Chapter 1: Examining the philosophy of psychiatric practice.

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1.1 Introduction
The recent renaissance of cross-disciplinary interest between philosophy and psychiatry has given rise to an impressive body of knowledge and to challenging new perspectives on psychiatric theory and practice. The general view is that both philosophy and psychiatry can benefit from work within this field. Kendler and Parnas (2008) list four reasons why psychiatry needs philosophy: the presence of a priori assumptions and beliefs on matters such as categorization, causation and explanation; the width and diversity of the field and the methodologies involved; the fact that psychiatry has seen major shifts in its central paradigms in its recent history; and finally, the fact that the subject matter of psychiatry deals with human behavior and experience, and as such is intimately connected to views of what it means to be human. Still, mental health workers can be forgiven for viewing this area as a chiefly abstract enterprise with unknown practical relevance to their everyday professional activities. This may simply be an expression of a corresponding layman view of philosophy, but it also does seem reasonable for professions mostly concerned with practical, pragmatic goals to ask of those working in philosophy: “How will your activities help my patients?”, especially if the relevance of philosophy for daily practice is not immediately apparent. In Fulford et al. (2006), the authors defend the practice of philosophy in psychiatry as a ‘consciousness-raising exercise’: “Philosophy gives us a more complete view of the meanings of the concepts by which we structure and make sense of the
world.” But though philosophy and psychiatry share a common interest in the human mind, their goals, methods, and professional parlance differ. This may lead to a ‘communication gap’ between the disciplines (ibid.), obstructing fruitful cooperation. Despite previous efforts in this area (e.g. Fulford and Colombo 2004), there remain worries about the accessibility of work in the philosophy of psychiatry to the average practitioner. Philips (2011) states: “Most publications in the philosophy of psychiatry are quite technical—whatever the tradition out of which they are written—and expecting them to have an effect on mental health practice is quite unrealistic ….If you really want to influence mental health care with Wittgenstein’s account of meaning as use and practice, you will have to get rid of the technical language and translate Wittgenstein’s analysis into the language of practitioners, show them, in their language, what might be the implicit philosophical assumptions they are working with, how those don’t serve them well, and how your suggestions might lead to better practice.”

Philips here appears to be arguing from the point of view of the value of the interdisciplinary for medical practice: the goal is to really influence and improve practice. I imagine many participants in the field would agree that this should be something it aspires to. The barriers he sees are the -philosophical- ‘technicality’ of publications and the related language difference between the disciplines. But he also points to methodological differences. Philips is suggesting that in order to make their work more accessible to medical practice, authors should adapt their methods towards practice, implying use of empiricism (‘show them’) and pragmatism (‘better practice’).

If we follow this advice, the empirical study of ‘implicit philosophical assumptions’ or Kendler and Parnas’ ‘a priori philosophical ideas’ seems a suitable starting point. In fields as diverse as cognitive psychology and ethnography, different terms have been used to denote what they refer to as ‘a priori beliefs and assumptions’. Related terms in this regard are ‘philosophical world views’, ‘tacit knowledge’, ‘hidden beliefs’ and suchlike. Though no exact definition of these terms is given, they refer to ideas, convictions, and beliefs on the part of the practitioner that relate to something deeper, or removed from, ostensive clinical knowledge as it is encapsulated in textbooks, cognitive algorithms or regimented practice. For convenience, the term ‘beliefs’ will be provisionally employed here. What characterizes these beliefs as ‘philosophical’ can be derived from the subjects of philosophy: the beliefs pertain to matters such as the nature of a given entity, such as mental disorder (ontology), the way this entity can be explained (epistemology), the legitimization of practice through science, human, natural or otherwise (philosophy of science), the actual nature of the experiences involved
(phenomenology) and what ‘good practice’ entails (ethics). A clearer and more precise investigation of where, when and how philosophical assumptions influence the practice of psychiatry might provide practitioners a pragmatic advantage (on the assumption that awareness itself leads to better practice). But should that assumption then not be examined empirically too? This proposal might meet with objections from philosophy such as those leveled at experimental philosophy, of threatening to substitute empirical findings for philosophy altogether and acceding to a teleological foundationalism (Williamson 2015), wherein philosophy’s value would be too dependent on human interests. How far down this empirical path should Philosophy and Psychiatry go?

We should not overstate this problem, however: both philosophy and medicine are not reducible to a singular methodology, and as Bechtle (1988) has described, we should keep our minds and research practices open to the development of interfield methods and language. Responses to criticisms of experimental philosophy have emphasized the complementary nature of empirical work vis-à-vis philosophy, and philosophy’s fundamental commitment to intellectual curiosity and diversity. We will return to this question of the manner in which the interdiscipline can develop and simultaneously remain accessible to both parent disciplines. First though, I suggest Philips’ thoughts can be developed further.

1.2 Towards philosophy in practice

The presence of a priori philosophical ideas is the most directly available and self-evident entry point for philosophy into psychiatric practice. Indeed, large bodies of literature have been devoted to the different ‘models’ of practice (e.g. biological vs. psychodynamic, reductionist vs. antireductionist philosophy of mind). However, the presence and functioning of such models and ideas within actual practice have rarely been studied (cf. Radden 2007, Slife and Williams 1995, McHugh and Slavney 1998). An assumption implicit in Philips’ suggestion is that practitioners possess a repository of reasonably consistent philosophical beliefs, which in turn are applied reasonably consistently in practice. But what do we know of the manner in which philosophical beliefs and notions, associated with abstract terms like ‘mental disorder’, ‘mind and body’ or ‘classification’ operate in practice? Are practitioners consistent in their beliefs? How susceptible are they to social and institutional influences? If they subscribe to certain ‘models’ of mental disorder, or profess allegiance to a therapeutic school, does this imply consistency of belief and expression thereof in practice? Furthermore, practice does not occur in a vacuum: individual practitioners are embedded in various levels of institutional cultures. Colombo and Fulford’s study (2004) of diverging models of mental disorder in
interdisciplinary teams highlights the diversity of thought at ‘ground level’. Their study could be seen as a starting point for further examination of the manner in which philosophical assumptions manifest in practice, without a priori assumptions as to their consistency, degree of complexity, or even ownership. Of course, the therapeutic encounter implies the presence of at least two individuals. This is a location of complex communication and conceptual interplay. In dynamic communicative processes involving developing exchanges of ideas, the question of ‘whose philosophy is it?’ may become difficult to answer. All this complicates Philips’ advice but does not obviate it, on the contrary: with this in mind philosophy in practice seems a highly interesting area for exploration.

If we take a wider view of the work in philosophy and psychiatry, we can broadly distinguish three methodological approaches with respect to the relationship between philosophical beliefs and actual practice: first there is ‘pure’ conceptual work, following the analytic philosophical tradition, examining concepts relevant to psychiatry such as mental disorder, mind, free will, classification, science, responsibility and suchlike. Such subjects are also studied in the recent resurgence of the continental-phenomenological tradition, adding enriching and novel perspectives on diagnostic entities such as schizophrenia (Wiggins & Schwartz 2007, depression (Ratcliffe 2014), or dementia (Millett 2011). Related to this work is the analysis of more general, encompassing ‘models’. The psychodynamic tradition has long been a subject of philosophical study (e.g. Hopkins & Wollheim 1984, Grünbaum 1985), but other psychotherapeutic models have also been studied (Slife and Williams 1995), as have evolutionary theory (Adriaens & De Block 2011) and biological psychiatry (Zachar 2000). Though generally seen as pre-paradigmatic, the ‘models’ approach is present if there is a set of ontological and epistemological assumptions and/or values in place with a sufficient degree of internal consistency and stability.

A second approach casts the philosophical net less widely, attending to (epistemic) perspectives, relating to the causes of mental disorders, and leaving from the assumption of a more pluralist practice than the more monolithic ‘models’ approach (McHugh and Slavney 1998). McHugh and Slavney describe several (internally consistent) approaches defined both as concepts and perspectives: the disease, dimensional, behavior and life story perspectives. In their view, for each patient, each perspective must be considered for its benefit.

The third approach, being proposed here, is to draw from existing research traditions empirically examining medical practice, leaving from the premise that philosophical ideas, beliefs and convictions can be studied in action just like other ideas, beliefs and convictions. This practically embedded approach is apparent in
the title of this thesis. As the study proceeds, the findings of this study of philosophy in practice will be related to themes and debates in philosophy and psychiatry.

The focus in this study is on psychiatrists. The choice to focus first on practitioners was made for the simple reason that this seems to be an area which so far has received, relatively speaking, less attention. Also, as the primary author is himself a practitioner, the choice was also one of convenience, requiring less time for immersion in the language of the participants. If the approach proves enlightening, the same approach could be taken to focus on patients’ views and actions and to the dynamic interactions between practitioners and patients.

With respect to the aforementioned methodological gap investigative methods commensurate with both parent disciplines will be used: a ‘common ground’ approach. There is no ambition to ‘prove’ the value of philosophy empirically or to attempt to integrate the parent disciplines, rather the results of the project itself may suggest fruitful ways of going forward. If there are recommendations to be made as to improved practice or as to philosophical output, these can only be made once the findings have been related to the relevant disciplinary domain, in the context of the relevant justifying frameworks. The primary aim of this study is to explore.

The central premise of this study is to leave from the point of practice, to identify where and how philosophy is operating, and thenceforth to follow it where it takes us. There is affinity in this practice-first approach with Dooyeweerd’s criticism of Enlightenment philosophy regarding the relationship between practical and theoretical knowledge. Positivist views have epistemically prioritized theoretical over everyday knowledge, and in the process ushered in a problematic subject/object dichotomy and a deficit view of practical knowledge as imperfect and fallible (Glas 2009). Glas argues that the scientific view of theoretical knowledge as absolute has led us either to believe that science will provide us with the full and definitive picture of reality, or, on the other hand, that our subjectivity precludes us from ever viewing this ideal. This positivist view of practice, however extensively criticized in philosophy, remains influential and an aspirational beacon for medicine, and psychiatry in particular (cf. Lieberman 2016). There are clear parallels between Dooyeweerd’s criticism and arguments in the postpositivist field of science studies (cf. Latour 1987, 1993, 1999, Hess 1997). Their approaches share a commitment to the openness, mutability and relatedness of entities, and an integration at the experiential level of knowing and acting. Furthermore, both acknowledge the intrinsic normativity of practices, be they medical or scientific. Tracking such normativity in interaction with entities may inform the question of how to improve practice, but cannot determine the answer. In this study the ‘science studies’ approach, ‘following scientists through society’ is applied (with
specific treatment and use of actor network theory) as a postpositivist method suited to this philosophically explorative goal. To paraphrase Latour, we will be attempting to ‘follow philosophy through psychiatric practice, society, and history’.

1.3 The ‘common ground’ approach to philosophy and psychiatry: methods and challenges.

Our first step in aiming to explore philosophy from the ground-level practice perspective, is to look to research traditions wedding empirical approaches to practice with philosophical and/or ethical analysis. Examples of philosophical fields incorporating empirical research include linguistics (Austin 1961), philosophy of science (Mitroff 1974), and consciousness (den Boer 2003). In ethics, there is a burgeoning research program incorporating empirical and philosophical perspectives termed empirical ethics (Widdershoven, Abma & Molewijk 2009a,b, Landeweer 2013, Ruisen 2015, Voskes 2015, Abma et al. 2010, van Elteren, Abma and Widdershoven 2012). The subdiscipline of experimental philosophy (Knobe and Nichols 2008) explicitly views the conducting of empirical research studies by philosophers as crucial to the project of figuring out how humans think. Meanwhile, within psychiatry, there is growing acknowledgment that performing qualitative and naturalistic studies may enhance the validity and applicability of much quantitative research, implying a growing openness to methodologies outside the classic natural science tradition. Recent work involving phenomenological inquiry is another example of a shared epistemic framework within which philosophers and mental health practitioners can collaborate (e.g. Owen and Harland 2007; Fuchs and Schlimme 2009). A further feature of psychiatric practice offering a possible empirical entry point is the status and application of (expert) professional knowledge.

Analysis of theory

The majority of the literature in psychiatry and philosophy aims at models, ideas, and assumptions that are taken to be prevalent in psychiatric practice or that are inherent in psychiatric and psychological theories. Ghaemi (2003), for example, presents four possible philosophical approaches he believes practitioners employ: dogmatism, eclecticism, integrationism, and pluralism. In fact, these descriptions apply to the scientific and practical problem of handling different theories and models for the explanation and treatment of mental disorder. He proposes his
model based on a thorough knowledge of these different theories/therapies and on personal experience of his colleagues’ views. Other authors focus on psychological theories/therapies such as psychoanalysis, biological psychiatry, and cognitive-behavioral therapy, examining the literature and uncovering the implicit or explicit philosophical assumptions within (Slife and Williams 1995, Slife et al. 2005). However, it is not clear from this literature how these assumptions come to the fore in practice, and what their (dis)advantages might be. Though these works may be taken to adequately describe the current philosophical state of psychiatric and psychological theory, the empirical researcher will be interested in the question of just how and where the philosophical beliefs inherent in theory influence practice, and will want to demonstrate it. A significant feature of much of this literature is that it is centered on assumedly coherent and consistent theoretical models: Ghaemi divides practitioners into 4 camps, and previous authors have variously proposed (with variations) biological psychiatry versus psychoanalysis, the medical versus psychosocial models, cognitive-behavioral versus humanistic theories, and so on. From a ‘models’ perspective, psychiatry has historically often been portrayed as at best a dialectic, and at worst a battle, between competing, monolithic theoretical paradigms (cf. Allan Hobson et al. 2002, Fancher 1995). The heterogeneity of available theory ostensibly provides the practitioner with an eclectic choice of which theory or theories to pick and apply in practice. Philosophical analysis of psychiatric and psychological theories is practically relevant on the assumption that in the translation from theory to practice, the theory-bound philosophical assumptions and entailments are carried along.

Most such analyses assume an uncomplicated relationship between theoretical and practical, or clinical, knowledge. There are reasons, however, for doubting a one-to-one relationship between theory-based beliefs and practice. The translation from theoretical/therapeutic model to actual practice involves modulations at various levels. The model itself may afford scope for variance in practice, if sufficiently encompassing and differentiated. The prime example hereof would be psychoanalysis, which throughout its history has undergone modifications and brought forth branching and developing theories, producing varied practices in the process. Institutional and financial constraints may limit and circumscribe provided treatment, deviating from what might be chosen from a theoretical point of view. Individual practitioners possess a ‘repository’ of past clinical knowledge applied to current cases, interacting in practice with theoretical knowledge. Last but not least, any therapy needs to be tailored to the unique characteristics and contextual circumstances of the patient. How professional practice is shaped and how these influences work are both still unclear matters
(Norman 2000, 2005). Therapeutic ‘eclecticism’ may come in many forms. It may be part of an “all the way down” eclecticism from theory to practice, but one might imagine other modalities of the relationship between theory and practice, where the practitioner subscribes to or self-identifies with one explanatory theoretical framework (e.g. psychoanalytic or biological theory) whilst applying therapeutic methods derived from alternative theories. It is at the least conceivable, and open to study, for a therapist to be theoretically monistic and methodologically pluralistic. Alternatively, a hierarchy of different theories is possible, entailing conflicts between background assumptions. In other words, the relationship between dogmatism and eclecticism need not be a dichotomy (or a hierarchy) but a distinction, with various modalities in between. Research in the area of personal epistemology suggests the context-dependence and domain-specificity of epistemological positions (Niessen 2007, Hofer 2001). The same might apply to philosophical views pertaining to various disorders or in different treatment settings. To put it differently: rather than practicing as dogmatic supporters of one monolithic theoretical approach (with the associated philosophical beliefs) irrespective of context or presenting problem, it is possible that practice is more heterogeneous, and practitioners more eclectic and pluralist, tailoring their approach to the problem at hand. For this study, the relevant question is: to what degree is philosophy in practice determined by bottom-up versus top-down processes?

Besides attending to world views and models, epistemological work on the relationship of knowledge to practice in psychiatry is relevant, on the assumption that philosophical views are part of the knowledge base with which practitioners approach their practice. Issues surrounding the legitimacy of science and knowledge claims in psychiatry are among the most contentious issues in the field (Grünbaum 1985, Horgan 1999). Dating back to Jaspers and beyond, the question of the balancing of nomothetic (general, lawlike) versus idiographic (individual, meaningful) knowledge has remained a complex issue for psychiatry. The individual practitioner welcomes valid nomothetic knowledge to guide treatment decisions, but also requires knowledge of the individual they are charged to treat, knowledge that is singular, meaningful and contextual. Running alongside the tension between the general and the particular is the question of the degree to which psychiatric practice, science and concepts are factual or value-laden (cf. Thornton 2007a, Glas 2013, Fulford 2008). Evidence-based medicine has been portrayed as a conscious move away from individual clinical knowledge and expertise, towards knowledge that is seen as more scientifically informed, more reliable, and less prone to bias. However, as Gupta (2014) has pointed out, EBM comes with its own conceptual assumptions and (epistemic) values. Where it has
been proposed as the singular source of valid knowledge in psychiatry, it has come under criticism for its limitations (Falkum 2008). This discussion on the validity and legitimacy of professional and scientific knowledge has been enriched by the increasing presence of experts by experience of mental disorder as user-researchers of philosophy and psychiatry (Rose, D. et al. 2006, Baart and Abma 2011). The authority of professionals’ knowledge claims has met with competition from the growing ‘expert by experience’ professional movement, and the parallel growth in user-led research (Weerman 2016, Faulkner and Thomas 2002). The surge of interest in the kind of knowledge deriving from personal experience may represent a reaction to the strong focus on nomothetic knowledge in recent decades in the mental health field.

A limitation of theoretical analysis lies in the way in which philosophy of practice is framed, namely chiefly in an individualistic, cognitive manner: underlying the value of philosophical analysis of psychiatric theory is the view that it is possible to analyze the philosophy of practice by attending to individual practitioners’ ostensive or hidden assumptions, as if these are the only or prime actors of philosophical import. However, as mentioned in the introduction, philosophical assumptions may be represented in multiple other levels exerting influence on the clinical encounter. Anthropological and ethnographic studies are especially effective in demonstrating the manifold ways world views and (philosophical) assumptions are embedded and enacted within social practices and institutions (cf. Nicolini 2012). A sensitivity to the importance of social and institutional context is a requirement of any empirical study, whether it leads to a methodology at reducing contextual variation (quantitative methodology) or aiming to capture it (qualitative methods).

In spite of these caveats, the work on psychiatric theory is crucial to efforts to examine the philosophy of psychiatric practice, in providing conceptual resources for the empirical project. The aforementioned considerations imply that any models-based account will need to specify its level of application, and its purported consistency across contexts. In order to map the terrain of psychiatric philosophy in practice, a broader view is required than that of psychiatric and psychological theory. As we will see below, this study proceeds from the basis of the one-on-one encounter, but aims to trace the philosophies in place to their epistemic, ontological, social and historical sources beyond the confines of the office.
Linguistic philosophy and qualitative research

Fulford (2008) has developed practical applications for philosophical ideas in psychiatry, most notably through his work in devising and implementing Values-Based Practice. This approach has received support from the British Government and has become integral to the National Framework of Values for Mental Health, and as such could be taken as a highly successful example of applied empirical philosophy. Much of Fulford’s philosophical work is rooted in the Ordinary Language Philosophy of J.L.L. Austin, and as such, has a specific empirical bent. A good example is the study of models of mental disorder (Fulford and Colombo 2004), wherein the authors analyze implicit models of mental disorder of mental health workers from various disciplines, using textual analysis and a case-study method, based on the assumption, rooted in the Oxford tradition, that one’s ordinary use of language offers a window into one’s philosophical assumptions.

This assumption is also one of the epistemic tenets of qualitative research (QR) (Silverman 2000), although what is termed ‘assumptions’ or ‘philosophy’ here may be referred to as ‘narrative’ or ‘discourse’ within some QR frameworks. It has been recognized before that QR is of a similar nature to empirical philosophical research, though the degree to which philosophical concepts, views and categories are described in studies varies. Under the broad heading of cultural studies, anthropological and sociological research has focused on the practice and concepts of psychiatry, employing a variety of quantitative and qualitative methods, including ethnography, participant observation, grounded theory practice, surveys and interviews (e.g. Luhmann 2001; Kleinman 1988).

Qualitative research can demonstrate the practical relevance of philosophy. For example, Ruissen (2015) applied qualitative methodologies in her exploration of competence in obsessive-compulsive disorder. The different methodologies yielded interesting perspectives on the conceptualizations of competence and incompetence at different levels of inquiry. Using semi-structured interviews of professionals, Ruissen et al. found them to conceptualize competence in terms of cognitive rationality, in agreement with the MacCAT (Ruissen et al. 2015, Grisso and Appelbaum 1998), and incompetence in terms of emotions, values and identity. Using a naturalistic case study approach, they subsequently studied practitioners’ and patients’ perspectives, which demonstrating that competence is not just an assessment by the therapist, but also a ‘co-constructed reality shaped by the experiences and stories of patient and therapist’. This implies the relevance of practical reasoning as constitutive of competence. The late R. Barrett, psychiatrist and anthropologist, performed a detailed ethnography of schizophrenia in a modern psychiatric hospital in Adelaide, Australia (Barrett 1996). His study
highlights the way in which ideas and values embedded in different levels of hospital work and interact to create and recreate the images and identities of patients who have been diagnosed with schizophrenia. For this study Barrett invoked the social phenomenology of Schutz (1972). This approach focuses on the 'philosophy of the mundane', the taken-for-granted language of hospital practice and the background assumptions on mental illness it implies. With this in mind the study attended to the ordinary daily round of activities, the common-sense reasoning of the clinical staff, and the tacit assumptions present in personal, theoretical, temporal and institutional frameworks. Special attention was paid to matters that seemed, to the staff, self-evident, so ordinary and natural that they are never questioned. Barrett was able to demonstrate that different theoretical perspectives reflect tacit beliefs expressed in different idioms. “Clinicians, scientists, patients, and the public alike are influenced by these cultural images and metaphors” (Fenton 1998). The (partially) tacit beliefs may, if they achieve a certain level of consistency and durability, form a conceptual network or ‘framework theory’ and be embedded at one or more of the previously mentioned structural levels. By attending to the content of such theories, which contain philosophical assumptions, and their consequences for daily practice, the empirical connection between philosophical beliefs and practical import is demonstrated. The studies of Barrett and Fulford & Colombo share a focus on the empirical study of ordinary language of professionals as a valid method of exploring the (philosophical) assumptions of mental health workers. In this study (see Chapter 2), this assumption of the language of practice as a window into active philosophies is integrated into a stepwise, mixed-methods qualitative research approach to the subject matter.

**Experimental research and clinical reasoning**

Promising studies from the field of experimental cognitive research have appeared in recent years. One area of interest pertains to categorization and causal reasoning, and in a number of papers experimental methods have been employed to determine the presence and nature of various related beliefs in mental health workers and laypersons. There is a substantial literature on illness experiences and conceptualizations of patients, including philosophical perspectives therein (e.g. Kay Toombs 1993, Davidson et al. 2008, Weerman 2016). Since this study focuses primarily on the views and actions of practitioners, this literature will not be reviewed here. Research on practitioners’ perspectives has taken place more within the ‘clinical reasoning’ tradition (Norman 2000), which has focused more on the structural aspects of reasoning. Recently however, conceptual analysis has
attracted more attention. For example, Ahn et al. (2009) found that clinicians conceptualize mental disorders on a continuum spanning from highly biological (e.g. autistic disorder) to highly psychological (e.g. adjustment disorders), and not as an ontologically homogenous kind. The study concludes that even expert mental health clinicians make strong distinctions between biological and psychological phenomena. Kim and Ahn (2002) found that clinicians hold causal theories with respect to DSM diagnoses, imputing a causal structure to the ‘atheoretical’ feature lists of the DSM, affecting clinical diagnosis: clinicians had better recall of causally central features compared to causally peripheral ones (cf. Ahn and Kim 2008).

Another study employed a vignette method to study covert dualistic reasoning in clinicians (Miresco and Kirmayer 2006). The authors concluded that mental health professionals continue to employ a mind-brain dichotomy when reasoning about clinical cases. “The more a behavioral problem is seen as originating in “psychological” processes, the more a patient tends to be viewed as responsible and blameworthy for his or her symptoms; conversely, the more behaviors are attributed to neurobiological causes, the less likely patients are to be viewed as responsible and blameworthy.” One obvious advantage of this experimental method with regard to one goal of this study (making philosophical analysis available to the practitioner) is the fact that its methodology accords more with the empirical methods familiar to mental health professionals. Its strength lies in its precision and its potential for demonstrating specificity of practical import of philosophical assumptions connected to specific circumstances.

The clinical reasoning research field is a useful complement to the kind of experimental cognitive research described above. If there is evidence of causal dualism or dimensional conceptualizations of disorder as described above, through what sort of conduit do such ideas actually influence practice? Can we take them to function as cognitive representations, and if so, how are such representations accessed in practice? Ahn et al. (2009) refer to the concept of ‘framework theories’ (Godfrey-Smith 2003) guiding inferences and reasoning across an entire domain, a concept that does not seem far removed from concepts developed within the field of ‘personal epistemology’ (see below). It is an empirical question whether clinical reasoning works through the accessing of cognitive representations and theory constructs containing such frameworks. Studies on clinical reasoning are one way of exploring the nature of the connections between theory and practice and are therefore relevant to the exploration of this study. In Chapter 3, a brief review will be given of research in this area.
**Historical and sociological research**

Being historically informed often alerts one to the contingency of one’s views, and it can be no surprise that the work in philosophy and psychiatry often incorporates historical analyses, most readily seen in studies of specific mental disorders (e.g. Blom 2003). Berrios has elaborated on the relevance of historical work in psychiatry in different domains such as conceptualizations of disorder, symptomatology, and taxonomy (Berrios & Porter 1995, Berrios 1999). In *A History of Clinical Psychiatry* (1995), he writes:

“The history of clinical psychiatry may be defined as the study of the way in which clinical signals and their descriptions have interacted in successive historical periods, and of their psychosocial context. To estimate the extent to which earlier meanings (terms, concepts and behaviors) are preserved when clinical categories are transferred from one discourse to the next, historian and clinician need to know how descriptive and nosographic rules are formulated. For example, can it be assumed that ‘mania’, ‘melancholia’, or ‘hypochondria’ mean in 1995 the same as they did in 1800? How can differences be made explicit? One of the objectives of historical nosography is to decode the rules controlling psychiatric discourse, and make explicit the drafts upon which it is based.”

It is these rules and drafts that we are interested in from the perspective of philosophy and psychiatry. History may be viewed as a repository of past philosophies (e.g. Widdershoven-Heerding 2000). Berrios’ argument also draws attention to the fact that we cannot presume conceptualizations of mental disorder are stable concepts in terms of their meaning, and in terms of their connections to what he describes as the ‘biological signal’ (the easiest example of such instability is the changing meaning attached to the concept of neurosis in different domains and historical periods). Sensitivity to such mutability is a requirement for philosophical analysis. But this citation also draws attention to historical work as an *empirical* source for philosophy. Historical analysis is, at least in part, an empirical undertaking. This is expressed in the extensive discussion of historiography¹ by Wallace (in Wallace and Gach 2008). Wallace draws parallels between controversies in history and in natural science on the subject of the relationship between theory and data: what are (historical) facts? Are they observed or constructed, organized or organizable? Facts of history cannot be observed directly, he notes, but they share this quality with the unobservables of natural science such as black matter or quarks. However, historical traces are open

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¹ Historiography: the study of the methodology of historians and the development of history as a discipline.
to empirical inquiry, requiring though a methodology sensitive to the role of interpretations throughout the event’s history, in the original perception and description thereof, its subsequent elaboration and interpretations through different social and scientific domains. A ‘one-sided and caricatured’ picture of the natural sciences has led to some historians clinging to a simplified dichotomy between observation and theory which has long been abandoned by natural scientists and philosophers of science who recognize the fluidity of the line between data collecting and theorizing. Such dichotomous views have also led to skeptical or postmodern views of the impossibility of establishing any factual basis for history, criticized by Wallace for leading to a form of infinite regress and nihilism towards meaning (a familiar charge against postmodern skepticism). Recognition of the theory-bound nature of any form of observation and of the role of rules of methodology recognized within a given scientific community as a means of affording scientific validity serves to defuse such criticism, to underpin the empirical basis of history, but to equally open it to critical analysis based on such rules of methodology. Widdershoven-Heerding notes that historical analysis may criticize anachronistic and positivist readings of the development of medicine as purely progressive either in ‘converging on truth’ (cf. Kendler 2012) or in improving professional quality, or on the other hand representing the history as one of change without improvement (since there are no independent means of establishing a measure of the latter).

**Integrating and translating the research**

An example will serve to illustrate the potential of combining and integrating empirical work from the diverse sources mentioned above with philosophical analysis. In the previously mentioned study by Barrett, there is explicit reference to practitioner’s ideas of patients being more or less (morally) responsible for their behavior. In his project he discovered that as patients remained in treatment longer, they were taken to be increasingly morally responsible for their actions. Those patients who, in the course of their hospital stay, conformed to the practitioners’ wishes and the treatment program, were seen as good, responsible patients whose outcome was favorable, whilst those that did not conform tended to be seen as manipulative, with an unfavorable outlook. But both groups were seen as gaining in personal responsibility (and accountability) for their behavior as time progressed. The concept of moral responsibility has high practical relevance for practitioners, some of whom are called upon daily to make assessments thereof. Other studies shed a different light on moral responsibility, tying it to assumptions of biological or psychological causation (Miresco and
Kirmayer 2006) or to increased understanding on the part of the practitioner (Ahn et al. 2003). The latter study offers an additional possible explanation for one of Barrett’s interesting findings: over time, the rational understanding on the part of the staff of patients’ experiences and behavior increases, and given the association of understanding of behavior with ‘normality’ and hence of moral responsibility, staff’s views on patients’ responsibility for their behavior change accordingly. This leads to the question of whether such reasoning is valid and ethically sound, which is an entry point for ethics suited to Philips’ goal of ‘improving practice’. It also opens avenues for observational study, for example focusing on assessments of moral responsibility through time of patients who are experienced as difficult to understand by hospital staff. Ahn’s demonstration of a continuum of causal attributions across different mental disorders also suggests further observational research on the relationships between such causal reasoning, conceptualizations of disorder, attributions of responsibility and blameworthiness, treatment modalities, etc. By locating and specifying philosophy in practice, the related questions for either philosophy/ethics or empirical investigation also become more specific, and the answers more easily recognizable to practitioners. Barrett refers to the institutional embedding of attitudes and assumptions in practices, but also in material arrangements (such as the categorizations applied to naming wards), suggesting further sociohistorical analysis of such arrangements. These studies not only characterize philosophical ideas, but locate them both within the theoretical frameworks and practices of individual clinicians as well as in the material and immaterial arrangements of mental health institutions, and within the broader sociohistorical context. Integrating the findings opens up new avenues for collaborative ‘philosophy in psychiatry’ field work, with clear potential to improve practice. This study aims to further this approach, combining empirical, practice-based, qualitative research with historical study and philosophical analysis.

1.4 Description and prescription
A final word on descriptions and prescriptions is required before we move on. With respect to the application of empirical methods in philosophy of psychiatry, and in this instance in the case of the application to ethics, McMillan and Hope (2008) address worries attached to the concept of ‘empirical ethics’, a research field integrating seemingly conflicting empirical and ethical methods. They first argue, in agreement with the line of reasoning in this introduction, for the primacy of issues rather than methodologies for determining one’s (research) field of interest: methodologies are tools, and follow aims. They then refer to Hume’s is/ought
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problem which makes the point that there is a logical problem involved in deriving normative or moral conclusions from matters of fact (‘no ought from an is’) (Hume 1978 [1740]) from McMillan and Hope 2008). The closely related naturalistic fallacy (Moore 1966, ibid.) states that one should not attempt to define moral properties in terms of ‘natural’ properties, or, in other words, there is something normative about moral terms which can’t be captured in terms of matters of fact. McMillan and Hope argue that these observations do not forbid a research field of empirical ethics, they only imply the necessity of adding methods derived from ethics to empirical analysis. However, the suggestion of an integration of empirical and ethical work is met with objections based on the possible contamination of the one or the other, compromising the integrity and validity of both: the methodologies should be kept separate. McMillan & Hope argue against this from what they term the ‘obvious moral premise’: an empirical description of a given situation may lead to a researcher concluding that something ought to be done about this situation, without explicitly defending a moral premise. So in the hypothetical case of an empirical study of the occurrence of violence on mental health wards, finding a significant relationship between violence and varying compositions of professional disciplines on such wards could lead to advocating for the constellation resulting in least harm, without requiring separate ethical argument for the latter conclusion. In other cases, empirical investigation may simply serve descriptive purposes, but involve examining normative content as it is present in the domain. An extension hereof is to say that empirical ethics directly engages with moral norms. If moral features are present in the world, no fallacy is committed in describing them (empirically) as such, moreover, Moore himself proposed that we can only become aware of moral properties by directly intuiting them in the actions of others, and therefore, the ‘empirical ethicist’ is better situated to study moral norms than the philosopher sitting at his desk. An example is the empirical analysis of ethics in practice performed via moral case deliberation (Abma, Molewijk & Widdershoven 2009) grounded in Gadamer’s dialogical conception of ethics. Throughout the study an effort will be made to empirically examine the location of values in practice, in view of authors who have located them in concepts of mental disorder (Fulford 2001) and within psychiatric taxonomy (Sadler 2005). Moore’s conception of morals residing in actions is broadened: we shall not presuppose any location. The primary aim of this study is descriptive, grounded in qualitative and historical studies. Subsequent philosophical and/or moral analysis may lead to prescriptive suggestions.
1.5 Implications for this study and overview

This overview suggests that the domain of psychiatric practice offers sufficient common ground for philosophers and psychiatrist-researchers to co-develop fruitful research programs. The study aims to contribute to fruitful cooperation between philosophers and mental health practitioners by following Philips’ advice to both describe (how clinicians’ philosophical assumptions affect their clinical practice) and advise (presenting them with the results of philosophical analysis geared towards better practice). From this premise, it is clear that both empirical and normative methods are required, but the initial step is exploration of practice. Although we expect an interfield domain of inquiry to, in time, produce methodologies of its own not necessarily reducible to the methods of its parent disciplines, at the early developmental stage of such a field validity should be ensured by adhering to the methodological rules apt to the subject at hand. Care should be taken in translating findings from one methodology to the other.

This study is about psychiatrists. The prosaic reason for choosing this group as an object of study is that the primary researcher is himself a psychiatrist. Where qualitative methodology is involved, this affords advantages in the requirement of immersing oneself into the domain studied. One should however attempt to avoid historically discredited ‘insider accounts’ of professions, the ‘Great Man histories’ and suchlike. The possible presence of biases pro and contra the profession are legitimate concerns within both qualitative and historical analysis. In part two of this chapter, the methodology of the qualitative study is described, wherein this possible bias is attended to. With respect to historical review, I have attempted as far as possible to clearly signal which interpretations are ours, and the same goes for connecting findings from one domain to the other. It is up to the reader to determine whether I have been successful. I have chosen to combine empirical qualitative study with historical reviews and philosophical analysis, hoping for a fruitful interplay between the three methodologies. At the outset, the research team made a decision to identify three broad domains of inquiry: Diagnosis, Science, and the Concept of Disorder. Diagnosis was chosen for its central location both within the activities and in the professional identity of psychiatrists. Science was chosen for its central role in the societal legitimacy of psychiatrists and their claim to a specific domain, and the concept of disorder was chosen for its purported function in demarcating this domain. Also, all these themes are well-represented in the domain of philosophy and psychiatry, and in historical studies of psychiatry.

The general framework for this book reflects the alternation between empirical, historical and philosophical forms of inquiry. The empirical backbone of the study relating to the present is formed by a qualitative study covering the three
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abovementioned domains, examining these themes in action in psychiatric practice from a naturalistic inquiry perspective. The methodology of the qualitative study is presented in Chapter 2, and the results are described in Chapters 3, 6 and 8, under the headings of Diagnosis, Science, and Mental Disorder, respectively. These primarily descriptive chapters alternate with chapters containing historical reviews of these topics and philosophical analysis aimed at integrating the findings of the qualitative study with the historical perspectives and current philosophical debates. This will lead to conclusions which are both descriptive and prescriptive, and care will be taken to distinguish the two, even in the face of the reassuring statement a philosopher of psychiatry (Bolton, D. personal communication) once gave me: “If you describe for long enough, your descriptions will eventually and inevitably become prescriptive.”