the cause of his or her affliction.

In the case of humans, in whose existence the metabolism of information plays a role much larger than in the case of other animals, violations of the two biological laws result in the lack of reward in pleasure and so they lead to fear and anxiety. For Kępiński, the two laws determine human good in the most general sense, which takes the forms of preservation, development and building, as opposed to evil, which is degeneration, regress and destruction. He says that "neuroses, psychopathies, psychosomatic illnesses, drug addictions etc. are revealed to us, at least to some extent, as a result of violation of the moral order. Persons who are afflicted by these disorders suffer a hell in life in exchange for their incessant negative feelings, for their indolence and unwillingness to undertake the effort of life, for their egoism etc."<sup>11</sup>

This moralized account of mental disorder provides Kępiński with a perspective on therapy. Therapeutic activities are responses to a recognition of the evil that affects those who suffer from psychiatric disorders. Psychosis, schizophrenia or anxiety deprive their victims of their potential for preservation, development and building. In order to identify the central causes of a disorder, the therapist must, Kępiński believes, attempt to know the patient as well as possible. There are two cognitive elements to the therapeutic relation which are of central importance to Kępiński. The first is letting the patient guide and control the process of diagnosis and treatment. The therapist should not have

---

<sup>10</sup> This and the following two paragraphs summarise the account I offered in Paweł Łuków, "Ethical Foundation of A. Kępiński's Psychiatry," in *Ethik in der Psychiatrie und Psychotherapie*, ed. Florian Steger, Jan C. Joerden, and Andrzej M. Kaniowski (Frankfurt a.M.: Peter Lang Publishing, 2015).

<sup>11</sup> Antoni Kępiński, *Łęk* (Warszawa: Państw. Zakład Wydawnictw Lekarskich, 1977), 126.

a plan of investigation of a given patient's problem. Such a plan would assume a goal of inquiry. Since in psychiatric therapy the causes of a particular patient's problem have to be discovered, the therapist should not impose any goal on the patient but openly participate in their searching efforts. In consequence, and secondly, the open-endedness of the therapist's stance requires that the patient and the therapist see themselves as equal. Their relationship is based on a two-way interaction, which has to take into account cultural, class, emotional and other contexts. The object of psychiatric inquiry is the whole person in, as Kępiński says, a primitive or archaic perspective, characteristic of relations between human beings. This kind of deeply humanistic perspective is an element of the human condition which is fundamentally social and governed by the two laws which found the "biological conscience."

Within this view of the therapeutic relationship, values are being made available to the patient by the therapist's attitude towards the patient. As said above, this attitude is guided by the therapist's commitment to the goods in question, which is displayed in their traits of character such as courage, confidence or faith, and love. They serve both as examples to be followed by the patient and as instruments of support. They also are expected to be emulated by the patient who in this way learns how to recognize moral goods, how to respond to them, and how to exercise them in their own actions.

The attitude of the therapist and the connection he or she makes with the patient changes the nature of the relationship between them and helps overcome the difficulties associated with the first-personal nature of mental illness. As mentioned above, a mental illness that is not caused by a somatic change in the patient's organism cannot be approached from a third-person perspective; it is also necessarily impossible for the therapist to take the patient's first person point of view. For Kępiński, these limitations can be overcome by the therapist's active and personal engagement with the key moral goods and with the patient's problems. The therapist displays in their behaviour such virtues as calmness and courage in the face of difficulties. These virtues help the patient regain confidence and overcome anxiety, which for Kępiński is the central element in most psychiatric problems.

The interaction between the patient and the therapist, which is mediated by the moral goods of human life, leads to the construction of a shared understanding of the patient's problem. It is not a reconstruction of the patient's first-personal perspective, nor is it the third-personal perspective of science. It is a personal relationship between two persons. One of the occupants of that perspective needs assistance in a crisis and the other is prepared to provide that assistance by focusing on the goods that are important to human life. The therapist does not re-create the patient's experiences (which would mean that the therapist themselves suffers from mental illness) but attempts to discover the severed links between the patient and moral goods and to assist the patient in

restoring them. This second-person point of view is analogous to that of a friend who cares about the other person and provides assistance even if the exact experiences of the other person are not known to them in their original first-personal perspective.

Kępiński's approach to the therapeutic relationship presented above was not intended as a solution to the problem of the pathological and the normal. One could easily criticise it as naïve or old-fashioned. The point was to illustrate how the conceptual difficulty of applying the distinction between the normal and the pathological can be remedied by a moral approach to mental pathology. This approach builds on the integration of psychiatry with ethics. In this way psychiatric care is seen as an educational and assistive activity rather than simply a treatment. Such an approach is in a way unavoidable in the face of the conceptual difficulties with mental illness, and it seems to be quite frequent in those actual psychiatric practices for which psychotherapy is central. If there are mental illnesses that cannot be explained by somatic problems the integration of ethics and psychiatry remains a feasible option. One might object that this approach is not dramatically effective or that it is old-fashioned in times of the development of new mood-changing and cognition-enhancing drugs. Such criticism would, however, be justified only if the nature of all mental illnesses could be reduced to a third-person perspective of human biology. But until we have convincing evidence that mental illness is ultimately a malfunction of the human organism, and until there remains at least one mental illness that does not have a proven somatic basis, we must integrate ethics with psychiatry or those who suffer from mental illness will be left with no assistance.

## BIBLIOGRAPHY

- Berrios, German E. *The history of mental symptoms: descriptive psychopathology since the nineteenth century*. Cambridge; New York: Cambridge University Press, 1996.
- Bolton, Derek. "Problems in the Definition of 'Mental Disorder'." *The Philosophical Quarterly* (1950-) 51, 203 (2001): 182–199.
- . *What is mental disorder?: an essay in philosophy, science, and values*. International Perspectives in Philosophy and Psychiatry. Oxford; New York: Oxford University Press, 2008.
- Eysenck, Hans Jürgen. "Classification and the problems of diagnosis." In *Handbook of Abnormal Psychology*, edited by Hans Jürgen Eysenck. London: Pitman Medical Publishing Company Ltd., 1960.
- Fleck, Ludwik. *Genesis and development of a scientific fact*. Chicago: University of Chicago Press, 1979.
- Foucault, Michel. *History of madness*. New York: Routledge, 2006.
- Hales, Robert E., Stuart C. Yudofsky, Glen O. Gabbard. *The American Psychiatric Publishing textbook of psychiatry*. Washington, DC: American Psychiatric Pub., 2008.
- Jaspers, Karl. *General psychopathology*. Baltimore: Johns Hopkins University Press, 1997.
- Kępiński, Antoni. *Łęk*. Warszawa: Państw. Zakład Wydawnictw Lekarskich, 1977.

- Łuków, Paweł. "Ethical Foundation of A. Kępiński's Psychiatry." In *Ethik in der Psychiatrie und Psychotherapie*, edited by Florian Steger, Jan C. Joerden and Andrzej M. Kaniowski. Frankfurt a.M.: Peter Lang Publishing, 2015.
- . *Moralność medycyny. O sztuce dobrego życia i o sztuce leczenia*. Warszawa: Wydawnictwo Naukowe „Semper”, 2012.
- Nagel, Thomas. *Mortal questions*. Cambridge; New York: Cambridge University Press, 1979.
- Papineau, David. "Mental Disorder, Illness and Biological Disfunction." *Royal Institute of Philosophy Supplements* 37 (1994): 73–82.
- Porter, Roy. *The greatest benefit to mankind: A medical history of humanity*. London: Harper Collins, 1997.
- Rosenhan, David L. "On being sane in insane places." *Science* 179, no. 4070 (Jan 19, 1973): 250–258.
- Szasz, Thomas. *The myth of mental illness; foundations of a theory of personal conduct*. New York: Hoeber-Harper, 1961.