Chapter 7: Science and Psychiatry.

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7.1 Introduction
We concluded the previous chapter with tensions between the professional emphasis on the natural science model on the one hand, and the pluralist, pragmatic, value-laden model of practice on the other. In the public domain, it often seems as though these models are in opposition, leading to a modern-day psychiatric version of the Methodenstreit or the ‘two cultures’ of science (Allan Hobson 2002). If we accept that the science model publicly adapted by professional psychiatric organizations and institutions fulfills a legitimizing function in the sense of ‘exclusive professional knowledge’, then the outcome of this struggle has real-world consequences: professional education and research will move more in one or the other direction, and policy makers will apply the norms of the (dominant) model to practice. Fear of certain negative consequences associated with either model has been a major feature of recent critiques, e.g. the marginalizing of non-technical aspects of medicine by the dominance of EBM (Thomas, Bracken & Timimi 2012), stigmatization and labeling due to what is
seen as inherent reductionism in biological psychiatry, or bias and factually incorrect practice due to insufficient attention to scientific evidence (Zachar 2012).

Though previously I postulated the natural science model to be both the current dominant model in psychiatry and the historically dominant model in medicine (based on the literature on medical education and the outcomes of our study), I left unexamined the question of whether the natural science model has historically functioned as the ‘official’ and public knowledge foundation of psychiatry in the professionally legitimizing sense (Falkum 2008) of fulfilling the terms of the ‘social contract’ (Bhugra, Malik & Ikkos 2011). To answer this question, I shall now examine the history of professionalization of psychiatry in the Netherlands, where the qualitative study was performed. The limitations of this project do not allow for a comprehensive account of this topic, for which I refer the reader especially to the extensive literature elsewhere (e.g. Oosterhuis & Gijswijk-Hofstra 2008, Wallace and Gach 2008, Gijswijk-Hofstra and Porter 1998, Gijswijk-Hofstra et al. 2005) and studies of the psychiatric and medical professions (Vos 2011, Abma & Wijers 2004), which served as the main sources for this brief historical review. The two main questions being addressed in the sociohistorical analysis are: what role did science play in the professionalization of psychiatry in the Netherlands, and can the scientific perspective that was espoused be characterized philosophically?

Plan of the chapter
First (7.2), I will characterize and discuss, from a historical and philosophical point of view, science in its relation to the psychiatric profession in the Netherlands. The historical analysis will bring us into the present and the way in which the psychiatric profession currently presents and legitimizes its scientific stance. We will see that this analysis confirms the impression gained above, that the natural science perspective has been and continues to be central to the scientific legitimacy of the profession of psychiatry in the Netherlands.

Next, I will argue that the observed discrepancy between practice and ostensive legitimacy is a potential threat to the profession, and requires a solution. A number of options are available, based on the professionalization literature: practice could be modified to adhere strictly to the natural science perspective, an alternative perspective on science could be chosen, the relationship between practice and scientific knowledge could be altered, or the primary source of legitimacy could be altered. Also, combinations of the above are possible. These options will be discussed, leading to a proposal for an alternative professional framework and alternative professional resources and competencies with regard to science. The role of values in science and practice will prove to be central to this framework.
7.2 Historical and philosophical perspectives on science and psychiatry

7.2.1. Science and the formation of the profession of psychiatry

In the early nineteenth century, before the term ‘psychiatry’ had been coined, care for the insane as we now know it in the Netherlands did not exist. Those insane who caused disturbances of the peace, or were too much of a burden to their families, were remanded by local authorities to asylums, poor houses, prisons and correctional houses. With a few exceptions, these institutions were not exclusively meant for the insane. Asylum doctors drew up a ‘medical declaration’ attesting to the nature of the insanity, but beyond that were hardly involved with the occupants, who were supervised by wardens without specific training or education. An investigation ordered by king William I in 1816 into the number of the insane and their living conditions found that their circumstances were very poor, leading to a royal intervention, the ‘Charitable Decree’ (Menschlievend Besluit), aimed at improvement, emphasizing the necessity of healing of the ‘unfortunates’ and of supervision by the provincial government, under whose administration the asylums fell. A repeat inquiry in 1825, however, showed little had changed: 1800 insane persons were counted, of whom 700 resided in various institutions, lacking entirely in medical care, in equally sordid circumstances (the total population of the Netherlands in 1825 was 2.515.000 (CBS 2014)). In contrast to the practice in surrounding countries which followed the paternalistic principles of moral treatment wherein the asylum doctor was also the asylum’s director and patriarch, Dutch asylums were run by local regents. Asylum care throughout the nineteenth century was mostly funded through the Poor Laws (1850): most residents of asylums were impoverished, and their care was funded through local religious or private charities. Only if these charities were unable or unwilling to fund care, could local government intervene on behalf of social order (Vos 2011). Such local groups resisted federal government interference with their policies.

Meanwhile, a group of civil servants from the Ministry of the Interior (including C.J. Feith, ‘referendaris’, i.e. head, of the Department for Poverty Affairs) and reformist physicians, most notably J.L.C. Schroeder van der Kolk, professor of medicine in Utrecht, pushed for change. Schroeder van der Kolk later became known as ‘the Dutch Pinel’, both for his persistent efforts on behalf of humane treatment for the insane, and for the actual inspiration he drew from Pinel’s ‘traitement morale’ (Vijsselaar & Bolt 2012). The effectuation of these principles by Schroeder van der Kolk at the Utrecht asylum (the Willem Arntsz House), including the use of

16 In this section, an effort has been made to use terminology suitable to the period described. Berrios has published extensively on the caveats relating to anachronistic use of psychiatric terms, see for example Berrios and Porter (1995).
medication and baths, labor and recreational opportunities, religious practice and the separation of patients according to gender, class and 'excitability', was taken up by other asylums and became nationally renowned, leading to government guidelines being passed down to the provincial government to effectuate smaller institutions following these principles.

Feith and Schroeder van der Kolk also laid the groundwork for the 1841 Insanity Law, enshrining the medical character of the asylums legally and effectuating central governmental supervision by the installation of national inspectors, the first two of which were, naturally, Schroeder van der Kolk and Feith. The inspectors, however, had no formal power over the local and provincial authorities to push through reform, and changes were slow in coming, if at all. Mid-19th century, the final responsibility for supplying adequate funding for care for the insane lay with the Provinces, but except for the Province of Noord-Holland, which built the provincial hospital Meerenberg, the Provinces failed to provide adequate funding, resulting in overcrowded asylums and increasing complaints from asylum doctors that their practice was far from their professional ideals of moral and hygienic treatment.

Many if not most asylum doctors did not actually practice 'psychiatry', but were employed as general physicians practicing primarily somatic medicine within a custodial approach to care. Due to their subordinate positions at the local level the Dutch asylum doctors were powerless to enforce change. Vos concludes that at the time there was insufficient sociopolitical backing to support a more powerful national intervention against the conservative local regents and religious governors. Schroeder van der Kolk attempted, and failed, to ensure that (legal) admission to the asylum would reside under medical authority rather than the judiciary. The influence of asylum doctors within the asylums remained very limited even after the Insanity Law, which, we may conclude, served primarily as an attempt to move towards medical and more nationally centralized oversight of the care of the insane, thwarted by powerful sociopolitical and socioeconomic localized forces resisting this move. It was the persistent marginalized position of the asylum doctors that therefore provoked the move towards professionalization instigated by four of their number: Ramaer, van Andel, Lammerts van Bueren and Donkersloot.

If Schroeder van der Kolk is the Dutch Pinel, then Johannes Nicolaas Ramaer is the Dutch Rush, the ‘father of Dutch psychiatry’. He was First Physician\(^\text{17}\) at the

\(^{17}\) Dutch physicians of the time were divided into three classes ('standen'), depending on their education. First class physicians had graduated from university and obtained a Ph.D. in medicine, obstetrics or surgery. The second class consisted of surgeons, apothecaries, country physicians and
asylums of Zutphen and Delft, and founder of the Dutch Medical Association (Nederlandsche Maatschappij tot bevordering der Geneeskunst, henceforth DMA). Ramaer was a highly active member of the hygienist movement and an internationally renowned advocate of the natural scientific method in medicine. The formation of the psychiatric profession in the Netherlands was a protracted and frequently arduous process, requiring considerable long-term effort from its main protagonists. The founding of a formal professional psychiatric society, the Dutch Association of Psychiatry (henceforth DAP), occurred later than in surrounding countries, in 1871 (compare this to the British Association of Medical Officers of Asylums and Hospitals for the Insane of 1841 and the German Gesellschaft von Deutschlands Irrenärzten of 1842). This may in part be due to the relatively small size of the country, enabling the DMA to function as a representative body for the asylum doctors for some time.

The internationally traveled route towards gaining public support for medical professionalization at the time was both through clinical effectiveness and the claim of expert knowledge. It is therefore perhaps no coincidence, remarks Vos (2011), that the formal initiation of the Dutch professional association coincided with the decade, beginning in 1870, historically identified in the Netherlands as the turning point in the transition to Modernity. Traditional social relationships were altered under the influence of a multiplicity of changes: population growth, increase in geographical scale and integration, industrialization and innovation, urbanization, social differentiation and mobility, emancipation and democratization (ibid.). The promise of natural science was aligned with both the formation of the profession and its ideals, which went beyond professional self-interest: the welfare of the insane was explicitly stated as one of the three aims of the Society: the promotion of psychiatry as a science, the representation of the interests of its practitioners and the betterment of the fate of the insane.

Ramaer became the first chairman of the society, and spoke as follows during his commencement speech at the first meeting of the DAP on 17 November 1871:

“Collective practice and development of psychiatry on the one hand, cultivation of psychiatric knowledge amongst Dutch physicians on the other, therein lies the aim of our Association. But thereby she envisions but one goal! That is the welfare of those to whom our branch of science is devoted, by ensuring an effective treatment, both at the commencement of their illness, and throughout its course... Her devotion to the

ship’s doctors. These physicians had served apprenticeships or had followed one of the seven Clinical Schools founded in 1928. Finally, army physicians had their own specialized training.
welfare of others however need not make it forget the interests of its own members.” (quoted in Vos 2011.)

The quote from Ramaer above draws attention to the dynamic nature of historical processes and the composition and variable nature of social explanatory factors: “Idealism and self-interest are certainly not mutually exclusive.” The proposition that what is good for psychiatrists, is good for patients, evoked by Ramaer’s words, was to remain a theme throughout the history of the DAP.

As may be apparent from the state of asylum psychiatry described above, Dutch psychiatry in the late 19th Century could not lay claim to any widely recognized therapeutic benefit in the treatment of the insane. Therefore, their professional foundation needed to rest on expert, medical knowledge. However, given the state of psychiatric science of the time, such claims had an unsure footing: at the commencement of the DAP, psychiatry was not included in universities’ medical curricula, and there was but one professorship for academic psychiatry, at the university of Utrecht. This situation implied a vicious circle for asylum doctors: they were increasingly becoming swamped with patients, and therefore unable to develop (academically and therapeutically) their treatment approach, entrenching both the adverse conditions of the asylums and the negative image of the profession, for at that point in time they had little in the way of effective therapies to show for their efforts. In order to reduce their workload, they needed to attract more physicians into the field, and for that purpose, an academic footing in universities was required. Both the federal government and the general medical establishment (through the DMA) rejected a proposal to include psychiatry as a mandatory subject in the medical curriculum, and worse, the professorship was downgraded, in 1886, to a readership. This defeat paved the way for the move towards neurology in the next decade, facilitated to a large degree by F.C. Donders, professor of physiology in Utrecht, who proposed, besides mandatory teaching of psychiatry to medical students, that such training should occur in a clinical setting, and be taught by one lecturer together with the subject of nervous disorders and neurology. The latter was a crucial move towards natural science mirroring Griesinger’s approach in Germany in roughly the same period, and also reflecting the increasing influence of the natural science approach throughout the nineteenth century generally (Engstrom 2004). Vos (2011) states: “Academic recognition was the most important prerequisite for the formation of a specialist profession.” The connection with neurology was enshrined in the renaming of the DAP in 1896 as the ‘Dutch Association for Psychiatry and Neurology’ (DAPN). The period that followed was marked by the broadening of the profession’s interests beyond the confines of the asylum and towards the domain of the ‘nervous diseases’.
Science was explicitly referred to in domain conflicts of the time, for example in the negotiations surrounding the revision of the insanity laws of 1841. These laws were viewed by asylum doctors as cumbersome and a hindrance to their view, based on principles of the mental hygiene movement, that early treatment was crucial for the prognosis of insanity (a view bolstered by the increasing influence of degeneration theory). Prevention and early treatment were seen as a potential solution for asylum overcrowding. The objective of early treatment came into conflict with (local) governments’ concerns with the costs of funding such treatment, given the rising tide of confinement, and with the judiciary’s attention to citizens’ legal rights in relation to involuntary treatment, which at the time comprised virtually all of asylum psychiatry. The DAP, which in its early years was dominated by the asylum doctors, maintained that it should the expert, the asylum doctor, who determines the advisability or not of admission, based on sound science. In reaction to first drafts of the revision of the insanity laws, which emphasized the role of the Justice Department in the procedure, the Society responded in its Committee Report: “Are the physicians of our Asylums deserving of so little trust in their expertise and honesty, that they require the watchful eye of a layperson?” The free access of the public prosecutor to the asylums was rejected because “it is insulting to the physician to be continuously confronted with an unscientific contrarian.” (ibid.)

This history illustrates the intertwined nature of science, professional ideals and professional interests at the incipience of the Dutch psychiatric profession. This is not to say that these were the only explanatory factors in the development of the psychiatric profession, for this can be viewed from far wider social and historical perspectives. Fancher (1997), for example, in describing the development of the psychiatric profession in the United States, identifies five historical influences contributing to the appropriation of insanity by the medical profession: Enlightenment views of humans as individuals both rational and free, moving towards realization of their inherent nature; Protestant theology emphasizing the possibility of individuals working towards their salvation; urbanization and modernization severing community ties and further pushing towards individualization and self-sufficiency; the social status of physicians; and the rise of modern science and medicine leading to the assumption that a wide range of distress could be relieved by the efforts of science.

The historical data allow us to conclude that science not only served the socially legitimizing function of expert knowledge (Eraut 1994) for professionalization in the Netherlands, but that also, institutional appointments and moves were made in order to ground psychiatry in natural science in an attempt to emulate general medicine. Interestingly, it was not the products of science that lead to psychiatry
being integrated into medicine on scientific merit. Psychiatry did not ‘graduate’ into medicine based on its scientific results, rather, on its naturalist scientific \textit{ambitions}. In retrospect, the move to integrate neurology within psychiatry, strengthening its links to natural science and the materialist research paradigm, was crucial in obtaining an academic, and consequently professional, foothold. Faith in the scientific method, derived from successes elsewhere, and in keeping with Modernist optimism, provided sufficient social support for the professional establishment of psychiatry.

\textbf{7.2.2. The science model of early psychiatry}

Having established the crucial role of science in the establishment of the psychiatric profession, we move on to the second question: what notion of science was presented and enacted at this time? The ideals of natural science, in accordance with Enlightenment skepticism of theory, emphasized the development and practice of the basic sciences, which were increasingly incorporated into medical education, previously dominated by theoretical knowledge. It is important to realize both the small scale and the marginal position of ‘psychiatric’ science of the mid-nineteenth century Netherlands. It wasn’t until 1893 before the first professor of psychiatry and neurology was appointed. Schroeder van der Kolk, then professor of anatomy and physiology at the University of Utrecht, offered lectures on insanity from 1831 onwards. Voorhelm Schneevoocht, affiliate professor from 1851 to 1862 of the Atheneaum Illustre in Amsterdam, was the sole other academic to offer lectures in psychiatry. Van der Kolk’s students Ramaer and Donders would later occupy highly influential positions, the former as the first chairman of the Dutch College of Psychiatrists, the latter as successor to van der Kolk as professor of physiology. It wasn’t until 1921, when several medical specialties were legally recognized, that psychiatry was formally admitted to the academic medical curriculum. Until the late nineteenth century theoretical education dominated medical training, with very little practical preparation for professional practice. What there was of practical training consisted of anatomical demonstrations and study of anatomical specimens. As we saw previously, the position of the asylum doctors in the actual ‘care’ for the insane throughout most of the nineteenth century was marginal. Therefore, we may conclude that the influence of (strictly speaking) psychiatric scientific theorizing in the actual treatment of the insane throughout most of nineteenth century Netherlands was very limited. Nevertheless, as we previously saw, the integration of the scientific method as role-defining was instrumental in establishing the
profession, and hence, the natural science view was of import both for the professional role of psychiatrists, and for their academic training.

As was the case in other mid-European countries (Engstrom 2004), empiricism began to dominate psychiatry in the latter half of the nineteenth century. The emphasis in psychiatry lay on studying the brain, as is illustrated in the following quote from a lecture by Ramaer to the German College of Natural and Medical Scientists in 1878 \(^{18}\) (Ramaer, 1878)

“Our science is in a highly extraordinary state, approximately that, in which a society finds itself after a revolution. At that point all emotions are in flux, one does not know what will become of the matter, the organizing hand is yet absent and from all directions people come running with plans to save the fatherland. Such is also the case with our science, it too has experienced a great revolution; the Psyche, which has dominated it throughout all ages, has been lifted from its throne and it is unlikely that its authority will ever be recognized again in science. It will be long, however, before its last traces are erased, and the names, which it has imprinted on our concepts, will retain civil rights within science for a long time; we cannot even accurately imagine what names will take the place of those, that are derived from her, mental phenomena, psychology, psychoses, psychiatry and so on.

I do not wish to look down upon theory, but if she is to carry some import, she will have to be grounded in actual facts and not leave from naked thought concepts, she must, to quote Napoleon, ‘crown the building’, though he, as a theorist, in fact gave his building one crown, and as you are aware of, but one powerful swipe was sufficient to collapse it.

Therefore, psychiatric science has no need for theories, but what can serve it, is the accurate knowledge of the workings of the different parts of the brain upon one another (Italics in the original). Previously Flourens, Longet and others have brought remarkable facts on this matter to light, but a new phase in this knowledge has begun through the studies of Hitzig, Ferrier, Nothagel and Fournié, and it is notable, that the pathological observations of recent times (Charcot, Vulpian, Pitres, Westphal, Samt, Bernhardt, Kuhn etc.) so thoroughly confirm the physiological studies, that we may expect to arrive at a complete knowledge of the relationship of different parts of the brain to one another. Then we shall, helped by a better analysis of the psychic phenomena than we currently possess, be able to think of a theory, which will be the crown of our scientific building.” (Ramaer, 1878)

\(^{18}\) Translation by the author. Representing differences in the flavor of late nineteenth-century Dutch compared to present-day Dutch has not been attempted, instead an as literal as possible a translation has been made.
This statement, encapsulating rejection of theory, emphasis on empiricism, coupled with material reductionism and hinting towards eliminative materialism, fits a medical translation of the natural science model which was increasingly influential internationally, and which was further emphasized by the professorship of F.C. Donders, internationally renowned physiologist in Utrecht, and the readership of C. Winkler, known for his research into brain physiology. It was Donders who was most academically influential in moving the profession towards neurology and the study of nervous disease. Therefore, I conclude that at the formal incipience of the psychiatric profession in the Netherlands, the aspiration towards a medical, natural science approach was foundational, defining the privileged, expert knowledge required for professionalization and thereby functioning as a cornerstone of the profession’s legitimacy.

7.2.3. Current developments in the profession of psychiatry

Having established the foundational role of natural science at its birth, we now quickly move forward to examine the same questions regarding Dutch psychiatry’s current public identity. After gaining its professional status, the psychiatric profession gradually began to differentiate, following the diversification of its domain, and mirroring developments elsewhere in the early twentieth century: the assimilation of nervous disease within its domain implied the first transition beyond the doors of the asylum, which was gradually accompanied by the development, through the ‘consultation bureaus’ and the ‘Medical Educational Bureaus’, of social medicine, aimed at prevention in the hope of saving costs, following the increase in both the general population and the population within the asylums. This move was reflected in changing membership of the DAP, with increasing percentages of psychiatrists in private practice or working for ambulatory services.

In the early twentieth century, a number of factors served to promote the ‘mental sciences’ (generally referred to as the human sciences): disillusionment with the results of the natural science project, Freud’s theories, and Jaspers’ works on the Natur- and Geisteswissenschaften. Members of the DAP were open, if critically so, to Freud’s ideas and willing to give them a try. There was an ecumenical and pragmatic attitude to differences of opinion with regard to the Methodenstreit, fitting this phase of gradual expansion and differentiation both practically, professionally, and academically. The DAP spent much effort on keeping developing subspecialities and sections, such as the child psychiatrists and the private practitioners, within their ranks, whilst also maneuvering between other developing medical associations. Also, the DAP had to contend with the rising importance of psychotherapy and tensions with non-medical mental health
professions in the domain. It goes without saying that all this required both scientific and political skill. The increasing differentiation finally led to the separation of the specialties of neurology and psychiatry in 1973, coinciding with what has been seen as a period of crisis for psychiatry, encompassing the ‘antipsychiatric’ movement and, allegedly, threats to psychiatry’s professional status. This is our starting point for assessing the recent public identity of psychiatrists.

The history of ‘antipsychiatry’ in the Netherlands has been excellently documented by Blok (2004). Her use of inverted commas is deliberate: the events, ideas and actions throughout this period were too heterogeneous to be represented as one coherent movement, and furthermore, were largely not aimed against psychiatry as a whole, but at improving various aspects of psychiatry: conditions and treatment, particularly in mental hospitals, civil and patient rights, emancipation, promotion of various forms of psychotherapy, and last but not least, consistent with the times, ‘opening the doors’ of both psychiatric institutions and the profession to democratic influence, and later, control. Interestingly, many of the most influential ‘antipsychiatrists’ were themselves psychiatrists, including Foudraine, now historically seen as the most influential psychiatrist of this ‘movement’. He lambasted the, in his view, dehumanizing and stigmatizing practices within mental hospitals and advocated personal, non-hierarchical forms of ‘meeting with’ patients as opposed to the classical ‘medical model’. His book, “Who’s made of wood?” (1971) became a bestseller and was widely read by mental health professionals at the time. One feature of this period was an alignment of resistance against perceived power differentials and abusive practices in psychiatry (e.g. the protests against ‘electroshock treatment’) and ‘reductive biomedicine’. As the argument ran, the reduction from the mental to the physical enacted through biological study of human behavior and mental processes was in itself dehumanizing, and through this dehumanization contributed to such practices. The polemics between protagonists of more humanist and more reductively biological approaches, van den Hoofdaker and van Praag, respectively, were a feature of this period, as was the vehement opposition to the work of Swaab on differences in brain structures between homosexual and heterosexual men.

As Blok and Kahn (2004) both point out, the antipsychiatry period was part of a more general, and international, phase both within psychiatry and wider society in which traditional authoritarian structures were questioned and altered, and various groups became highly politically engaged with regard to civil rights and civil liberties. However, Oosterhuis and Gijswijt-Hofstra (2008) note that there was
much in these developments that was consistent with previous features of psychiatry: the use of social and psychological treatments had started two decades previously, and though there were many polemics against the use of psychopharmaceuticals, they remained in place throughout the period of ‘antipsychiatry’ as treatments for serious mental disorder. The psychotherapeutic ideals of the ‘younger generation’ of psychiatrists and psychologists chimed with the interpersonal-phenomenological and humanist views of older professionals, and these groups aligned. There was broad support, both within the profession and without, for an increase in the therapeutic facilities for patients, aided not in the least by the positive economic outlook at the time. In other words, from the professionalization perspective, psychiatry can be seen as having aligned itself, through the antipsychiatry movement, with emerging sociopolitical values, consistent with social contract theory: professions should respond dynamically to changing social values in order to endure. Blok and Vos both note that there was broad support within the psychiatric profession for mental health care reform and the bolstering of investment in psychotherapeutic treatments. The ‘anti-authoritarian’ aspects of ‘antipsychiatry’ were more a manifestation of a wider reordering of society which was to affect the psychiatric profession, than the cause of the profession’s reduced societal power.

The threat to the profession did not actually derive from debates over science and abuse of power (though these affected its public perception), rather from a broader international development of increasing encroachment of society and government on professional domains. Postwar government’s creation of the welfare state was accompanied by an increasing role for the state in health care, to which end many representative advisory institutions and governing bodies such as the Central Council for Public Health and the National Health Council (Ziekenfondsraad) were founded. Mental health institutions were represented in these bodies, but the influence of the DAP was severely diminished. In the Seventies, the government began restructuring mental health care towards a more regional organization, emphasizing local cooperation between primarily ambulatory services such as the Social Psychiatric Services, Medical Educational Bureaus and Consultation Bureaus. Such restructuring inevitably creates new domain conflicts and competition, and in this case, it was the position of the private practices that came under threat. Meanwhile, national economic prospects turned sour, and budget cuts and savings became the focus of government policy. The number and frequency of new national policy initiatives led the then chair of the DAP Beyaert to state: “Policy documents in mental health care follow one after the other, because time pressure is more and more becoming a favored weapon of the government.” (ibid.) Where a century earlier, the asylum doctors had fought to
obtain a position of some power within the mental health institutions, now the patients, and, in their trail, the government, were encroaching on the professional sovereignty of psychiatrists. The DAP also had other matters to contend with, not in the least the question of the monopoly of psychiatrists on psychotherapy, which it eventually conceded. The limited personnel resources of the DAP also limited their capacity for political action. Vos concludes that up until the early nineties, the DAP remained ‘inward looking and insufficiently capable of adapting to a dynamic environment’. He comments, with some astonishment, on the apparent passivity and silence of the DAP throughout this period, especially when it seemed the profession itself was coming under threat, and points, besides to the point made above of a large degree of agreement with many ideas of the antipsychiatry ‘movement’, to the highly heterogeneous composition of the DAP at the time, a consequence of the process of Weberian differentiation described above. In 1991 the chair Rooijmans noted: “The Association lacks a consistent policy vision supported by its members. Outwardly, the Association’s policy leaves a fragmented impression.” Steps were taken to reorganize the DAP itself, including increasing the number of staff, and a commission was installed to develop a ‘Profile Sketch’, with the intention of “clarifying the image of the psychiatrist externally.” (ibid., p 226). The combination of the threats of reduced autonomy through external government or market interference, and internal differentiation and heterogeneity is a recognized challenge for developing professions (Abbott 1988).

In 2005, an altered Profile Sketch was compiled. Interestingly, an oppositional stance to the science views attributed to antipsychiatry was instrumental in redefining the professional identity. The former chair (2002-2005) of the DAP, R. Kahn, characterized antipsychiatry as “optimistic, naïve, self-satisfied, unscientific and overinvolved”, leading to “Dutch psychiatry falling years behind, to the detriment of hundreds of thousands of patients who unnecessarily were left to suffer from untreated psychoses, manias, or depressions. A generation of psychiatrists has been trained with no attention to or respect for scientific research...” (Kahn 2004). The supposedly antiscientific nature of the antipsychiatric period was used, at least publicly, as a stalking horse and argument for the remedicalization of psychiatry, thereby returning it to its roots in (natural) science. Describing mental disorder as brain disease accompanied this medical repositioning, allowing the profession to align itself with the enthusiasm generated by the up-and-coming neurosciences, embodied, amongst others, by the ‘Decade of the Brain’ initiative in the nineties of the previous century. This description of the development of the profession, as moving from the nonscientific, nonmedical, and naïve seventies to the realist and scientific present within medicine, paints a dichotomous picture of the developments in the profession, and may be seen as a
rhetorical device to realign the public science image of psychiatry with the increasing public valuing of natural science at the time. In this sense, there is historical continuity in the adaptation the professed knowledge base to what is socially valued. This does invite the question, however, of how much change a profession can withstand in making such shifts without losing consistency of its professional identity (criticized in works such as Allan Hobson 2002, Fancher 1997).

Vos notes that both the public (external) image of psychiatrists and their ‘market position’ were in fact favorable at the time, implying that the Profile Sketches primarily served an internal purpose: an attempt to form a more homogeneous shared professional identity within the group of psychiatrists themselves as a countermeasure to progressing professional differentiation. Such a shared sense of identity would serve the purpose of offering the board of the Association, now reduced to a less unwieldy five members, more scope for (political) action. These actions were part of a conscious move towards professionalization of the DAP, and a repositioning of the psychiatrist as a medical professional, to safeguard the profession in a period of increasing standardization and bureaucratization of mental health care, in which the profession’s traditional position of power and authority had been removed through the institutional reconfigurations instigated by successive governments and the increasing scale and professionalization of mental health institutions. According to Oosterhuis and Gijswijt-Hofstra, the themes of growing scale, professionalization and rationalization are the main themes of the development of the mental health care system in recent decades (Oosterhuis & Gijswijt-Hofstra 2008).

The Profile Sketches are the foremost official documents stating the professional and public identity of psychiatrists, therefore we shall examine them in more detail with regard to the representations of science within, which constitute the profession’s formally professed scientific legitimacy.

7.2.4. The science model of the current psychiatric profession: the Profile Sketch

The first Profile Sketch (NVvP 1996, henceforth PS), developed by a commission under the chair of W. van Tilburg, professor of psychiatry in Amsterdam, described psychiatry as ‘the medical specialty that occupies itself with behavioral disorders which are typified as “sick”’. The definition of sickness was not limited to the

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19 A linguistic note is necessary here: the Dutch language’s terminology for illness and disease differs from English and does not convey the same meaning. The term ‘ziek’ may apply to illness, and is also used as ‘feeling ill’ (‘zich ziek voelen’), but is also used for the English concept ‘disease’, therefore the
biological aspect thereof, the object of psychiatry could, according to the commission, best be described as ‘mental illness’. Psychiatrists’ methods were ‘clinical-descriptive’, and medical in the sense of ‘leaving from complaints and/or symptoms and through examination and diagnosis deriving a prognosis and treatment’. The first PS, therefore, relates the professional identity of the psychiatrist to a concept of mental disorder. As we will see in chapters 8 and 9, and was remarked at the time, this is not without its conceptual difficulties. According to Ten Doesschate and Hubben (2006), the PS was also aimed at cementing a new role for the psychiatrist, reclaiming a position as the ‘playing captain’ amongst other mental health disciplines after having lost his position of authority throughout the antipsychiatry period. The legitimation of this role was derived from a purposely broad (bio-psycho-social) role definition, defining the psychiatrist as the sole professional with such a broad grasp of knowledge and hence, *primus inter pares*.

The revised PS of 2005, as noted above an effort to bolstering medical identity, resulted in a ‘narrower’ definition as a medical specialist (ibid.). Kahn publicly argued for this change based on the idea that ‘psychiatrists have been viewing themselves more and more as ordinary medical specialists’ (Maassen 2005). In the PS itself, the following reasons for revising the 1996 PS are mentioned (NVvP 2005):

- New legislation (the law on Professions in Individual Health Care, PIHC) required professions to possess and describe ‘specific expertise’, obtained by its specified education, and to describe its specific qualities with regard to its individual relationships with patients.
- The report ‘Care for Many’ (*Zorg van Velen*) of the national Commission for Mental Health, requested by the then Minister of Health Borst-Eilers to offer advice on the problem of growing demand for mental health care and failing social support systems (family, church and neighborhood), advised a reorganization of mental health care in which the less serious cases would be cared for in primary care, reserving a place for psychiatrists in secondary, specialist care. The report was critical of the lack of clear boundaries with regard to psychiatry’s domain.
- The introduction of Diagnosis-Related Groups in the organization of reimbursement in mental health care, necessitating a ‘further description of the psychiatrist’s services’.

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Dutch do not convey the difference between ‘illness’ and ‘disease’ in the way English speakers do. The alternative ‘aandoening’ is closest to ‘affliction’.
- The PIHC law required psychiatrists to demonstrate specific psychotherapeutic expertise tailored towards patients distinguishing them from other professions.
- The PS should allow for integration of advances in neuroscientific knowledge.
- The social (governmental) pressure for clearer definitions of the professions and the services in mental health care had led to another report, “Professions on the move” (Beroepen in beweging) (Hutschemaekers & Neijmeijer 1998), adopting three dimensions to characterize professions in mental health care: education, being primarily treatment or primarily care-oriented, and generalism versus specialization.
- In 2001 a revised version of the Framework Plan Medical Training (Raamplan Artsopleiding) was published, defining both characteristics and capabilities of physicians at the completion of their training. Also, the Central College for the Recognition and Registration of Medical Specialists adopted the CanMEDS model as a basis for determining general competencies of medical specialists.

From this list we may conclude that it was primarily sociopolitical developments that were prompting the DAP into redefining its position. To list alone all the relevant government institutions is to illustrate the degree to which processes of rationalization of care were developing. It had also been clear for some time that the structure of mental health care was moving towards a more market-oriented system (hence the introduction of DRG’s), increasing the pressure to sharply define both one’s professional role and one’s ‘products’, here conceptualized as ‘competencies’, in order to retain professional jurisdiction (Abbott 1988). The broad ‘bio-psycho-social’ identity was seen as too broad, too vague, and, crucially, insufficiently distinctive from rival mental health professions. Renewing their medical credentials allowed psychiatrists to fulfill many of these requirements, whilst simultaneously safeguarding their position as providers of care to the seriously mentally ill. From one perspective, we might say that psychiatry had come full circle, having left the asylums behind and expanded its domain towards the lighter, nervous disorders, continuing its expansion throughout the postwar period and into the seventies, subsequently being reined in by successive governments, and being exposed, like other health professions, to rationalization and increasing (bureaucratic) control by the government. The most influential recent development is the gradual shifting of such control towards private Health Insurance companies (Ralston 2012). The 2005 PS, which is still formally operational, contains a specific paragraph on knowledge and science. It is translated here in full in order to examine the inherent views on science. Italics have been added where these are present:
“The work of every physician rests on medicine as science. This means in the first place that the diagnostic and curative acts of the physician must be based on testable assumptions. Such assumptions are, in principle, offered by the basic sciences: medicine in this context is applied science. Besides this, medicine is grounded in numerous sciences, such as physiology, genetics, pharmacology, but also psychology, sociology or philosophy. What is important is that diagnostic and therapeutic actions can be substantiated with testable findings from relevant scientific areas. The state of science therefore defines, to a high degree, the domain of both physician and specialist. This fully applies to the psychiatrist.

A second aspect of science is related to the status of diagnosis and treatment itself. As an independent science medicine determines the validity of diagnoses and the effectiveness of treatment. For the individual physician this means, that for all his diagnostic and therapeutic actions he should be able to indicate at which level of scientific knowledge this is based. In this context ‘evidence based medicine’ is applied. EBM defines levels of scientific knowledge. Most certainty can be derived from knowledge which is based on repeated experiments which themselves conform to quality standards of reliability and validity. A weaker but not unimportant base for knowledge is, for example, expert experience. EBM demands that the physician lets his professional actions be guided by the highest level of evidence from research that is available combined with systematic experiential knowledge, whilst taking patient’s wishes into account. It goes without saying that in many complex medical problems, the highest rung of this ladder cannot be reached. The physician’s duty of accountability entails that he can indicate at which, highest attainable, level he has oriented himself. In choosing between two forms of diagnosis or treatment he in principle shall choose the form that is supported by the highest level of evidence, provided this is applicable to the individual patient.

Empirical or experimental knowledge generally applies to research on groups of patients. Such knowledge, combined with practical knowledge, can be summarized in guidelines. In medical practice many situations occur in individual cases, which can be insufficiently represented in protocols or guidelines. This implies that the physician must be capable of acquiring ‘evidence based’ knowledge himself and translating this to the individual situation whilst thereby weighing the many factors, which may be relevant in this individual situation. The translation from pre-clinical knowledge or knowledge at group level to the individual circumstances is denoted as ‘the art of medicine’. The capability of applying the
skill contained in that concept to practice in a testable manner, requires intensive and prolonged practical experience, which can be tested through supervision and peer-to-peer coaching. *In the practice of medicine EBM and ‘the art of medicine’ coincide.*

*Every psychiatric treatment should be scientifically accountable.* This implies that for such a treatment it should be indicated at which level of ‘evidence based medicine’ it is based. In so far as there are guidelines available, compiled or accepted by the professional association, the psychiatrist takes these guidelines as a starting point. The psychiatrist thereby explicitly takes into account the particularities of the individual patient, such as follow from his age and development, personality, life and illness history, future perspectives and life circumstances. Based on this the psychiatrist adapts the available guidelines to individual cases in such a way, that this adaptation is transparent and accountable. Reasons for deviating from the guidelines in individual cases are documented.

This means that when instigating treatment for the diagnosed psychiatric disease, the psychiatrist makes use of *clinical-epidemiological knowledge and knowledge in the field of psychopathology/nosology.* In treatment the psychiatrist applies techniques, which are well-described, the balance of which between advantages and disadvantages is determinable, the effect or effectiveness of which has been tested in scientific research and which is accepted within the profession. The psychiatrist informs the patient on the indicated treatment, including besides the expected effect also possible disadvantages or side-effects. If for a certain psychiatric disease more than one treatment is possible, the psychiatrist not only lets himself be guided by his own expertise and experience, but explicitly by the patient’s wishes with whom the different options are discussed. If necessary the psychiatrist refers to a colleague, who is more proficient in the specified technique.

As is the case for all of medicine, in psychiatry techniques are used which have been developed outside its own discipline. This goes for technical utilities, for medication, but also for *psychotherapeutic techniques.* Specific to a specialism is that such techniques are applied to patients with those kinds of afflictions, that the specialism aims to treat. The expertise of the specialist implies, that to this end the correct indication can be made based on clinical-epidemiological data and the analysis of *pathogenetic* factors in an individual case. This expertise also relates to the weighing of advantages and disadvantages of the indicated treatment, equally based on general clinical-epidemiological knowledge and
deliberations in an individual case. Because psychiatric diseases can interfere with the capacity for judgment of the patient and his ability to communicate, the balancing of the indicated treatment with the specific wishes of the patient requires special expertise in psychiatry.

Some therapeutic techniques the psychiatrist can apply independently of cooperation with others. Other techniques however are too complex or require such knowledge or skill in a specified area, that the specialist cannot possess this fully. In such a situation cooperation with others is necessary. Such cooperation can follow a stable pattern and be incorporated into a multidisciplinary guideline or protocol, but can, in individual cases, also be determined ad hoc. Also, a situation may arise in which a certain therapeutic technique also belongs to the therapeutic arsenal of another profession. In the interests of the patient the psychiatrist makes clear arrangements regarding coordination. For some techniques there are official registrations. This applies to prescription medication but also for electronic equipment. The psychiatrist in principle limits himself to registered methods and indications. Applying a registered agent outside its indicated area ('off label') is discussed with the patient and accounted for in the report. Applying methods that have not been registered and for which there is no evidence of effectiveness in a certain indication, in principle only occurs within the context of scientific research, for which the patient has given informed consent and for which permission has been granted by a medical-ethical committee.

Where possible the psychiatrist contributes to the development of psychiatry by promoting scientific research, for example by initiating it himself or by participating in it."

The following philosophical assumptions can, at least, be identified embedded in this text:

Firstly, the connection between medicine and science is strongly emphasized, almost as one of identity: ‘medicine is science’. This is later weakened to the claim that medicine rests on science. Nevertheless, the role of science in professional legitimacy is strong. What kind of science is implied? There is a clear nod to pluralism when multiple scientific disciplines are mentioned, including human sciences. However, this pluralism is narrowed down when the translation from science to practice is described. Here, a number of epistemic values are noted: assumptions should be testable (empiricism), EBM should be applied, and EBM’s
evidence hierarchy is transplanted into practice. The physician’s decisions should be transparent and scientifically accountable, she should apply techniques that are well-described and whose effects are determinable.

These norms are empiricist and limit knowledge to that which is codifiable. Note that this wording allows for psychotherapeutic or sociological knowledge, as long as it has been acquired through empirical methods. A claim is made for science defining the domain of medicine, implying naturalism (Kingma 2013). This also applies to the claim that science determines the validity of diagnosis (ruling out, for example, pragmatic validation of diagnosis such as suggested in Chapter 3). Medical practice is defined as applied science, thereby locating this view of science firmly within the Aristotelian techne and technological rationality tradition (cf. Philips 2008). This implies the (possibility of) separation of technique from individual practitioner. The suggestion of describing psychotherapy as a technique extends the latter concept towards practices which previously have not been conceptualized as such. Evidence based medicine is adapted as scientific methodology. A hierarchical relationship between technical knowledge and phronesis, represented here by ‘experiential knowledge’ is consistent with this position. Tacit knowledge seems to have no place in this scheme: both knowledge and actions must be testable, accountable, and accounted for. No mention is made of meaningful explanation, nor of empathic or phenomenological understanding. Also, there is no mention of values and ethics other than those applying to informed consent regarding treatment and scientific research. There is no description of scientific approaches to meaning or ethics described within the human sciences, nor of emerging norms emanating from human sciences to medical practice, as has been extensively developed within EBM for the empiricist approach. So, while there is indeed mention of human science in this passage, the elaboration thereof is skewed towards the epistemic values of the natural sciences. Through omission, therefore, the PS could be susceptible to a charge of scientism (Sorell 1994).

It seems reasonable to characterize this description as representing the naturalist, ‘values out’, view of science (Fulford, Thornton & Graham 2006). This is not to say the PS as a whole pays no heed to values or ethics, on the contrary: based on the CanMEDS model ethical prescriptions relating to practice are offered within a number of competency areas. However, on the whole values are segregated from science, and the role science, and in this case a naturalistic, empirical perspective on science, plays in the PS’ professional legitimation is paramount.

Two features hereof I wish to highlight before moving on. Firstly, the degree to which the model of practice presented here deviates from the knowledge model developed in our qualitative study (hereafter: the QS model). Secondly, the PS
science model is equivalent to the ‘scientist-practitioner’ model, emphasizing empiricism, technical reasoning, and tracing as far as possible causal or inductive relationships between facts, cordonning off values for the application of the central, factual knowledge. The centrality of codifiable, technical knowledge professed in the PS stands in stark contrast to the findings from our study, where the emphasis lay on a combination of methods, including but not limited to EBM, to gain and apply knowledge. Personal, professional and pragmatic values came into play from the onset of the encounter, and the process of diagnosis was both value-laden and theory-laden. Technical reasoning was recognizable, but was associated with specific practices (pharmacotherapy, somatic diagnosis and treatment), and took up less time in encounters than meaningful understanding. Also, though there was much support for natural science and EBM, there was a significant degree of skepticism on the question of whether EBM is (or will be) capable of adequately covering all clinical situations, and also significant support for the centrality and necessity of meaningful understanding in order to adequately perform diagnosis and treatment. As I noted in Chapter 6, our participants were supportive of EBM, but viewed its utility at the present as limited. Also, their faith in pragmatic clinical judgment in affording practice legitimacy runs against the EBM hierarchy and the knowledge hierarchy described in the PS. Perhaps the biggest discrepancy is in the area that the PS does not address: the domain or practice in which evidence is either not available or not applicable. If we take the findings from the study to represent valid dimensions of current practice, then the PS model does not offer a full account of this practice. On the contrary: the majority of participants viewed the range of application of the (then available) evidence base as limited. There are some parallels with the findings of the study in the cordonning off of facts and values to separate domains, and in realist views of natural, factual science (shared by some if not all participants), but on the manner in which science should be foundational and legitimizing for practice, these accounts diverge.

7.3 Addressing the divide
To recap, so far this chapter I have explored the role of science in the professionalization of the psychiatric profession in the Netherlands, and found that it has served a crucial role both in legitimizing the profession outwardly and in achieving internal professional homogeneity. Both currently and at its inception, the profession’s dominant formally professed and institutionalized perspective on science is naturalistic, whilst the most recent version thereof is open to charges of scientism. This stands in stark contrast to both the practices and views extolled in the qualitative studies performed as part of the current project, which espouse
pluralism, pragmatism, and emphasize the substantial area of practice unresolved from the scientific perspective. In other words: the view professed in the PS does not cover, nor legitimize, the practices found in this study. This can be taken two ways: either the subjects of this study are simply bad professionals and in need of (re-)education and training, or there is a problem with the PS. Of course, such a qualitative study is open to the objection that it is not representative of professional practice as a whole (I set aside momentarily the well-trodden differences in validating principles with regard to generalization between qualitative and quantitative studies), and clearly, we would welcome replication and further exploration of the (findings of the) QS. However, in the following I will argue that the position espoused in the PS is both philosophically and practically untenable. This line of argument also serves to ward off the worry, mentioned at the inception of this study, of committing the naturalistic fallacy.

7.3.1. Critique of the epistemology of the Profile Sketch
First, we return to the philosophical characteristics of the PS model. I have taken the scientific assumptions identified in the QS from chapter 4 and contrasted them with those within the PS (table 1).

<table>
<thead>
<tr>
<th>Science view</th>
<th>Profile Sketch</th>
<th>Qualitative Study</th>
</tr>
</thead>
<tbody>
<tr>
<td>Epistemology</td>
<td>Empirical, naturalist,</td>
<td>Empirical, hermeneutic,</td>
</tr>
<tr>
<td></td>
<td>reductionist</td>
<td>phenomenological, pluralist</td>
</tr>
<tr>
<td>Ontology</td>
<td>Realist, naturalist.</td>
<td>Weak realist, weak constructionist.</td>
</tr>
<tr>
<td>Dominant mode</td>
<td>Techne</td>
<td>Phronesis</td>
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<tr>
<td>Relationship profession</td>
<td>Identity</td>
<td>Instrumental/pragmatic</td>
</tr>
<tr>
<td>Core legitimacy</td>
<td>Scientific knowledge</td>
<td>Normative practice</td>
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*Table 7.1. Overview of differences between the science views of the Profile Sketch and those found in our qualitative study.*

The received view of science
The PS view by and large approximates the received view of science: scientific knowledge is based on the products of (verifiable) experience (facts) which are organized into theories. These theories are universal and involve law-like relations involving cause and effect. The experimental method, involving objective observation and measurement, and allowing for falsification, is fundamental to this
model. Fulford et al. (2006) note that this traditional model is the line taken by modern 'biological psychiatry'. The well-recognized pragmatic strengths of this model are its purported capacity to protect against prejudice, whim, and fashion, or, as Zachar (2012) mentions, “snake oil salesmen”. Also, as noted in the text of the PS model, science potentially offers clear boundaries and focus and therefore protects against the ‘grandiose and unwarranted expansion of the scope of psychiatry’ (Slater and Roth quoted in Fulford et al. 2006).

Fulford et al. (2006) relate a number of ways in which the traditional view of science has been challenged philosophically. First, they note that all data, including those within the basic sciences, are theory-laden and goal directed. Observation and theory cannot be separated, and science is a human activity connected to certain aims. Science itself is norm-driven, and incorporates values, including those influencing the choice of research programs, what counts as ‘data’, and theory choice. Duhem’s (1914) and Quine’s (1951) work on underdetermination states that for any set of data there will always be several alternative explanatory possibilities, and therefore which theory we choose is not determined solely by data. Given this uncertainty, scientific judgments are made which may involve values (the so-called ‘gap argument’, Brown 2013). Fulford et al. (ibid.) furthermore point out the dual nature of explanation within psychiatry, involving causes and reasons, referring to the wider debate in philosophy of science and philosophy of mind on the feasibility of reduction from the one (reasons) to the other (causes), and add that ‘modern biological psychiatry has chosen to ignore Jaspers’ ‘meanings’ and to run only with his causes’. On the subject of theory testing, they describe Popper’s falsificationism, noting its influence in science, before presenting Kuhn’s notion of a disciplinary matrix (or ‘paradigm’) as a better model for the actual process within science: rather than viewing science as a continuous, linear progress, towards improvement or towards truth, Kuhn conceptualized science as a problem-solving activity, in which paradigms remain stable as long as they continue to adequately solve problems, and are not simply defeated by one episode of falsification. Though Kuhn limited the jurisdiction of values in science to epistemic values such as consistency, accuracy, scope, and fruitfulness, his work opened the door to the further development of ‘values-in’ accounts of science. Douglas (2016) distinguishes the descriptive, boundary, and normative challenges to the value-free ideal of science. First, descriptive feminist studies of science revealed sexist background assumptions within methodologically exemplary research. This illustrated the difficulties of attempting to eliminate non-epistemic values from science: testing can only be performed within existing theories, and only through one’s own background assumptions. The argument that background assumptions in science may encode social values
(Longino 1990) led to the desire for studies aimed at uncovering such values, aimed at generating better values in this context. This formed the impetus for the sociological study of science, broadly aimed at describing social (e.g. human, economic, political) activities within the practice of science. Controversies subsequently arose as to the depth to which human values could legitimately be seen to permeate science, and to issues of separation of science and society, fact and value, and even the human and the nonhuman (Hess 1997). Next, the plausibility of making a clear distinction between epistemic and non-epistemic values was challenged. Rooney (1992), for example, found cultural and religious values shaping allegedly epistemic values in science. Finally, the normative or ‘error’ argument, states that given the ‘endemic uncertainty’ in science related to underdetermination, and the fact that the epistemic authority of scientists is recognized in society and also to be normatively desired, this authority implies responsibilities on the part of the scientist to be neither reckless nor negligent in their actions (Douglas 2003). Tellingly, evidential support is not set at a fixed level across all contexts: what constitutes sufficient evidence will vary according to what is at stake.

“For example, if one is testing a new treatment for a disease, the level of evidential sufficiency will vary depending on whether the disease has an alternative, mostly successful treatment or whether there is no existing treatment, as well as on how deadly or harmful the disease is. If the disease is highly fatal and there is no treatment, a lower threshold of evidential sufficiency is often warranted before we claim the treatment has enough evidence to support its implementation. If the disease is mild and/or we have successful treatments, we can legitimately demand a stricter standard of safety and efficacy before releasing it on the market.” (Douglas 2016).

Douglas argues that a set of alternative ideals should be formulated to replace the untenable value-free ideal for science. The aim here is to formulate and guard acceptable and unacceptable roles for values in science. In this ongoing debate, Kourany (2010) has argued for science jointly meeting epistemic and social standards according to an ideal of socially responsible science. This approach could be made to accord with a model of the relationship between science and practice following Dooyeweerd’s notions of spheres of responsibility (Chaplin 2011), interacting with each other, in which the sphere of science is made to ‘open up’ towards the values of practice and society. We will return to this later in the chapter. For now, it is sufficient to argue that the presence of values within science is widely accepted, and that philosophy of science has moved beyond the received view to more pluralist, and values-inclusive, views of science.
This presents a problem for the PS model of science, which offers no guidance, other than the practice of EBM, for handling such values. It could be argued that the practice of EBM itself is adequate to this task. However, EBM has been recently criticized on just this point: offering insufficient resources for the analysis and evaluation of values within scientific activity. EBM prescribes a set of norms related to a set of epistemic values that are well-recognized within the empirical tradition. EBM recognizes the presence of values in science, for example affecting the choice of objects and areas of interest to research, or in the applications of scientific findings, but its strategy is to ringfence a scientific method which is seen as possessing only epistemic (cognitive) values, thereby ignoring the preceding arguments. A number of authors (e.g. Gupta 2014, Machamer & Wolters 2004) have argued that nonepistemic values have been proven to penetrate deeper into science practice than is assumed by EBM. For example, in their introduction Machamer & Wolters (ibid.) point to categorization in scientific judgment. This frequently involves values only indirectly connected to the judgment being made. They cite the example of the determination of ‘brain death’ as a criterion for death, put forward by an ad hoc committee of Harvard Medical School in 1968. A central aim of this committee was to define death in such a way as to allow for organ harvesting and the possibility of transplants. Replacing the older cardiorespiratory criteria by new criteria for brain death increased such opportunity. The authors point out that the criteria for brain death in Germany differed (at time of publishing), requiring a reassessment after twelve hours, obviously resulting in a delay in the harvesting of organs. This serves to illustrate the influence of pragmatic values in the constitution of scientific norms which carry forth into clinical judgment. I would argue that Frances’ decision to raise the bar on evidence (Chapt. 4) is analogous to this example. EBM must remain silent on the evaluation of such decisions, as they fall outside the domain set by its method. Kourany’s proposal for joint adherence to epistemic and social norms seems a better fit for these practices. In referring solely to EBM with respect to managing values in science, the PS model falls short of current thinking in philosophy of science.

7.3.2. Ethical and pragmatic problems for the Profile Sketch

Besides these philosophical objections, there are further ethical and pragmatic arguments against the PS model. The following arguments will be discussed:

1. Tacit knowledge and problems of non-codifiability
2. Consequences of prioritizing technical rationality
3. Values blindness and reification
1. Codification, tacit knowledge, and objectivity
Within the PS lies the prescription that (scientific) knowledge should be codifiable. However, both within the sciences and within medicine there is an element of tacit knowledge which is both ineliminable and uncodifiable. Tacit knowledge is often illustrated by Polanyi’s phrase: “We know more than we can tell.” (Polanyi 1966). He admits this definition is quite vague, but it at least implies that what is tacit is not ‘tellable’. Examples include: recognizing someone’s face, riding a bicycle, reading a map, understanding a language, ‘reading’ a patient, or excising a brain tumor (Gascoigne and Thornton 2014). These activities might be cast in terms of knowledge, but also involve something that cannot be fully put into words. The second element introduced by Polanyi is that tacit knowledge is personal knowledge. This was part of an attempt to overcome the traditional dichotomy between objectivity and subjectivity by showing the personal plays an essential constitutive role in objectivity. This involves two aspects: first, it involves action, related to skill and ability. Having greater skill is equal to possessing greater practical knowledge, which may be manifest both in performance and in judgment. The second aspect is that personal knowledge is connected to the exercise of a skill in particular contexts. This latter aspect is linked to the aforementioned ‘phronesis’: perceiving the moral demands of a particular situation.

Gascoigne and Thornton (2014) offer an epistemological defense of tacit knowledge. Their analysis focuses on the problem that if what is known cannot be put into words, in what sense is anything known, and how can this count as knowledge? This leads them to a conception of tacit knowledge as context-dependent, conceptually structured, practical knowledge. Their view of tacit knowledge is that it does have content, but content that cannot be captured in context-independent or linguistic terms. The articulation of the content requires practical demonstration and is non-codifiable. Therefore, if tacit knowledge is taken to be an essential element of clinical practice, then this is a major obstruction to the PS model, which does not allow for non-codifiable knowledge.

2. Technical rationality and its consequences
According to Philips, technical rationality states that “for any problem area there is a systematic body of generalized knowledge, with specific rules for application, which can define the handling of a particular case and thus minimize or eliminate the need for real judgment on the part of the individual practitioner.” (Philips 2008). Zachar and Bartlett (2008) add: “Technological rationality refers to methodological approaches becoming norms of rationality so that thinking and acting in conformity with technology comes to define what it means to be rational.
Technology refers not only to the use of tools, but also to acquired methods and procedures for solving problems so that the probability of a successful solution is enhanced. Technological procedures are rules for action.” This phenomenon is also seen as a wider social characteristic of our times (Poster 1984). Technical reason is a form of instrumental reasoning, dominated by the values of efficiency, efficacy, production, and outcome (over process). At numerous points in the PS section cited previously, the model of the relationships between science, knowledge, and practice conforms to Philips’ definition of technical rationality: psychiatry as medicine is taken to rest on scientific knowledge, and specific rules of application thereof to practice (“testable, accountable, transparent”) are mentioned. Such rules reduce the need for judgment on the part of the practitioner, moreover, the practitioner is expected to transparently offer reasons for deviating from the scientific norms. Furthermore, treatment, including psychotherapeutic treatment, is repeatedly referred to as the application of a set of techniques. These techniques should be well-determined, and scientifically tested for their effectiveness. Many authors agree that technical rationality and instrumentalism have come to dominate medicine and mental health (Philips 2002, Sadler 2008, Zachar and Bartlett 2008, Radden 2008). Philips criticizes the technical approach for its consequences within the therapeutic relationship. The technical approach focuses on the nomothetic rather than the idiographic: the general type of problem or disorder, rather than the individual instantiation of the general type. According to Philips this threatens to detract from both the individuality of the patient and that of the practitioner. Further examples cited in the literature are the elevation to ‘gold standard’ status of evidence-based guidelines based on technologically grounded research (Mender 2008), the dominance of mechanistic neuroscience in academic psychiatry, and the purported centrality of psychopharmacology to treatment by psychiatrists.

The individual dimension of this argument relates to what is lost when reducing a therapeutic encounter to this mode of thinking. Most frequently, it is the subjective dimension, the contents of intentionality, the idiographic and meaningful that are mentioned in this regard, in brief: the ‘understanding’ side of Jaspers’ methodological dualism. A related worry is the effects on the self-understanding of patients derived from technical reasoning and possible renewed avenues for (self-)stigmatization (Pilgrim & Rogers 2005). User literature illustrates the consistent importance and relevance of the idiographic approach for patients:

“Until I learned about the concept of recovery as a journey, I was my disorder. I was provided with only one truth about my psychotic vulnerability and this was presented as the only truth. I was this devastating brain disease that could not be cured, and I
would be limited more and more in my functioning in daily life. Never -- during the years of my life that I was this ignorant, obedient patient -- was I given alternative options for what happened to me. Neither did professionals, psychiatrists, around me know about alternatives. For them, their (medical) truth was the only truth....

The largest part of my recovery journey so far took place outside and in fact despite the psychiatric system. The professionals in mental health care who ‘took care’ of me had never heard of a recovery perspective nor of the possibility of me changing from a patient position to citizenship. They worked within the medical framework that was disorder centered, not patient centered, and definitely not person centered. I had to fight for every step in my process. I wanted to come off medication, but didn’t find a psychiatrist to take up that challenge together with me. I wanted to talk about the contents of my psychoses, because they had been very traumatic, but this was considered too risky. What if it would trigger the next psychosis? And moreover, I wanted to revise the official story of my life of me being diagnosed with schizophrenia.” (Boevink 2012)

This excerpt refers to the concept of recovery. In his overview of recovery, Slade (2009) argues that subjective experience is primary and essential in mental illness. However, experience is accessible to observation. Therefore, a challenge to any science of mental illness is to accommodate knowledge both from observation and subjective experience. He argues that throughout history (and in mental health) either subjectivist or objectivist epistemologies (this latter epistemology being involved in technical reasoning) have been applied, with risks involved in both: subjectivism relegating the clinician’s judgment to mere intuition, and objectivism risking the objectification of patients. This objectification is produced due to the necessity of reduction (from meanings to causes), thereby ‘squeezing all the meaning out of patient’s experiences’. Slade sees this as dehumanizing: “By ignoring all that makes a person human, what is left is an undifferentiated shadow of humanity.” Other criticisms in this vein include the ‘voice of medicine’ versus the ‘voice of the lifeworld’ studies, and ‘postpsychiatry’ critiques (Mishler 1984, Bracken & Thomas 2005, Lewis 2006). For clinicians, the marginalizing of idiographic knowledge may lead to blind spots, including a susceptibility to treatment vogues, difficulty in using multiple models of understanding to offer genuine choice, and a belief that a diagnosis is true rather than a hypothesis (issues of reification and essentialism with regard to mental disorder will be covered in chapter 9) (Slade 2009). Slade also notes an impoverishing effect on science, marginalizing the relevance of the human sciences, such as sociology or anthropology, making certain issues, such as compliance, or the experience of ‘being a patient’, less visible.
To this picture, Radden (2008) adds a strong ethical dimension of the role redefinition involved in adopting the model of technical rationality with regard to the profession of psychiatry: the psychiatrist becomes the skilled purveyor of technical expertise, and the patient becomes the consumer of this service, or commodity. Radden contends that the ethics of such expert-client relationships within mental health differ from elsewhere in society and even in medicine, based on a criticism of five presumptions of this model: 1) the consumer acts with full agency; 2) is roughly socially equal to the expert with whom 3) purposes and understandings are also shared; that this relationship is 4) governed by a contract nullified when either party violates its terms and is 5) incidental to the effectiveness of the transaction beyond the maintenance of ‘contractual’ trust. These presumptions ignore a number of issues inherent to at least some areas of psychiatry: the (temporary) loss of personal autonomy and/or competency due to mental illness, the power differential (e.g. in involuntary admission) between patient and psychiatrist (evidenced in Boevink, above), the frequent lack of shared purpose and understanding, or fluctuation thereof, during treatment, the obligation on the part of the psychiatrist to maintain the contract even in the face of ‘contractual violation’, and the fact that establishing a trusting and authentic relationship is an essential element of treatment. Such specific features of mental health care call for additional, or specific, virtues on the side of the psychiatrist, insufficiently captured by the model of a technical application.

3. Values-blindness and reification
A further worry illustrated in this study (see Chapter 5) is the injection into the sphere or domain of medical practice of values inimical to that practice. Recall the objections on the part of some participants against ‘DSM-psychiatry’, a concept embodying certain epistemic, ontological and social values that they saw as in opposition to their own professional values. Informational instrumentalism and the valuing of cost-efficiency, for example, is a possible example of alignment of an ‘external’, societal value with an ‘internal’, epistemic value. As we saw above, the impetus for the adjustment of the PS lay chiefly in social developments. Within these developments, a clear emphasis on the value of specificity is apparent: on the identity of the profession, of the nature of professional activities, of the domain of the profession, and of diagnosis. All these are bound up in social developments, such as the introduction of a new health care system in 2006, encompassing a move towards a more privatized system, and the introduction of DRGs. This desire for specificity and clear demarcation is met, in the PS, through the epistemic values within EBM, and through technical rationality. This, I would argue, is an example of alignment of purportedly social and scientific values. Gupta’s analysis of the ethical nature of EBM offers numerous examples of value commitments,
entailments and consequences that have been argued to be at odds with medical values (Gupta 2014). The point here is not to argue against the legitimacy of such processes per se (these should be argued for and against on a case-by-case basis), but to argue that the segregation of fact and value and allocation of values solely to the patient-clinician realm is invalid and disempowers the professional because it restricts her access to the action of values in the scientific domain and especially in the interaction between scientific, social, and political spheres.

The ontological analogy of this epistemic argument is the unqualified and unreflective reification of concepts derived from other spheres (mainly the scientific). The arguments against the reification both in practice and in society of DSM concepts are well-trodden: where taxonomic concepts are imported into the practical diagnostic context, an epistemic awareness is required (i.e. realizing the different contexts of taxonomy and practice), and care is required in making this translation. In Chapters 2 and 3, especially in the unfolding of the DEF, we saw psychiatrists' awareness of this requirement of translation as a two-way street: in abstracting away from the phenomena in the encounter towards taxonomic and theoretical concepts and back. It was also apparent how much care is taken and how much emphasis is put on a dialogue which is at once the development of an individualized narrative comprising personal and (translated) theoretical elements, and sometimes a negotiation, when both clients and psychiatrists accept or reject certain ways of framing the problems. What this alludes to is the fact, ignored by the PS, that concepts observed and constructed in the scientific domain of the DSM (and also infused with the epistemic and other values involved in their construction), in their translation within the realm of practice, are given new meaning, within both the individual contexts of patients (and practitioners) and within societal contexts. Reification, understood as the ascription of objectivity and misplaced concreteness to concepts, results in unassailability of the concept as it traverses spheres between science, society and practice, and disregard for the values involved in the emergence of the concept. This results in diminished scope in the professional domain for the negotiation described above: a depression is a depression, no matter what house it is in. Awareness of the historicity and domain-specificity of epistemic and other values enveloped in psychiatric concepts, and the translations required when these enter different domains, requires awareness, reflection and expertise, all of which are given short shrift in the PS model. Latour has referred to the process of seeming objectification of scientifically accepted concepts as 'blackboxing' (1987).

In his 2002 article, Nick Manning coupled actor-network theory with policy network analysis to examine the ‘stabilization’ of the diagnosis of Dangerous
Severe Personality Disorder (DSPD). DSPD is an atypical phenomenon in psychiatry as it is an example of a disorder concept which did not initially originate from within the profession, but from the UK Departments of Health and the Home Office. The article demonstrated how a new psychiatric concept (DSPD) attained “stability” through efforts of actors in a network traversing science-political boundaries. ‘Actors’ in this network included (humans) the British Government, the Royal College of Psychiatrists, special interest groups, persons diagnosed with personality disorder, and (nonhumans) the category of DSPD, DSPD assessment tools, VISPED (the Virtual Institute of Severe Personality Disorder), government-subsidized special DSPD units, and concepts such as ‘safety’, ‘risk management’ and ‘stigma’. Manning describes a complex network of actors, from traditionally separate domains (multiple health professions, the government, patient groups, special interest groups, research departments, mental health institutions), but also locates sociopolitical values acting within the network, for example in the elevation of risk management alongside treatment and punishment as one of the major rationales for the development of this service. The combined methodologies of ANT and policy network analysis allow Manning to conclude that while the British government was well aware that at the time there was an insecure basis for the treatment and legislative innovation it had set in motion, it nevertheless took a number of steps to create that knowledge. There was strong and consistent opposition from the clinical and legal professions to the Government’s proposals, exemplified by this BMJ editorial:

“The Government’s proposals masquerade as extensions of mental health services. They are in fact proposals for preventive detention … They are intended … to circumvent the European Convention on Human Rights, which prohibits preventive detention except in those of unsound mind. With their promises of new money and research funding, they hope to bribe doctors into complicity in the indefinite detention of certain selected offenders. Discussion of the ethical dilemmas that these proposals present for health professionals is absent, presumably because they are ethically and professionally indefensible” (Mullen 1999, p. 1147)

From a normative perspective, we can view this debate as one of competing sociopolitical values, from different social domains: from the public domain the desire for safety, the entailed valuing of risk assessment, and possibly detention becoming instrumental to the social value of punishment as the boundary between mental health services and the criminal justice system is blurred, and from the professional domain concerns about human rights and individual autonomy, (non)-benefit to the patient, and scientific values concerning the validity of the concept. These concerns did not deter the Government from proceeding with
substantial investment into the DSPD program (around £70 million per year), and finally it was lack of success in terms of demonstrating reduced re-offending or health improvement which led to the scaling down of the initiative (Rutherford 2010, Duggan 2011).

Now for the sake of the argument let us imagine a possible future, in which DSPD has gained admission to the DSM system. Perhaps there will be some memory of the conflicts surrounding its development. But in so far as the future doctors work within a realist perspective on diagnosis, they will accept this concept as tracking an objective feature of nature, given by the world. The strongly value-laden societal and political factors which played a part in the construction of the concept, retreat from memory, from sight, and from awareness. This is not to say objects cannot be the subjects of ethical deliberation, but to argue that in performing a false objectivation of a concept, the deliberation may be misdirected e.g. towards ‘how should we ideally treat persons with DSPD?’ rather than ‘what are the social consequences of the professional use of the politico-scientific term ‘DSPD’?’ Processes of reification have been described with regard to other diagnoses within the DSM system (Sadler, 2002) and in the history of psychiatry (Berrios and Porter 1995) In the case of DSPD, this means that the normative decisions involved in deciding to what degree characteristics of personality and perceived dangerousness are valid criteria for demarcating mental disorder and thereby legitimizing decisions to curtail autonomy, are cloaked under a reified concept.

7.3.3. Alternative conceptions of science and practice
I conclude that if the PS model is taken to comprise the scientific legitimacy of psychiatrists, it is insufficient and should be rejected. What alternative route should be taken? Taking into account the role of sovereign, expert knowledge in relation to professionalism (Abbott 1988), the alternatives for the profession of psychiatry are:

1. Formulate a different account of practice to accommodate the PS model. This was also assessed in the above, and seen as untenable and unworkable.
2. Alter the hierarchy of the science-practice relationship from science dictating practice, to primacy of practice, allocating to science an adjudicatory role. This might be seen by some as a regress, since the point of EBM and the PS model is the epistemic prioritization of empirical evidence over clinical idiosyncrasy.
3. Formulate a different account of science to base the science-practitioner relationship in.
4. Make a more qualitative epistemetic distinction between the nature of scientific and clinical knowledge. Recognize clinical knowledge and (normative) expertise as sui generis and use these as the knowledge basis of the profession, where science plays a foundational rather than a qualifying role (Glas, under review).

5. De-emphasize the knowledge base of the profession and prioritize outcome as legitimizing.

Note that a number of these alternatives are not mutually exclusive, and that some differences are subtle. First, options 1. and 5. should be rejected. Altering practice to a kind of ‘bare bones’ purely EBM-based practice whilst maintaining the hierarchical relationship of the PS model requires a reduction of meanings and values to facts, rules and algorithms that, if possible philosophically (and this is challenged above), is highly unwieldy and ethically disempowering. With regard to prioritizing outcome (a wider development internationally as health care systems embrace variants of ‘values based health care’, cf. Porter 2009), if this comes at the expense of a weaker knowledge base, this entails a loss of the requirement of maintaining a recognized and exclusive repository of abstract professional knowledge which is also foundational of practice. The risk here is of deprofessionalization (Abbott 1988). Option 2 turns the hierarchical relationship between science and practice around, prioritizing practice. This is a reflection of the strong emphasis in the QS model of the primacy of benefit to the patient as the fundamental qualifying norm of practice. This option leaves EBM and science as they are (allowing for naturalist/realist philosophies of science) but affirms and bolsters the clinician’s responsibility of translating the products of science towards the unique individual context. In contrast, option 3 proposes an alternative, values-inclusive philosophy of science. An important feature of this option is the entailment of different norms and competencies in both the scientific and clinical realms: these require attunement to the nature and role of values, and the competency to recognize and handle them. Sadler’s proposal’s for the handling of values with respect to psychiatric taxonomy are a fine example of the direction this option heads for (Sadler 2005). In this option, the hierarchy of science to practice depends on normative (professional) assessments of appropriateness and applicability. Option 4 takes a slightly different course, making a stronger distinction between the epistemic spheres of scientific knowledge (e.g. classification) and clinical knowledge (e.g. diagnosis), allowing for a foundational connection between the two, but meanwhile stressing the difference between them, and prioritizing the latter, as it is, as it were, the sphere in which the general (scientific) is related to the particular (practice) in aim of the medical betterment of the patient. This option accords with statements of participants in the QS who legitimize their practice by making a distinction between those areas that are
dictated by scientific evidence and those that are not, and affirming the legitimacy of clinical wisdom in the latter domain. This is also the approach taken by Jochemsen & Glas (1997) and Glas (forthcoming) in their normative practice model. We will examine this approach below.

Option 2, in my opinion, should be rejected too: this option leaves the segregation of science/fact and practice/value in place, and would lead psychiatry into what has been called the ‘deficit model’ of science (Fulford et al. 2006), in which the profession aspires to natural science credentials and makes promises within the social contract accordingly, but subsequently to fall short. This deficit is not simply a matter of the relative youth of its science and the complexity of brain and mind, but a consequence of an inappropriate scientific model entailing untenable standards. Psychiatry in this model sets itself up for a fall.

This leaves options 3 and 4, which are not mutually exclusive, but in which some differences of emphasis might be made. First, we will examine Glas’ normative practice model, which provides a heuristic framework of normative principles grounding professional legitimacy, responsibilities and relationships between practice, science, and society. I will argue that this approach can be strengthened from the perspective of the individual professional by adding ‘values-in-science’ methods to aid in identification, assessment and handling of values not only in but across domains, and not only in scientific perspectives but in the objects and concepts thereof themselves.

7.3.4. Towards a normative account of professional practice: the normative practice model

The normative practice model developed by Jochemsen and Glas (1997) is based on the idea that normativity is inherent in human practices and actions, not an add-on based on post-hoc application of principles, rules, and duties (Glas 2009). Influential in this account are MacIntyre’s (1981) elaboration of Aristotle’s virtue ethics and Dooyeweerd’s philosophy of dynamic and layered social practices (Chaplin 2011). Dooyeweerd offered a framework of how different types of norms and principles are related and cohere in the functioning of institutions and practices such as the state, the family, churches, industrial companies and volunteer associations. Besides this ‘constitutive’ aspect of social practices he also distinguishes a ‘direction’, or directedness, in the process of ‘opening-up’ or ‘disclosure’ of practices. Professional and other practices not only possess structure (the constitutive aspect), they also develop in a certain direction. This directedness can be conceptualized in terms of concrete targets or objectives, but
also entails and represents a broader, regulative dimension. Virtue ethicists call this regulative dimension ‘telos’, the overarching purpose of a practice, indicating its ‘internal destination’. Practice, according to the virtue ethicists, embodies certain goods: they are intrinsic. This points to an internal, normative coherence of practices which also carries forth into interactions with different societal domains. Dooyeweerd uses the concept of the ‘opening up’ of practices to emphasize the dynamic and adaptive nature of developing social practices. In this development, professions must express their ‘telos’, or risk deprofessionalization. And it is embodied in the ethos of the participants in that practice. Dooyeweerd’s philosophy strongly accords with Abbott’s account of professionalism, which emphasizes the necessity of strong connections between actual professional practice and social legitimization.
In his/her professional role the professional relates in different ways to his/her own professional role fulfilment [A-E]

Fig. 7.1. Relations between person, role and context in the professional encounter
(Glas 2017c)
The NPM model asserts that values inhere in relationships, and locates the essential normativity of medicine in the physician-patient relationship. It offers a layered account of the multiplicity of relationships pertaining to the clinical encounter (see fig. 7.1) thereby illustrating the many levels at which values exist in psychiatric practice (cf. Glas 2017a). Glas is critical of the dominant vein of scientism in psychiatry, its neglect of the distinction between scientifically abstracted aspects of reality and reality itself, its entailed physicalism and the risk of illegitimate reductionism (Glas in press). The NPM model allows for and offers a foundation and legitimation for the practices found in the current study.

**Fig 7.2. Essential components of the NPM (Glas, in press)**

Fig 7.2. shows the essential components of the NPM. The model applies Dooyeweerd’s distinction of three constitutive rules defining professional practice as the practice it is: qualifying, conditioning, and foundational. These rules are affixed to the regulative direction of the profession, i.e. the normative expression of the telos embodied in practice through ethos and competencies. Qualifying norms refer to those aspects, or modes of functioning, or functions, of psychiatric practice that give this practice its own, distinctive quality. Glas identifies the medical ground situation as one in which the sick person has become dependent and is seeking help from someone else who has the qualifications and jurisdiction to do so, and wherein the aim of increased well-being of the patient is paramount.
(beneficence). The professional relationship is fundamentally moral, and it is this moral core that qualifies the medical professional relationship as such. Note how this view accords with QS participants’ prioritizing of outcome, even over truth or theoretical validity. This is an expression of its leading aspect. In Dooyeweerd’s terms, other aspects should ideally ‘open-up’ to this aspect: they should function in such a way as to optimally support and sustain the practice in its moral meaning (Glas, forthcoming). This has implications for foundational rules, which in the model include those pertaining to science. Science, for medicine, is not an end in itself, but a means - albeit a crucial means- thereto, furthermore, scientific knowledge must be ‘molded’ to contribute to moral medical practice. This aspect is exemplified in the ‘translation’ of guidelines, evidence-based knowledge and treatment algorithms, to the specific context of the individual, but also may be expressed in the wording of such guidelines themselves. Clinical knowing is epistemically distinct from scientific knowing and expertise is required to bridge this gap. This expertise, variously termed clinical wisdom, expertise, or phronesis, of correct application, considering both the abstract knowledge, the local, individual context, and not only the ‘patient values and preferences’ but all proximal and relevant values in play, and negotiating these in service of the telos of medicine, the benefit of the patient, is an essential element of psychiatric professionalism. Conditioning norms and principles are those norms that facilitate and enable practice, but do not qualify it as it is. Functioning well in social, economic and legal spheres is useful and desirable for psychiatrists, but not essential for their profession, neither are they required to be experts in these fields.

A core suggestion of the NPM is that professional legitimacy should not be and is not solely based on expert knowledge and skills, but fundamentally on the way in which it realizes its moral and other (legal, economic, social) responsibilities (ibid.). It is with this point in mind that a number of complementary perspectives to the NPM model will be discussed below, focusing especially on values-inclusive perspectives of practice and science. Following Dooyeweerd’s philosophy of modal distinctions, the NPM model describes tasks, responsibilities and competencies within different social practices, such as the practices of medicine, science, or health care management. Different practices and (micro, meso and macro) levels imply different norms, competencies, etc. The NPM then sees as one expression of the telos of medicine that these different spheres should ‘open up’ i.e. be supportive towards, the benefit of the patient, and that medical professionals operating within or at the interface with these spheres, should apply their expertise towards this, balancing their civic and institutional responsibilities with those of the medical expert role at the micro level, shifting attention to responding to service needs and improvement of capabilities at the meso level, and at the macro level attunement.
to providing the conditions to ensure mental health care is accessible, qualitatively sufficient, safe, and efficient whilst providing distributive justice.

The NPM offers a substantive and coherent account of professional practice, legitimacy, and the place of science therein. As a heuristic tool, its primary aim is to clarify the normative structure of psychiatry. It thereby offers ideals of how the profession(al) should function. Conforming to Dooyeweerd’s principles, as the model moves from micro to macro, not only the required expertise of the professional shifts (though the core telos remains the same), but the nature of interactions and the roles and (normative) responsibilities of the actors encountered change. At the macro level, the account mirrors the literature on public health values inherent in health care systems (Childress et al. 2002). Glas acknowledges the fact that reality rarely fails to live up to the ideal, in fact, this disparity is one of the driving forces of the relational account of normativity: this discrepancy between an inherent ideal and circumstances being a prime motivator to take moral action. He also acknowledges that there is some debate as to the jurisdiction and expertise of the professional, especially at meso and macro levels, to legitimately act to forward the professional ideal, and supports the notion of professional action and responsibility at these levels, whilst remaining attuned to the values, responsibilities and agendas of all others. However, though we can agree with the normative principles of practices at these levels opening up to the professional ideal, what kind of expertise should be required of the professional when operating in these spheres? Glas’ account is extensively detailed for the clinical situation, and aptly so. At the macro and meso levels, however, the account shifts to action and negotiations at the level of (amongst others) institutions and governments (Glas 2017b). This is fitting for the scope of the NPM. Should additional knowledge and skills (expertise, competencies) be applied by professionals to further their telos in other domains than direct clinical practice? To return to the aforementioned example of the DSPD process: if one were to, as a majority of professionals did, concur that this initiative was in conflict with the moral core of beneficence to the patients involved, one might argue that in order to express and defend one’s telos, competencies are involved that lead to effective action at the meso and macro level, for example reasoning from economic, social, and political perspectives (e.g. arguing from a legal perspective of Human Rights).

In the Netherlands a recent and ongoing controversy on Routine Outcome Monitoring is a case in point. One offshoot of the movement in the Netherlands to a more privatized, outcome-focused model of health care, was the requirement for professionals to perform pre- and post-measurements of treatment outcome, with a view to providing health insurers with benchmarking data which would enable
them to practice selective contracting based on quality, a cornerstone of the economic perspective on a well-functioning health care market system. However, some years ago, in a quite unique move, a substantial number of professors of mental health care co-published an article criticizing the scientific foundations of this ROM project. Mirroring the process in the UK, this scientific protest did not deter or delay the rollout of ROM as a legally obligatory practice, connected to reimbursement, throughout Dutch mental health care. In early 2017, a government agency compiled a report reiterating the methodological problems of ROM in relation to benchmarking, and in reaction to this, a small group of mental health professionals set up a petition to ‘Stop ROM as Benchmark’. This petition caught the attention of actors and stakeholders at all (micro-meso-macro) levels, and a debate ensued. Crucially, a legal impediment to the handling and collection of private medical data proved to be instrumental in creating a legal barrier to halt the national collection of ROM data, providing a temporal and political space to renew the debate and widen it to questions of professional transparency and legitimacy, methodological issues, and alternative forms of outcome measurement. In this process, the petition group had formed alliances with persons with legal expertise and applied this expertise towards their concept of the medical good (van Os et al. 2017). This example illustrates a point following from the NPM, namely the responsibility of professionals to act beyond the micro level, if actions emanating from the meso and macro levels impinge and detract from their professional telos. Furthermore, this action requires skills, either in acquiring the knowledge related to the subject at hand (the group comprised, amongst others, professionals with legal, epidemiological, and ethical expertise), but also skills relating to the sociopolitical work of forging alliances, negotiation, and public communication. To a degree this argument corresponds to recent writings on ‘new professionalism’, however, this literature, though admirable for its reiteration of core values of the profession, offers less specific guidance as to what kind of expertise is required for defending and/or furthering core medical values in other spheres. Also, it does little to counter the ‘values-blindness’ described above, a phenomenon, I would argue, requiring knowledge and expertise to counter, if one is to defend moral practice from the effects of concepts introduced into practice. The NPM model provides strong arguments for a more diverse skill set on the part of professionals and a call to action in the public sphere. With its focus on values inherent in relationships and social practices, it could be argued that the NPM tends towards being anthropocentric. If we take the example of ROM above, we could perform a social or actor network analysis (more on this later) of its development and institutionalization, demonstrating an increasing degree of unassailability from the perspective of practitioners. Recall the processes of prompting (bottom up), alignment and penetration from previous chapters, where
phenomena and concepts are associated by practitioners with certain theoretical points of view, carrying certain ways of understanding the world. More than one participant resisted “the DSM way of practicing.” This manner of phrasing recognizes the cultural and social agency of 'the DSM', where the DSM is not simply the text, but all the institutionalized practices, texts, rules, norms, economies (Sadler’s Mental Health Medical-Industrial Complex, 2013) connected to it. Of course, all these matters require human action (and therefore relationships in the sense of the NPM), and therefore it is of interest and relevant to professionals to be capable of tracking these relations, again, from the NPM perspective, with a view to attuning them with the telos of the profession. Also, some might argue that values not only inhere in relationships, but may inhere in artefacts, purposefully made through human agency. It is unnecessary here to delve further into this argument, since whatever the outcome, methodologies that aid the uncovering of values in the development of concepts, objects, and institutions are useful to the professional from the NPM perspective. Besides their usefulness in an empirical sense, they are useful for providing a counterweight against unwarranted scientism and values-blindness. Such methodologies can be found in the so-called sociomaterial and related approaches in Science and Technology Studies (STS), focusing on “the constitutive entanglement of the social and the material in everyday organizational life” (Orlikowski 2007). Sociomaterial research, and especially actor-network theory, will be discussed below, as one of the values-sensitive approaches available to enhance the competencies of the professional psychiatrist conforming to both the NPM and QS models of practice.

7.3.5. Enhancing professionalism: values-sensitive approaches
To recap: so far, we have identified the natural science perspective as crucially involved in the professionalization of psychiatry and still dominant currently, and have pointed out weaknesses in its philosophical tenets, and in its scope and potential in informing and legitimizing practice: the PS model is philosophically and practically untenable as a qualifying foundation for the profession. We found the practices of this QS to be in conflict with the PS model, adhering to a strongly normative, pragmatic, and scientifically pluralist perspective on professionalism. The NPM provides an alternative framework and legitimacy for this perspective, and entails a more diverse set of capabilities for professionals than the scientist-practitioner model inherent in the PS does, specifically, awareness and skill in attuning knowledge (scientific, experiential, tacit) to the normative demands of the contexts one is working in, with the ultimate aim of the telos of the profession: the benefit of the patient, as a fundamental guiding principle that should inhere and be
expressed within practice. This expanded skill set I will denote as ‘enriched professionalism’, to draw attention to the degree to which it is a departure from previous medical models. A number of methods and perspectives are currently available for effectuating change in training and practice towards enriched professionalism.

Values-Based Practice

Fulford, in response to the question of legitimacy of psychiatry, points to the fact that in philosophy, the developments of the twentieth century, including those in epistemology, have led us to the conclusion that ‘foundations are not to be had’ (Fulford 2013), and warns us of the historical fact that it was just the misguided conviction that a certain model provided a suitable foundation that was conducive to some of the worst abuses in psychiatric care. Fulford’s solution to the tension between society’s desire for legitimation (of knowledge, practice, etc.) from a profession and this philosophical gap is to move from ‘strong foundations’ towards ‘good process’, analogous to the move, within science, from a recourse to truth-correspondence, to scientific method and the values of the epistemic community as imputing objectivity and legitimacy. His approach, Values-Based Practice (VBP), has been an influential approach to the question of how to handle fact and value in practice. The method, which is proposed as complementary to evidence-based practice, was integrated into mental health care and professional training in the UK (NIMHE 2005). VBP is defined as the theory and skills base for medical decision making where legitimately different, and therefore potentially conflicting, values are in play (Woodbridge & Fulford 2004). It is a methodological framework, based on the linguistic analytic philosophy of J.L. Austin (Fulford 1989), where conceptual problems are seen to be derived from the distorted views of the meaning of complex concepts we arrive at when we try to define them (Wittgenstein’s ‘grammatical illusions’, Fulford 2013). Linguistic analysis’ approach to conceptual problems is an empirical one: looking and seeing how the concepts in question are actually used. Performing such ‘philosophical field work’ never offers any settled meaning of a concept, but does offer a more complete view of a complex concept. Fulford refers to Ryle’s ‘logical geography’ as a metaphor for the linguistic mapping of concepts. This approach is translated into an approach to values in which awareness, exploration, knowledge and communication of values relevant to the specific clinical situation are central ‘practice skills’. The impression that this seems to involve a set of techniques rather than a set of principles, as we might expect of an ethical approach, is correct, moreover, it is deliberate: VBP sets itself apart from ‘rules-based’ approaches towards the handling of values in practice, instead striving for ‘balanced’ judgments of the values present in any medical decision, acknowledging the importance of the values of those concerned.
This is not to say VBP does not possess any internal values hierarchy of its own: the exploration, identification, and balancing of values is based on values close to those of a liberal democracy, its premise, for example, being ‘mutual respect for differences of values’ (ibid. 2013). As a practice-oriented set of skills, VBP is highly suitable for the aim of uncovering and handling values both in the immediate context of practice, and at the meso and macro levels.

VBP has come into criticism for lacking clarity on the meaning of values (Brecher 2011), and for its basis in ‘good process’ rather than a substantive (e.g. principles-based) ethical foundation - lacking persuasive authority (Thornton 2011). Rather than opt for the ‘radical liberalism’ of VBP, Thornton argues, one could supplant the insufficient principles-based approach (lacking sufficient resources to handle conflicts of principle) with a ‘modest’ version of VBP, in which judgments of value are taken to be more like judgments of facts than arithmetic judgments (ibid). That is, arithmetic can be formalized in accordance with axioms, and therefore the correct answer to an arithmetic question can be determined algorithmically from these first principles. This is, to a degree, analogous to ethical reasoning from principles. In contrast, Thornton advocates moral particularism, where moral judgments answer to real (moral) features of the world, and, like facts, one can apprehend them rightly or wrongly. The apparent lack of moral foundations is also seen as a weakness ready to be exploited, where VBP could be a ‘Trojan horse’, legitimizing the political views of the majority through ‘good process’. As Fulford recognizes therefore, part of this debate is centered on a ‘forced-choice’ in moral philosophy between ‘top-down’ moral authority derived from principles and ‘bottom-up’ authority from the perception of moral particulars as features of the world (Fulford 2013). Fulford posits that values-based practice is based in neither, its prescriptive authority being based on ‘nothing more’ than competing views genuinely being heard. As Fulford sees it, this approach is ‘radical’ in the sense that it challenges the aforementioned authorities, both those of (powerful) groups drawing up the ethics rule books, and those allegedly possessing the skills to recognize moral features of the world, and offers stakeholders a foot in the door, as it were.

Fulford’s approach is attractive in a number of ways, not the least in the promise it harbors to give voice to the values of historically disenfranchised groups in mental health. The ‘tool box’ it supplies for identifying, reasoning and discussing values has already proven to be of value, and its empirical bent does render it more amenable to likeminded health care professionals. Significant questions remain, such as the translation of VBP to real world surroundings, and the question of how we should understand adequate identification and ‘balancing’ of related values. VBP’s ‘toolbox’ may contain ways of navigating such difficulties, but further work
is required in translating and testing VBP principles in real-world situations. A further question hangs over the way in which VBP is proposed to ‘complement’ evidence-based medicine. Gupta (2014) argues that EBM itself offers insufficient ethical resources for the values involved in both the science process and its application. VBP so far has focused on the clinical domain. Should and could the VBP method, or ideas inherent to VBP, be extended to the domain of scientific taxonomy? Recall the previously mentioned example of Allen Frances ‘raising the evidence bar’ for the DSM-IV for, by his lights, a valid utilitarian reason (to prevent ‘false epidemics’). Following Gupta’s analysis, EBM does not have the resources to evaluate this decision from an ethical perspective. VBP’s attention to patient values draws our attention to possible clinical real-world implications, perhaps temporally and spatially distant, of values-informed epistemic (in this case taxonomic) choices: if Frances’ values-based decision affected the taxonomy, limiting the (increase in) the number of identified ‘cases’ of mental disorder, this has affected a certain number of individuals whose complaints fall just either side of the DSM-defined demarcation. Should individuals affected by such decisions have a say in the matter? Sadler’s (2005) proposals for ‘good process’ in the development of the DSM share with VBP the attention to a sense of democratic representation of values: the suggestion to ensure patients are an integral part of the process of the development in all stages mirrors the VBP principle of patient values being the ‘first point of call’ and of respect. Next, we turn to an approach firmly rooted within science: immanent critique.

Immanent critique
According to Zachar and Bartlett (2008), being reflective of one’s own techniques is a matter of professional honesty and conscientiousness. They note the well-known caveats in the introductions of the DSMs as an example. This line of reasoning implies that the much-criticized (in view of its supposedly nonscientific procedure) decision to remove the diagnosis of homosexuality from the DSM, could be defended as an instance of beneficial pragmatic action. This also goes for Allen Frances’ moves, as chair of the DSM-IV Task Force, to prevent ‘false epidemics’ by taking a highly conservative attitude to admission of new disorders into the taxonomy (interestingly framed as being rejected to ‘lack of evidence’) (Greenberg, 2013). This line of thought can be extended into a defense of the practice in our study, one main feature of which was the centrality of pragmatic and value-laden considerations throughout the encounter including the choice to explore one or another explanatory avenue. If we conceptualize the act of diagnosis as both a technical and an epistemic act, then according to this pragmatic view of (the
application of) technique, such considerations are not illegitimate. Such pragmatism implies values and an ethical framework. This is apparent in Zachar and Bartlett’s other example, of Kendler’s reflections on taxonomy, based on his participation (hence: insider critique) in DSM Working groups. His realization that the choice for criteria for validation of a disorder cannot proceed independently of choosing a construct for the particular disorder led to the conclusion that in choosing, certain scientific values (or as Sadler would say, epistemic values) are emphasized over others. Reflective criticism brings such values to light and makes them subject to consideration.

Zachar and Bartlett underline the fact that we are a technologically dependent species, and that there are major advantages to technological understanding. They refer to the critical theorists’ immanent critique20 as a past response to worries over technological domination. Their assessment of the critical theorists is that on the one hand, they alerted us to the ways in which we become blind to the institutional and technological forces shaping us, but on the other hand, there was an (understandable) anti-instrumentalist theme to their work, leading to little sympathy for technology, nor for the Enlightenment project itself. They contrast the critical theorists’ understanding of instrumentalism of simple means-ends thinking with the dynamic instrumentalism of John Dewey (1929), according to whom means and ends are in constant need of mutual calibration. Also, their idea of immanent critique is that it should arise internally (rather than as a form of externalist critique), from users of the technique themselves, as some problems only become apparent through use (note the connection to tacit knowledge here).

This focus on ‘consciousness raising’ with regard to values in science and taxonomy is a main feature of Sadler’s thorough work on psychiatric classification (2005). He too points to the fact that either through repeated and seemingly uncontroversial use, or through the common traditional view of science, we are often unaware of the values embedded in our technologies (including instruments such as guidelines and taxonomies). Two features of this tendency are ‘values subjectivism’ and the ‘politics-science dichotomy syndrome’. The former indicates the view that value judgments are entirely subjective, uncertain, and dubious, and therefore should be eliminated, if possible, from the process of developing a taxonomy. Sadler opposes this view on the grounds that values may possess a degree of consensual agreement lending them objectivity, and on their necessary presence in rationality,

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20 Immanent critique: the philosophical or sociological method of analysis towards cultural forms by locating contradictions in the rules and systems necessary to the production of those forms. Contrasted with "transcendental" Kantian critical philosophy, this method aims to contextualize not only the object of its investigation, but also the ideological basis of that object; both the object and the category to which it belongs are shown to be products of a historical process. (Source: Wikipedia)
and hence, in science. The politics-science dichotomy syndrome refers to a worry voiced by Schacht (pertaining to the DSM-III process) that treating science and politics as separate activities in a dichotomous fashion is ‘false, misleading, and leads to ‘double talk’ (Schacht 1985 in Sadler 2005: p.365). Sadler presents the debate between Schacht and Spitzer on this point, and notes that Spitzer acknowledges ‘ideological considerations’, and ‘subjective judgments’ pertaining to most of the important decision-making in DSM-III. Though the debate is illustrative, Sadler notes that neither author engages the issue of what kind and degree of politics there should be within the DSM process, and proceeds to argue both for a substantive role for politics (understood in specified forms) within science and taxonomy. It is here where we can find an important feature of an alternative to foundationalism. Sadler refers to Kuhn (1977) and Longino (1990) who emphasize the community features of science and place evaluative features of this epistemic community on an equal footing with the methodological aspects: openness, equality of opportunity, peer review, epistemic freedom, and criticism. This leads to the assertion that science requires political considerations (in the sense of ‘the most morally justifiable means of living together’) in order to get any epistemic work done. His views on values and hence, the necessity of (forms) of politics in the DSM, lead to proposals for improvement of the DSM process, but also, and in my view crucially, he adds to his requirement of a politics as defined above, a politics “seeking and maintaining a moral vision of aiding the mentally ill.”

Sadler’s proposal is as inclusive towards scientific method and technology as Zachar’s, but whereas Zachar emphasizes the internal professional qualities (of the reflective technician), Sadler places a moral vision in the center of the scientific endeavor and leads it back to the moral core of medicine: the aid of the ill. This, I believe, is an example of exactly the kind of Dooyeweerdian ‘opening up’ that the NPM refers to.

Thornton on skilled judgment
An alternative defense of the validity of values in science and practice, inclusive of values but nevertheless claiming objectivity, comes from Thornton (2007) who builds on McDowell’s arguments against a neo-Humean world view, in which “reality is exhausted by the natural world, in the sense of the world as the natural sciences are capable of revealing to us.” (McDowell 1996, cited in Thornton 2007). The ‘view from nowhere’ presupposed by this view cannot account for the fact that features are of the world, but also depend on subjects having a particular perspective (e.g. color or taste). McDowell adds to this argument Wittgenstein’s critique of a Platonist account of our conceptual structure in which correct
judgment depends on latching onto an extra-human order. His argument is that nothing can occupy the extreme end of a scale of objectivity understood in terms of mind-independence. McDowell’s alternative is of a world containing features whose understanding and detection require certain conceptual capabilities, e.g. the quality of phronesis vis-à-vis the moral demands of the world, but nevertheless, such moral demands are genuine features of the external world, not merely our projections onto it. This implies that the simple fact that a taxonomy or a science possesses values, does not imply a lack of validity. Thornton describes this position, which is that there is more to nature than can be described within the natural sciences, as ‘relaxed naturalism’. Values and meanings are also real features of the clinical encounter requiring skilled judgment. In a different paper, Thornton contrasts objectivism with evaluatism regarding psychiatric taxonomy (2008). Objectivism holds that psychiatric disorder is a strictly factual matter, whereas evaluatism holds that it necessarily involves a value-laden judgment. Thornton describes two senses of objectivity. Objectivity might mean requiring no special subject for the conception and framing of relevant judgments. Or, it might mean disciplining and providing a contrast between correctness and incorrectness, or truth and falsity, for the relevant judgments. Value judgments fail the first criterion for objectivity, but Thornton argues that there are both ‘disciplined’ and ‘undisciplined’ evaluativist accounts. If value judgments are ‘undisciplined’, mere expressions of subjectivity (and therefore not judgments in the sense of being capable of truth or falsity), then their presence (in a taxonomy) will undermine its validity. The alternative, it would seem, is an objective underpinning of taxonomy (and hence, of EBM). However, Thornton argues against the feasibility of this aim, based on antireductionist arguments mentioned earlier. His alternative of ‘disciplined evaluativism’ is rooted in ‘relaxed naturalism’: the idea that values are real features of the world. This implies that a taxonomy, or the practice of EBM, construed in this manner, can aim to ‘get right’ the complex mixture of facts and values that make up the realm of psychopathological phenomenology. Concepts of disorder would not need to be reduced to factual terms to be accommodated, whilst meanwhile the aim would be to underpin literally true judgments. Thornton’s perspective may offer a bridge to those professionals wary of ‘subjectivism’ and supportive of attempts to perform psychiatry in the scientific image (Murphy 2006).

Sociomaterial approaches

Another perspective comes from post-Kuhnian philosophy of science, namely the field of science studies (overlapping with STS) and related sociomaterial research. Put briefly, we could say that Kuhn opened the door for social studies of science by
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describing the role of social factors within scientific communities. Scholars in these areas examine how social, political, and cultural values affect scientific research and technological innovation, and how these, in turn, affect society, politics and culture. Such cross-domain approaches add to our disciplinary resources a dimension which is absent from domain-specific methods. A further feature of part of these studies, specifically the sociomaterial studies, is tracking the interactions between humans, human artefacts, naturally occurring objects, and human conceptualizations thereof in science and practice. Examples thereof include practice theory, complexity theory, new geographies, ‘new materialisms’, and activity theory (Fenwick, Edwards & Sawchuck 2011). The main premise they share is that social and material forces, culture, nature and technology, are enmeshed in everyday practice, whether in society or in science (Fenwick 2014). One example of such an approach, albeit a controversial one, is actor-network theory (ANT). In the analysis above, we already began chipping away at traditional dichotomies between science and society, subject and object. ANT is well-known, and some would say notorious, for breaking down such dichotomies completely. As such, it may represent an asset to enriched professionalism as both an empirical method providing a dynamic geography of values-related actions and relationships, and a countermeasure against the dichotomies inherent in scientism, naturalism and entailed risks of illegitimate reductionism and reification. In a previous article (Ralston 2010), I supported the combination of ANT and Values-Based Practice as an ethical framework of the kind alluded to above, the strengths of VBP in identifying and managing values in the clinical encounter being amplified by the resources of a cross-domain analysis of science in interaction with society in identifying the action of values through science and society (Latour 1987).

Actor-network theory was primarily developed by Bruno Latour (1993, 1999). Callon and Law (1982), amongst others, have contributed further to this approach, and in the Netherlands Mol (e.g. 2002) and Pols (2003, 2004) have applied ANT to their studies. ANT presents a unique view of scientific objectivity. Objectivity, according to ANT, is not generated by the ‘neutral gaze of the observer upon an independent reality’, but is the result of an interaction between the observer and the world. ANT emphasizes the coming into being of a ‘scientific fact’ as a consequence of the practical cooperation of multiple ‘actors’, which may be both human and nonhuman, and which are described as elements of a network. These actors may either strengthen or weaken the ‘fact-in-becoming’. In this phase, man and object are in cooperation, and the traditional separations of nature and man, ‘real’ and ‘constructed’, are irrelevant. Once the fact-in-becoming is sufficiently established as scientific fact it becomes ‘blackboxed’: the traces of its constructed-
ness are erased. However, the fact remains connected to a network of actors, entailing the possibility of future weakening of the local network and rejection of the phenomenon as scientific fact. The ANT approach entails examining how all the elements, human and nonhuman, fit together and how they are active in enrolling or in organizing the strategy of the network. Part of ANT is the idea of treating human and non-human actants as equals. Latour criticizes what he calls the ‘diffusion model’ of power which holds that a successful command moves under an impetus given it from a central source. In his view this leads to belief in the existence of society conceptualized as separate from science and technology. In place of the diffusion model Latour proposes a translation model in which such a command, if it is successful, results from the actions of a chain of agents each of whom ‘translates’ it in accordance with his/her own projects (Latour 1984). This process allows a scientific fact or a machine to not only establish itself locally, but to spread throughout the world. In Latour’s view this requires a lot of effort: others (people, machines, black boxes) need to be ‘enrolled’, and their behavior needs to be controlled (the latter in order to avoid the trajectory of the proposed prototype or claim being diverted too strongly). Strategies such as creating shared interests with others, cutting off alternative solutions, creating a short-cut, inventing new goals and new groups, and finally rendering the possible detour invisible may serve to illustrate the size of this task. Once this job is fulfilled, the fact is established and ‘blackboxed’, it looks as if this spread has been accomplished by the “impetus” of the claim or the machine, its “inner strength”. By virtue of the strength of their support in the actor network, these black boxes seem to flow effortlessly through space and time. Latour connects the diffusion model to the principle of asymmetry: according to this model, the concept of society is necessary to explain the uneven diffusion of ideas. The co-production and process necessary in the translation model is forgotten, and social groups either accept or resist the initial idea. The side-effect hereof is the view of science and society as separate. Latour’s main criticism here is directed at the false way entities are being separated. Therefore he also rejects explanation by social factors: besides the technical determinism (the ‘inner strength’ of the machine or idea) a social determinism is added, but in Latour’s view both are artificial. Just as was the case with Nature, Society is unknown until controversies are settled, and only then will a stable state with identifiable interests emerge. Actor-Network theory, as Fenwick notes, is more of a ‘diffuse cloud of sensibilities than a theory given its many internal contestations among key writers such as Latour and Mol (Fenwick 2014). According to Fenwick, ‘its lasting influences are a networked view of reality, and a radical treatment of human and non-human elements as equal contributors to the ‘networks’ that continually assemble and reassemble to generate particular activities, objects and knowledge’. 
Is there an argument to support the idea that ANT’s perspective ‘fits’ psychiatry better than that of the natural sciences or social constructivism? As the reactions to strong realistic and constructivist positions as exemplified by both sides of the antipsychiatry debate show, the subject matter of psychiatry is insufficiently served by a philosophy of science taking up just one of these sides. ANT prides itself on refusing to commit to one position on this continuum, instead focusing on processes. The price ANT pays for this is in explanatory power. The actual features of a substance in its stable modus, being the dependent variable, can feature in explanation, but only as one in a chain of variable length. This variability denies the observer the possibility to lend the (features of the) substance any definite causal weight regarding its stable condition. Again, this does not imply wholesale relativism as Latour does make these blackboxes answer to the world, it is just that a “final word” on explaining just what has allowed this phenomenon to attain stability, cannot be attained with the resources of ANT. And in this there is a clear difference from the stronger constructivist and realist positions which do occupy a position (society or nature) from which to explain reality. Latour does not want to provide explanations, just descriptions. Given this characteristic of ANT, what benefit could it have in its application to psychiatry?

In his 2002 article, Nick Manning coupled ANT with policy network analysis to examine the ‘stabilization’ of the diagnosis of Dangerous Severe Personality Disorder (DSPD). Manning’s analysis, integrating factual and value-laden elements, from multiple domains, accommodates an ethical analysis in a way that a domain-centered approach cannot: by identifying their dynamic and diachronic interaction across domains, enabling ready identification of shared and conflicting (epistemic and other) values and their possible mutual alignment and reinforcement (we will explore his analysis in more detail in Chapter 9). It is just this methodology which is necessitated by a commitment to a framework which acknowledges values beside facts within science and commits itself to a disciplined methodology of identifying and dealing with them. Another illustrative example of the value of the ANT perspective for the aim of uncovering values with respect to science-practice attunement is the study by Halpin (2016) of the use of the DSM by mental health professionals in three contexts: research, practice and institutional. The DSM text proves highly influential in shaping conceptualizations of disorder in the context of research and institution, whilst professionals were found to ‘work within’ the DSM to produce evolving diagnoses as individualized conceptualizations surpassing the diagnostic precision required by the DSM and much akin to the processes and interactions described in the DEF in Chapters 2 and 3. The relative autonomy of the clinical sphere was emphasized:
“While participants lauded increased construct validity for their laboratory work, they argued that increasing diagnostic precision was largely disconnected from improving patient care. For instance, a psychiatrist who was initially involved with DSM-5 stated:

‘We’re creating some new categories, which I think is great for companies but not necessarily good for the overall management and treatment of patients. I think the DSM-5 is still an attempt to try and create very specific diagnoses that have a very specific epidemiology, very specific pattern and hopefully very specific treatment. But I think we’re still splitting hairs with what’s going on in DSM-5. And at the end of the day is it going to be helpful for patients? And is it really going to impact the way we treat these individuals? I don’t think so…. Moving some things from anxiety spectrum disorders to other things, is that going to make a difference? No. I think it’s conceptually not bad in some areas, but is it really going to alter the way that I practice? I don’t think so.’” (Halpin 2016)

In the institutional sphere, the study found the DSM to comprehensively influence the enactment of professionals’ work. Work. Intra-institutionally, the DSM operated as an obligatory passage point (Callon 1986) through which department managers could enforce standards and shape professional activities. Inter-institutionally, the DSM connected professional practices to insurance and pharmaceutical companies. In another parallel with the current study, participants viewed billing as a primary function of the DSM. Halpin offers a number of examples of participants voicing concern or resistance to potentially stigmatizing effects of such practice, and the tension between their preferred iterative and co-construction view of clinical diagnosis and the institutional power of the DSM text, and concludes: “Through the DSM, the financial interests of hospitals and insurance companies were directly inserted into the enactment (Mol 2002) of clinical care, with the DSM translating professionals into a product and patients into customers, creating a service that could be monetized by both the host-institution and insurance providers.” Note how, from the sociomaterial perspective, interests are furthered not just through relationships but through texts like the DSM. It is especially this aspect of ANT that in my opinion is a valuable addition to the NPM. In fact, with ANT (and related methods) it is possible to track the way in which professionals relate to such texts. The ‘working within DSM’ and negotiating between the DSM text, the process of diagnosis, and the individual context of the patient towards in aid of his or her benefit is a crucial part of the aforementioned attunement, in this case, in relation to the spheres of science and institutions, and through the response to the DSM text and its enactment in different contexts (Mol 2002).
These examples demonstrate the way in which ANT allows for description of human and nonhuman actants interacting within networks with stronger and weaker ties, demonstrating how the interaction of one with the other leaves both changed. Researchers are enriched with a much wider panorama of (factual and evaluative) elements than analysis of the initial text would give. Is ANT in itself a substantive, foundational philosophy of science? This is highly debatable, and this study does not require a full answer, as we can suffice with choosing any one of a number of values-inclusive and pluralist perspectives on science to provide ample philosophical foundations for the scientific sphere of psychiatry. What is crucial in this study is the final, qualifying role of professional values, and the implications for professional legitimacy for expertise in the handling thereof; in relation to science, this implies being able to recognize and assess values not only within the spheres of science (production) and practice, but also in the dynamic actions of objects, concepts and actors that traverse the supposed boundaries between politics, science, and practice.

7.3.6. Values in science
The above suggestions harbor of a set of philosophical views of science which can accommodate the practice identified in the study. This support, however, also carries implications: there should be some (professional) expertise framework present to relate this judgment to. Such a framework was only present in general terms (pragmatism, professional values) in the responses to our study. Combining the heuristic framework of NPM with the practical and research methods described above offers a route to an appropriate perspective on professionalism connected to skills and competencies aimed at furthering normative direction thereof, resulting in an enriched professionalism.

Within philosophy there is an ongoing debate on the role and place of values in science. Bolton holds that scientific method is value-free (Bolton 2008ab), notwithstanding the fact that it is used by individuals and structures that are pervaded by values and concerns. He argues that the method for tracking whether A causes B or whether treatment A effects a particular condition, or has particular side effects, is neutral to value questions such as whether this question is interesting, whether the condition is of interest, whether the research is worth funding, etc. He acknowledges and supports the necessity for value-laden political action and process within science, whilst retaining this value-free core of scientific method. Similar arguments are made in Machamer & Wolters (2004). Various authors in this collection argue as to the possibility and desirability of identifying so-called cognitive or purely epistemic values (corresponding to scientific
objectivity), and the feasibility of defining areas and methods in science circumscribed by such values. However, as we might expect from the perspective of philosophy of science, judgments of what is seen as epistemic, and seen as objective, are made against a backdrop of intersubjectivity, socially acquired linguistic categories, and science communities representing paradigmatic views. Machamer and Osbeck (2004) therefore argue against the possibility of validly separating social and epistemic values. Machamer and Wolters point to the worry involved: objectivity has historically been central to scientific justification. If objectivity becomes laden with values (seen from the positivist point of view as devoid of knowledge content), then relativity ensues. However, various authors (e.g. Lacey 2004, Longino 2004) criticize, like Sadler, such dichotomous views on subjectivity, objectivity, science and society, and the epistemic and nonepistemic. Rather, putative nonepistemic values can and do function within scientific practice, and there is a stability and objectivity to the norms developed within a scientific community. The nature of related values and the degree to which they are present, depend on the nature of the objects involved and their objective ‘resistance’ to human manipulation. But there is no a priori schema we can draw up dividing scientific phenomena into the objective and subjective: this is itself a production of socially embedded scientific practice. Hence, it is argued, it is better to recognize the presence of values within science, to describe them carefully, and to manage these taking into account both the norms of the scientific community and ethical deliberations that are apt to the values involved. Such judgment cannot be prescribed in a priori fashion.

These reflections lead to the possibility of formulating a philosophical framework capable of supporting and legitimizing the relationship of science and practice suggested by our study.

1. Not only medical practice but science itself is pluralist in nature.
2. Science involves values.
3. Science may legitimately involve both pragmatism and politics.
4. The facts and values involved in 1-3 require disciplined methods for their identification and analysis.

This framework suggests a different view of science, and hence, a different view of professional legitimacy, than that which is inherent in the PS. The scientific views of the profession should be adapted to current views in philosophy and science, which offer legitimacy for the place of values in science, but consequently require methodological rigor in identifying, evaluating, and handling such values. The requirement of disciplined methods aimed at both fact and value calls for reflective awareness of the interplay of fact and value, both in practice and in science. The
tendency to partition off science, facts, evidence and the ‘doctor’s hat’ within one perspective, and clinical judgment, values, meanings and the ‘psychotherapeutic approach’ is a dichotomy shared by both the PS and some, but not all, participants (e.g. through causal dualism and alignment). The philosophical analysis rather points to differences of degree, and dimensions rather than dichotomies, with respect to these matters. But the value-laden and pragmatic nature of both practice and science, and the necessary connections this implies to societal values and practices, suggests that it is these dichotomies themselves that may be a hindrance to the task of ‘getting the values right’.

The historical review has demonstrated how value choices, such as a decision by the profession to align with scientism, have consequences further down the professional line: a stronger emphasis on EBM, for example. The Profile Sketch is an example of a document with a certain degree of institutional power, therefore its epistemic priorities will be carried forth into the profession, as an institutional value, entering into practice in a similar manner e.g. through alignment, to other institutional influences described in Chapters 3 and 4. This could lead to a reduced likelihood of those persons suffering from what psychiatrists view as ‘biological, material’ disorders, having their meaningful experiences attended to within the setting of the psychiatric consultation. Perhaps some critical voices will attest that this is already the case. Whether or not this is valued or disvalued, the point is that in order to make such a value judgment, one must adjust one’s lens to detect the presence, action, and direction that values travel in. Whereas EBM tends to limit the apperception of values to those involved in patient preferences, a dimensional view of values casts a wider net to examine value commitments and value entailments not only within the presented phenomena, but also embedded in the relevant scientific and theoretical concepts, and within the institutional setting. The ethical dimension of disciplined methodology requires us to critically examine the values involved. Cartesian separations of the domains of science, society, and practice are a hindrance to this form of critical inquiry. In other words: we need to be capable of tracking values as they traverse the ‘boundaries’ of science, society, and practice, moreover, we wish to be able to identify how and where they interact with scientific methodology, value choices within science, and even in the conceptualization of facts themselves.

This framework corresponds to the general thematic framework of this thesis, combining empirical analysis with historical reviews and philosophical and ethical reflection. If one is to not only describe but also evaluate psychiatric practice, then this should not only be related to the (traditionally seen as) scientific facts, but should also be viewed from an ethical perspective (values), necessitating historical
work to furnish a moral context. Moreover, the interactions between these traditional domains offer fresh perspectives.

7.4. Conclusions

This chapter, devoted to examining the role and form of science in psychiatry, began with psychiatry’s birth as a product of Modernity and ended by examining a philosophy which characterizes itself as ‘pre-modern’ (Latour), collapsing the modernist dichotomies between man and nature, fact and value, science and society. We found that psychiatry has modeled itself on successful forms of (medical) science, and has done so for both scientific and sociopolitical purposes. Psychiatry has encountered significant obstructions to its moral aims, and has enlisted science in several ways to attain them. If societal pressure on the profession increases, the likelihood of ‘values alignment’ with influential extra-professional groups and institutions increases, a feature present at many points throughout its history, and again relevant today, as technical rationality, bureaucratization and rationalization processes profoundly influence professional practice, and with the increasing influence of market forces within Dutch mental health care. I have argued that the traditional methods of natural science have been, and continue to be, effective instruments within some areas of psychiatric science, and that aligning with natural science has been an effective instrument both for attaining internal homogeneity within the profession, and societal legitimacy. However, there are philosophical, ethical, and practical problems attached to limiting professional identity to such a scientific model. Therefore, an alternative approach was proposed aimed at accommodating disciplined treatment of both fact and value through the NPM, amplified with methods aimed at facilitating the recognition and assessment of the dynamic interaction of facts and values across the domains of medical practice, science, and society. This approach was shown to allow for the form of practice so far explored within our qualitative study, whilst suggesting a strengthening of ethical methodology for practice to accompany the traditionally strong factual element, providing an alternative model of professional legitimacy. It also suggests areas for cross-domain empirical ethical research (Widdershoven, McMillan & Hope 2008). The requirement for locally grounded normative judgments in the development of taxonomy was found to be an additional argument for the suggestion made in Chapter 4 of a pluralist system of pragmatically organized taxonomies, and entails a normative framework to accompany such a system. The common thread through this account is an alternative view of the relationship between science and practice and of science itself and hence, of professional legitimacy, incorporating values
‘through and through’ (rather than declaring them irrelevant through reduction or cordonning them off), and identifying and assessing them within the local science context (involving norms from the relevant ‘scientific community’) whilst also relating them (e.g. through linguistic and network analysis) to wider (social, professional) normative communities, and, crucially, attuning them to the normative direction of the profession. It should be clear by now that this does not entail a relaxing of scientific standards (these are embedded within the scientific communities) but a further requirement for awareness, competency and skill in the handling of values within the different contexts (practice, science, education, public, political) professionals act in. Rather than weakening the legitimacy of the profession, this proposal enriches it by adding this requirement to professional expertise. Additionally, the tasks and responsibilities, and the particular complexity of related values in psychiatry implies that such expertise will be specific to the profession.

How would we assess some of the examples of the justification of values in practice (Chapters 3 and 5) and in the history of the profession (Chapters 4, 6 and 7)? We have seen that for the participants in our study, ‘improvement’ on the part of the patient was top of the values hierarchy. This is a transparently value-laden term, and therefore, the (democratic) question then becomes to what degree patients are allowed to define the sense of improvement determining practice. We noted that different participants provided different ways of understanding improvement, whether in terms of improved autonomy, improved social functioning, improved insight, etc. Though we did not perform it here, an analysis could be undertaken of the degree to which certain values were more or less shared across participants, and between patients and physicians. This could offer us a logical geography of the values related to improvement in psychiatric practice, and again, to whom they belong. VBP provides a method and skill set for the required attuning of the uncovered values. Besides improving aspects of ‘good process’ not only in taxonomy but more widely in psychiatric science, better training and improved resources for professionals should enrich discussions and deliberations within the profession and across professional-societal boundaries. I would argue that this more inclusive approach to science and psychiatry is already taking place, albeit in a relatively embryonal form, with the recent collaborative involvement of different client organizations, including the National Platform for Mental Health Care (the LPGGZ), an association of 20 client and family organizations in Dutch mental health care, in the development of new care standards (Spijker 2017). This chapter has focused primarily on science and its relation to practice and the profession. In Chapter 10 a fuller account of the view of professionalism emerging from this study will be given.
Meanwhile, a main theme of current philosophy and psychiatry, the concept of mental disorder, has been hovering at the fringes of the discussion. As we saw in Chapters 3 and 4, the model we constructed was potentially a threat to mental disorder as conceptualized within the current taxonomy. If diagnosis is as much construction as identification, then the question arises whether a general concept of mental disorder can accommodate such practice. As has been noted repeatedly in the introductions to the DSM, there is no single definition that adequately encompasses the myriad forms ‘mental disorder’ may take in practice. If clinicians, as we noted, apply various conceptualizations of disorder corresponding to both psychotherapeutic/psychiatric theories and layman narratives, in a piecemeal and pragmatic fashion, without necessarily integrating them into a singular concept, then what is the role of mental disorder, as a singular concept, for practice? Is it ‘in play’ as a relevant concept? Is it useful? To what degree is it a unified concept? In Chapter 8 we will shed more light on these questions and use them as a springboard to look ahead. Also, the models of taxonomy and science developed in Chapters 4 and 7 are fundamentally pluralistic and value-driven. If we agree with Kuhn on incommensurability, and allow for pluralism, there is a possibility that one phenomenal set, under one taxonomy, would qualify for ‘mental disorder’, and wouldn’t under another. Is this a threat to pluralism, or a threat to the concept of disorder? What consequences could this have? These and further questions relating to the philosophical framework under development will be taken up in Chapter 8.
The natural science perspective was crucial in the social establishment of the profession of psychiatry in the Netherlands. This foundation was based more on the promise of natural science than its scientific standing and findings at the time. Related epistemic positions were: empiricism, material reductionism, and a trend towards eliminative materialism.

Throughout its history, the profession of psychiatry has aimed to emphasize its ‘medical identity’ as a political effort to bolster its professional status. In the current document professing its identity, the Profile Sketch, epistemic values of empiricism, objectivity (taken as freedom from values) naturalism, technical rationality and the implied separation of theory/treatment and practitioner are apparent. This profile conflicts with the image of practice identified in this study.

The philosophy of science espoused in the PS offers insufficient resources for handling the values present in science. Also, the full codification of medical knowledge implied is untenable: some knowledge is inevitably context-dependent and cannot be codified without loss.

There are resources available for handling values and science from a practical perspective, such as Values-Based Practice and immanent critique. Methods differ with respect to their views on the place and relative import of values in science.

Social studies of science aim to track the interplay of fact and value, social processes and scientific method. Actor-Network Theory is one example of a method enhancing the ability to trace interactions across domains. This approach suits the findings of the qualitative study as it may aid in identifying bottom-up and top-down epistemic and ontological alignments and resists a priori segregation of fact and value, nature and society.

The recognition of the presence and importance of values inherent in science and society and their intrinsic relationship with practice, requires frameworks ensuring good democratic process for handling them. Medical professionals require domain-specific knowledge and expertise in identifying and handling values. Professional education should be based on an updated philosophy of science.