Summary

As a hybrid discipline and field of inquiry, ‘philosophy and psychiatry’ has great potential for both parent disciplines, and since its renaissance in recent decades, has been developing an identity of its own. Nevertheless, its wider impact on either philosophy or psychiatric practice may be limited by more than its relatively novel blossoming as an interfield study area: the ‘communication gap’ inherent in combining domains which have fundamentally different aims and incorporate diverse methodologies, may prevent the fruits of research labor becoming available to both practitioners and philosophers. In Chapter 1, the starting point of this study was sketched, beginning with the observation that for the most part, work in philosophy and psychiatry has been conducted in abstracto. Theoretical models, concepts and phenomenologies of disorder, classification and scientific perspectives, have all been philosophically examined as they are idealistically represented in literature rather than as they are manifest and active within practice. This, I argue, not only reduces its accessibility to pragmatic and empirically-minded practitioners, but may also reduce its validity, since there are numerous potential distorting processes between philosophical belief or conviction, and actual practice. Therefore, the main question of this thesis is: what does philosophy in psychiatric practice actually look like? Can we, following the advice of Philips to ‘show practitioners, in their language, what might be the implicit philosophical assumptions they are working with’, empirically trace the presence of philosophical beliefs in practice, see how they manifest themselves, and perhaps even follow their influence on practice? Can we also take Philips’ further, normative step of ‘showing practitioners that their philosophical assumptions don’t serve them well, and how your suggestions might lead to better practice’?

The pioneering work of Fulford and Hope inspired us to undertake an exploration of the presence and action of philosophical beliefs in psychiatric practice, beginning with the most general of distinguishing subjects (Diagnosis, Science, Disorder), and following our findings where they might lead us. This empirical explorative perspective was grounded primarily in the desire to bridge the communication gap by applying a ‘common ground’ methodology accessible to both practitioners and philosophers. After briefly reviewing current approaches in philosophy and psychiatry to examining the philosophy of practice, examples were given of methods with ‘common ground’ potential: the ordinary language approach applied by Fulford and Hope, the experimental cognitive work focused on categorization with respect to mental disorders exemplified by studies by Ahn and
Kim, and ethnographic qualitative studies focusing on the everyday construction and maintenance of ‘frameworks’ through which the phenomena of psychiatric practice are viewed and themselves reconstructed. Combining the ordinary language principle of everyday use of language as a window into operative philosophies with the methods of qualitative study was defended as a valid method of inquiry. Also, in order to ‘follow philosophy through practice’, knowledge of clinical reasoning research, personal epistemology, and the history of psychiatry were identified as relevant domains. The general structure of the study was laid out: alternating chapters presenting the results of the qualitative study with chapters offering historical and philosophical contextualization and analysis of these findings. The three main themes: Diagnosis and Classification, Science and Legitimacy, and Mental Disorder, were purposively chosen as broad domains both recognizable in the philosophy and psychiatry literature, but sufficiently open to allow for explorative freedom. Finally, the boundary-traversing perspective of Latour’s actor-network theory was referenced, as a prelude to the importance of going beyond traditional dichotomies between practice, science, and society.

**Chapter 2** presents the methodology of the qualitative study. A naturalistic inquiry approach was used, characterized by research in natural settings, qualitative methods, purposive sampling, inductive analysis, a grounded theory approach, a case study reporting mode, tentative application of findings, and special criteria of trustworthiness. The openness and flexibility of this approach suited the explorative nature of this study, as the nature of the ways in which philosophy manifests in practice was still to be determined. A central idea in this study was the notion that the language used in practice is a clue to philosophical beliefs in play. This however does not imply an unambiguous transparency of meaning. Therefore, text sequences were initially coded as ‘locations of philosophical beliefs’, with memos attached offering ideas as to possible content. The content was subsequently derived from the interview, from multiple coding and triangulation, and respondent validation at multiple steps in the process. It was noted that, though the study focuses on psychiatrists, due to the dialogical nature of practice, and the presence and influence of institutionally embedded philosophies, ‘ownership’ of philosophical views may be difficult to determine. The study was initially construed as the first in a three-part series, adding one study from the patient perspective and one integrating both perspectives concurrently. Therefore this study does not strive to present itself as an encompassing view of ‘the’ philosophy of psychiatric practice. Three sectors of psychiatric practice were chosen by the research group, representing the main sections of mental health care contemporary psychiatrists worked in. A total of 30 psychiatrists, 10 from each sector, participated in the study. Sensitizing concepts consisted of the three main
themes mentioned previously, Jaspers’ distinction between meaningful and causal explanation, and Engel’s biopsychosocial model, both recognized as high-level, ubiquitous conceptual themes. The initial thematic framework was developed with the help of these concepts. Following an iterative approach, data collection took place through a series of 4 steps: collecting audio recordings and psychiatrists’ written reports of initial encounters between psychiatrists and patients; completion by participants of a Dutch translation of the Maudsley Attitudes Questionnaire; semi-structured interviews in which the intake, the written report, and the MAQ were discussed and iterative member checks for the developing frameworks were performed; and finally, a final case report of each participating psychiatrist was compiled characterizing the views of participants within the main areas of the study, and comments and corrections were subsequently sought and integrated as respondent validation.

For the data analysis, framework analysis was applied, a five-step method comprising a) Familiarizing; b) Identifying a thematic framework; c) Indexing; d) Charting; and e) Mapping and Interpretation. Methodological rigor was ensured through triangulation, thick description, constant comparison, theoretical sampling, deviant case analysis, audit trail, and respondent validation.

In Chapter 3, the results of the first part of the qualitative study, focusing on diagnosis, are presented, preceded by a review of empirical research on clinical practice. It was noted that diagnostic practice in psychiatry is conceptually complex: it has multiple aims, is performed in a wide variety of professional contexts, relates to entities with uncertain etiologies, is epistemically dualist, and may vary over time in accordance with broader professional developments. The research on clinical reasoning has moved from theories focusing on general processes to more finely-grained and specific ones, and from one general reasoning process to multiple forms of knowledge representation and processing. Cognitive experimental research points to (causally) theory-laden processes of observation rather than ‘naked’ description with respect to diagnosis in psychiatry, with consequences for treatment choice. Unconscious ‘information processing’, including, at least partially, different forms of intuition, is an apparently valued element of clinical reasoning, and one that increases with experience. Anthropological and ethnographic studies demonstrate the effects of general professional theoretical models, the care environment and institutional context on reasoning in practice. The complex nature of clinical reasoning underscores the earlier point regarding the consistency of philosophies embedded in theoretical models or concepts when these are translated into practice.
The final state of the thematic framework comprised three levels: clinical reasoning modes, interaction, and methodical reflection. Six modes of clinical reasoning were described: descriptive, meaningful, actuarial, collaborative, medical and unclassified. At the interactional level, a general structure was derived, the Developing Explanatory Framework, containing dynamic elements affecting interaction: binding, prompting, partitioning, and perspective. Themes related to the content of explanations were causal dualism, metaphysical alignment and pluralism. Finally, at the third level of methodical reflection, six themes were derived: intuition, pragmatism, theoretical knowledge and affiliations, individual values, institutional values, and import. The resulting picture of diagnostic practice is pluralist and pragmatic: psychiatrists apply different modes of level 1 reasoning within the dynamics of the DEF, developing explanations preferably bound together with the perspectives of the patient within the DEF, aimed at a sense of medical improvement (where ‘improvement’ includes personal/professional/institutional values), without necessarily leading to an integration in a singular diagnosis or case formulation. Significantly, multiple theoretical perspectives (with associated categorizations) were applied, and the DSM classification was generally assigned a peripheral role. Diagnosis in this study is both identification and construction. The most significant philosophical positions described in the framework analysis were theoretical pluralism, causal dualism, and values-oriented pragmatism. To these, a fourth was added: clinical realism, denoting the participants’ prioritizing of the reality of the clinical situation and their professional expertise in representing this reality. The complexity of epistemic/ontological and normative interactions means describing the process as a combination of idiographic and nomothetic perspectives does not it justice. Implications for research in clinical reasoning were noted, especially the relatively marginal role of the DSM: rather than functioning as a touchstone of accuracy, it seemed to also to be open to a degree of manipulation, evoking questions of scientific legitimacy, both of the DSM-project itself and of such practice. The constitutive role of personal and professional values intrude in diagnosis also suggests subjectivity in an area in which psychiatry has aspired to be objective. If such practice seems sui generis, is it also legitimate scientifically or professionally?

A history of psychiatric classifications is presented as a series of transitions in Chapter 4, which aims to contextualize and shed light on these questions of legitimacy. Based on taxonomic characteristics, the following were distinguished: a) theory-based Linnaean taxonomies to Kraepelinian course-based taxonomy; b) multiple heterogeneous taxonomies to a single dominant (Kraepelinian) taxonomy (the Statistical Manuals); c) from Statistical Manual (descriptive/syndromal) to hybrid descriptive/syndromal and psychodynamic national taxonomy (DSM-I); d)
from hybrid taxonomy (DSM-II) to descriptive/syndromal neoKraepelinian taxonomy, supranational (DSM-III) and e) DSM 5 concurrent with competing taxonomic program (RDoc). With the help of Kendler’s useful distinction between empirical and nonempirical factors driving such transitions it became clear that for most transitions, nonempirical factors played a significant and sometimes decisive role. Sociopolitical factors rather than scientific discoveries prove to have been decisive at transitional points in its history. This challenges a portrayal of psychiatric classification as a progressive scientific process, a convergent iteration towards reality. Examples such as Frances’ epistemic conservatism, born of an ethically-grounded desire to prevent a false epidemic, demonstrate the deep connections between the political sphere, professional ethics and value-bound decisions on taxonomy. Meanwhile, Berrios notes that much of the epistemic perspective has remained the same: the phenomena of mental disorder are seen as essentially material, the preferred approach is empirical, and categories implying pathophysiological entities are preferred, the slight shift towards dimensionality in DSM 5 notwithstanding. The discrepancy already noted in Chapter Three between the professional image of the science practitioner applying evidence-based knowledge derived from research organized round an empirically-grounded classification and the pragmatically and normatively driven pluralistic practice, finds an echo here in ostensibly political and pragmatic decisions made at the level of scientific communities and committees deciding on taxonomic principles guiding scientific classification, whilst the DSM is often presented as a project ever getting closer to the reality of mental disorders. But does this state of affairs compromise the scientific standing of the DSM?

The answer depends at least in part on the position one takes in the ‘Umpire debate’ on psychiatric classification. From the five umpires representing well-known epistemic positions, the ‘middle grounds’ of weak realism/nominalism and pragmatism appear to be the positions garnering most favor and preferring Zachar’s validity pluralism to Ghaemi’s full-on scientific realism. Recognizing that our epistemic access to reality is always limited and recognizing the role of human interest in a classificatory project such as the DSM is not dissonant to current philosophy of science. We must recognize, however, that those human interests have shifted and expanded throughout the DSM’s history, complicating an assessment of its value. Moreover, the scope of psychiatry and of the DSM project has expanded and differentiated into so many areas, that the DSM may have become ‘too big to fail’, inoculated against criticism by its sheer embeddedness. However, competing approaches have sprung up, such as the RDoc project, raising the prospect of competing taxonomic systems. Also, granting a role for human interest ushers in questions on the management of values. Sadler’s work proposes
equally rigorous attention to good process with respect to values as to facts. Sadler has defended the integration of democratic principles into the classificatory project without invalidating its scientific legitimacy, and this perspective was translated into the proposal for a normative framework supporting Pincus’ system of ‘tribal’ classifications as a way to manage an hierarchical system of pragmatic/interest-based, smaller-scale classifications. The role of scientific communities and their ‘opening up’ to societal values is both an essential element thereof and a fascinating domain for further study.

Would such a proposal accord with professionals’ views of science and their attitudes towards professional legitimization? We began to answer this question with a literature review on the role of science in professional practice in Chapter 5. The central role of privileged knowledge and its intrinsic connection to expertise and practice was noted as a cornerstone of professional legitimacy. The literature on the theoretical content of psychiatrists’ knowledge sources and their epistemological assumptions and philosophies of science was examined from developmental and institutional perspectives. The personal epistemology literature has moved from initial linear stage models of development such as the 4-step Perry scheme, to more differentiated models (e.g. Schommer’s belief model) which are to a degree context-dependent, allowing for epistemological beliefs in an individual to vary in different disciplinary contexts, activated as cognitive resources, and to a degree socially constructed in instructional environments. Epistemologically, psychiatry is less ‘hard’ and well-structured than general medicine, suggesting a challenging epistemic transition for young physicians entering psychiatry. Contextual influences on the development of personal epistemology are more explicitly addressed in the socialization and ‘hidden curriculum’ literature. Contrary to the spirit of the Flexner Report, scientific medicine in America is deemed to have been dominated by positivist science views. Medical education may socialize students towards realist, naturalist epistemology, leading to relative neglect of the ‘voice of the lifeworld’ and of skills connected to the social sciences and humanities. Importantly, the norms of the hidden curriculum are transferred through institutional culture, personal experience, role modeling, and personal interactions with supervisors, team members and patients. Choice of ‘therapeutic orientation’ is also influenced by features of personality, and mirrors PE in its development: from dogmatism, to doubt, to commitment within pragmatic flexibility.

The structural perspective on sources of knowledge and epistemological influences was presented as a hierarchy of spheres surrounding the professional. Though a comprehensive analysis of the epistemologies of psychological and
psychiatric theory was beyond the reach of this study, the Modernist basis of these disciplines was recognized, and their subsequent embrace of empirical methods, scientific realism and the correspondence theory of truth, leading to an image of professional knowledge as ideally objective, unbiased, and value-free. Psychoanalysis and the humanistic psychotherapies constituted challenges to this epistemic perspective, waxing and waning in their influence. More recently, the empiricism and naturalism embedded in the DSM and in EBM have reassumed their dominant positions, at least, in theory: a feature of debates surrounding EBM is the question of an adequate balance between phronesis and techné, the relative importance of explicit, formalized knowledge versus practically embedded knowhow. From a wider point of view, modern medicine is seen as an Enlightenment project, encompassing ‘received views’ of science. Inevitably, society’s views of science and what comprises legitimate knowledge, will affect science-as-practice. Public understanding and faith in science prove to be complex issues, where increased knowledge is associated with less ideological and more utilitarian attitudes. Further study of this area is required, however, before any general statements can be made.

A broad picture arises of a dynamic interplay between developmental and structural influences: personal characteristics and attitudes, training and professional experiences, developing within institutional and societal contexts. Epistemologies may be explicit and traceable within learning materials of medical and psychiatric training facilities, but are also expressed in less ostensive institutional cultures, and are demonstrated and transmitted in practical training activities, which contain significant tacit elements. This picture deviates from a dichotomous view of natural and human science, fact and value as it implies fundamental interactions between factual and normative matters throughout professional development, affecting theory choice, styles of practice, and personal professional norms. Values reach deep into professional development.

In Chapter 6 we returned to the qualitative study. The results of the second theme, science and legitimacy, were presented. The final state of the iterative framework consisted of three main themes: philosophy of science, legitimacy, and professional development & theory choice. The majority view of science, corresponding to the results of Chapter Five, was that real science is natural science. The aspiration to ground psychiatric practice in science received wide support, though there was some skepticism as to the feasibility of a naturalistic reduction. The application of theoretical knowledge in practice, however, was pluralist, context-based, and pragmatic. EBM was seen as of limited practical utility as science stands, with the exception of the domain of psychopharmacology. Those holding received views of
science legitimized such practice from a deficit standpoint: where science has not provided definite answers, the use of context-bound professional expertise is legitimate. A significant minority, meanwhile, held pluralist philosophies of science, allowing for a positive scientific legitimacy of their pluralist practice. Most participants see their normative assignment, the betterment of patients, as their primary legitimacy, trumping scientific validity of the knowledge applied. "It does not need to be true to be effective." The causal dualism already noted in Chapter Three may help practitioners achieve a sense of clarity: for some phenomena there is scientific evidence, which points to a specific treatment, and for other phenomena there isn't, and the clinician is free to exercise 'non-scientific' clinical expertise.

These psychiatrists' psychological theoretical frameworks mostly consist of (psycho)therapeutic theories. The fact that these are therefore aimed at improvement is significant in their adoption by psychiatrists. Such theories are partially judged on their face validity, consistency, empirical grounding etc., but equally and perhaps primarily, psychiatrists evaluate the practical validity and utility of theories by practicing them and experiencing their results. This underlines the goal-directed emphasis of knowledge in psychiatric practice. Personal experiences, mostly but not exclusively in practice, were frequently noted as important influences on personal professional development. The concept of affinity captures the combination of critical theoretical acceptance, positive personal and practical therapeutic experience, and personal value alignment that seems to contribute to adherence to one or another theory. Given that affinity is also a dimensional concept, it captures the eclectic nature of theoretical allegiance in psychiatrists. Psychiatrists see clinical judgment and expertise as a central foundation of their practice. This offers them legitimate space to take a position towards both the bottom-up pressures of prompting and the top-down pressures of epistemic views either embedded in institutions or traveling into the encounter via alignment. Psychiatrists apply theories, causal stories, but also concepts and phrases pragmatically and sometimes strategically towards the aim of medical improvement. How such improvement is defined is influenced by personal preferences, values, and judgment. The dominant value of patient autonomy however implies that it is the patient who should primarily define the sense of improvement being aimed for. The constitutive role of values in professional development, theory choice, and practice necessitates a normative framework for knowledge-in-practice, which will be elaborated on in later chapters. However, the tension running through this study between the ideal of a natural science, and pluralist and pragmatic practice, returns here, leaving at least two possible courses: continuing with the natural science aspiration whilst practicing from a
deficit science’ point of view, or altering the basic philosophy of science. Given
what we previously learned of the importance of the social contract and hence of
the accordance or discordance with public understandings of science, the answer
to this question might have substantial consequences for the profession. Can
psychiatry attain a philosophical foundation that offers legitimacy to the practice
observed in this study?

Chapter 7 consists of four parts: a review and characterization of the socially
legitimizing role of science in psychiatry at its incipience as a profession and in its
current state, a philosophical critique of the scientism intrinsic to the current
Profile Sketch (PS), a proposal for an alternative conception of psychiatric science
and of professional legitimacy, and an overview of a number of methods with
potential to deliver the ‘enriched professionalism’ which is advocated here. The
historical review demonstrated the crucial role of the promise of natural science in
Dutch psychiatry’s societal recognition, requiring a professional merger with
neurologists in the late 19th century. The PS, which can be seen as an extension of
the reassertion of the profession’s medical credentials begun in the late Seventies,
was shown to contain numerous epistemic commitments to empiricism,
naturalism and scientific realism. In its emphasis on verifiability and its
encompassing view of the relationship of science to practice, it is positivistic and
even scientistic. It is therefore open to the philosophical criticisms thereof
developed in the second half of the 20th century. Particular attention was paid to
Douglas’, Longino’s and Kourany’s work on the place of values in science. The PS
disempowers professionals by offering insufficient resources to assess and manage
(non)epistemic values in psychiatric practice. Also, the PS runs into problems with
respect to its rejection of the role of tacit knowledge, its technical rationality, its
requirement of codifiability of knowledge, and its susceptibility to reification of
disorder concepts and blindness to the possible role of values in the development
of (scientific) disorder concepts, as illustrated by Manning’s analysis of the DSPD
concept.

In order to relieve the aforementioned tension between practice and the
profession’s positivist public face, an alternative was required. The best available
routes were formulating a different account of science to ground the science-
practice relationship in, and/or applying a qualitative distinction between
scientific and clinical knowledge (harking back to the ‘clinical realism’ espoused by
practitioners). Jochemsen and Glas’ Normative Practice Model (NPM) provides a
model granting science a foundational rather than a qualifying role, based on
Dooyeweerd’s philosophy of dynamic, layered social practices, where normativity
is inherent in human action, and practice, at different societal levels, should ‘open
up' towards the professional telos: its overarching normative mission. Professionalism comprises the embodiment of this telos in everyday practice: professional ethos. As a model, the NPM may serve to provide a foundation for an alternative to the PS. Arguably though it could be bolstered by methods improving the skills of professionals in performing the ‘negotiations’ at higher (meso and macro) levels of society, in recognizing (non)epistemic values within these levels, and within concepts, objects, and institutions. A number of values-sensitive approaches were mentioned which could fulfill these objectives: Values-Based Practice, immanent critique, Thornton’s ‘relaxed naturalism’, and sociomaterial approaches such as actor-network theory. The accompanying view of science is sketched: medical practice and science are both pluralist in nature, both involve values, and both may legitimately involve pragmatism and politics, but the facts and values involved require disciplined methods for their assessment and management.

Now that a pluralist, normatively laden path had been forged to the future, whither mental disorder? If practitioners are so pluralist in their conceptualizations of the phenomena of practice, and happy to resist integrating these into a singular diagnostic concept, then what is the role of the concept of mental disorder in practice? What of the aspiration to offer a singular, defining concept of MD? This question is taken up in Chapter 8. First, an overview was given of the philosophical literature on mental disorder. Nine perspectives were summarized, together with accompanying objections. We noted Bolton’s observation that the disorder debate has centered around different foundationalist conceptions, and Fulford’s claim that ‘foundations are not to be had’, leaving us perhaps with some form of social/scientific coherentism, relativism, or even quietism, but certainly with curiosity as to how the concept of mental disorder is constituted and applied in practice. The qualitative study yielded three main themes: concepts of disorder, philosophy of mind and interplay between ontology and practice. As to the former, seven concepts were distinguished: material-biological, failure of understanding, functioning and adaptation, loss of autonomy/freedom of the mental, suffering, family resemblance/ideal type, and social construction. Many of the concepts in the philosophical literature were identifiable, whilst some notable variations were seen, such as the preference for ‘suffering’ over ‘harm’, emphasizing the striving for a first-person perspective. Inevitably, practitioners views on philosophy of mind, consciously held or not, affected their mental disorder conceptualizations. Their positions were organized around the following concepts: materialism/reductionism, dualism, functionalism, emergentism, and holism/atomism. The third theme, interplay, offered support for Austin's adage that ‘the negative concept wears the trousers’: though their conceptualizations are
readily identifiable in practice, participants rarely had a definition ready at hand, simply for the reason that boundary conflicts rarely arose in the research setting. However, with respect to the way mental disorder is constituted in practice, highly interesting interactions and tensions were observable. The interactions in the DEF show the application of multiple MD perspectives relating to the phenomena at hand, the local context, the maintenance of a shared understanding, and the aim of ‘medical improvement’. Heterogeneity of the phenomena leads to legitimate plurality of MD conceptualizations. The final (though temporary) ontological state of the MD at the end of the intake is a result of a weighing up of a plurality of conceptualizations. Umbrella terms like ‘dysfunction’ serve to cover for such pluralism and offer pragmatic ontological flexibility. Again, the prime legitimacy is sought in the fundamental aim of practice: “It works!”

However, this is not to say this practice does is relativistic and does not answer to the phenomena. The dynamics of the interplay in the DEF process encompass the correct (in reference to relevant professional and science communities) knowledge to phenomena. There may be multiple perspectives possible, but they are not endless, nor should they be idiosyncratic. Also, where normative/pragmatic strategies are applied to formulations in the DEF, they should answer to ethical judgment, again in relation to relevant communities, including, first and foremost, the patient.

This picture veers away from the tradition of aiming for ‘one definition to rule them all’. Disjunctive conceptualizations nevertheless may be valid based on their relationship to local phenomena and context. The world of mental disorder may be dappled, and cognitive command still holds, though from a local perspective of getting the judgment right, in my view comprising both factual and normative judgment. The same goes for higher level boundary issues, such as demarcation of the DSM: demarcation is less a consequence of driving natural forces than of communal social, scientific, and professional activity. The analysis provides a deepening of professional diagnostic and therapeutic expertise as the singular and situationally embedded understanding of co-occurring factual, normative, and pragmatic phenomena, expressed as ‘faith towards the phenomena’.

Armed with this perspective on practice, in Chapter 9 we returned to history and the ways in which mental disorder has been constituted in the past. As a full historical overview was beyond the scope of this study (and numerous excellent works are available elsewhere), a case study approach was used, applying the actor-network theory described previously. Using the examples of medieval supernatural possession, neurasthenia, the spread of psychoanalysis, dangerous severe personality disorder, and the Dutch CVZ reports, I argued that
conceptualizing mental disorder as a product of either society, profession, nature, or science, does not fit well with historical developments. Mental disorder concepts are molded both by the facts of the world, but also by the outillage mental, time-bound ontological views, scientific advancements and communities, and social forces. Concepts may be durable, but whilst surviving are translated and transformed. Specific MD perspectives may serve to bolster social MD status in one context, whilst weakening its status in another. Societal values shape the process, but may become inconspicuous if norms are widely shared.

Temporal and geographic contextualism implies that historical likeness arguments are precarious, as Berrios has argued. This thesis argues that mental disorder status should be judged from a local, contextual perspective. Haslam’s ‘kinds of kinds’ overview of the ontologies of MD accords with the pluralist views of this study, and the negotiations surrounding DSPD and the CVZ report may be seen as processes surrounding non-arbitrary practical kinds: boundaries are contested, but reasonable arguments, and sound and unsound judgments, are possible. Correctly judging which kind of a kind is appropriate, within the context but related to relevant communities, then becomes a clinical skill, an element of enriched professionalism. This includes normative sensitivity: the skill of being aware of the values in play in an encounter in a given context, but also of ‘extra-professional’ values impinging on the encounter. This all translates into a view of good practice.

Chapter 10 briefly summarizes the main findings and the limitations of the study, recognizing awareness of the different perspective on generalization inherent in qualitative studies, and the limitations entailed by the demographics of the participants. Five main conclusions were noted: the grounding of professional legitimacy in a normative assignment, the ontological heterogeneity of the phenomena of psychopathology, the non-dichotomous relationships between fact and value, science, society and profession, the recommendation for pluralist epistemology for psychiatry, and the prioritization of enriched clinical judgment for professional legitimacy. These recommendations were then connected to the debates on professionalism in society, medicine, and psychiatry of the past decades. The portrayal of professionalism as ‘under threat’ by Bhugra provoked historical parallels with the findings of the Flexner Report, and descriptions of professionalism as a ‘third logic’ between state and market. The normativity of the medical professionalism literature, reaching for shared professional values through charters and proclamations, was noted, alongside the apparent differences in values hierarchies between such proclamations. The modern medical professionalism movement is characterized by a search for common values as a basis for shared identity, a systems orientation, and a narrative of
professionalism of loss, rediscovery, and recommitment. The latter, though perhaps effective as a rhetorical device, has come under criticism for its lack of historical accuracy. Hafferty and Castellani provide a more complex picture comprising seven different values hierarchies relating to medical professionalism. Psychiatrists, it seems, are not the only medical professionals who disagree with each other on matters of import. Though striving for values consensus should not be abandoned, it should be supported by living moral communities. Also, proclamations are no substitute for the embodiment and enaction of values in practice. Such practice extends to the moral traditions and practices constituting educational professional cultures in which residents are reared. This more enacted approach to professionalism leads to a twist to the ‘professional autonomy’ concept from a defensive ‘freedom from’ to an active, normative ‘freedom to’ stance, advocated by Montgomery. Professional values should be enacted in dynamic engagement with relevant moral communities.

All this leads to a view of the profession and of good practice as open and sensitive to its scientific, moral, and historical context. The profession should both be aware (and study) its own values geography, and engage with those of patients, communities, and society. Just as heterogeneous conceptualizations of mental disorder are valid in different phenomenal contexts, so varying professional values hierarchies are appropriate to different sociohistorical contexts. Again, this does not imply a fragmentation of professional identity, as the profession is bound by shared values within its professional/scientific/moral communities, and by shared aims embedded in social contracts. In other words: yes, there are forces pushing towards differentiation and fragmentation, but there are also science, moral, and professional communities, knowledge, practices and institutions binding the profession together and to the society it resides in. A central proposal of this study is the requirement for professionals of sound ‘ethical competency’ to add to their science- and practice-based expertise: being aware of the presence and actions of values at different levels and emanating from different domains with respect to the clinical encounter, and possessing skills and methods such as values-based practice to manage them with a view to the goals of medical improvement. Virtue ethics and communitarian ethics provide a wider scope for the ‘opening up’ of practice to the related scientific and moral communities. Promoting such expertise in training and CME should be done not just from the cognitive perspective but with recognition of the practical embeddedness and partially tacit nature of ethical skills. The increasing influence of first-person knowledge e.g. from ‘experts by experience’ may serve to enhance such values awareness and sensitivity. In negotiations and higher (meso and macro) levels, professionals should take responsibility in promoting the ‘medical good’, but based on their prime moral
assignment, also seek to attune themselves to the values of patients and their representative organizations, and to collaborate towards shared goals.