Chapter 6: Science and legitimacy in practice

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6.1 Results from the qualitative study
The results are given (as in Chapter 2) as an overview of emerging themes including selected citations. There is some overlap between the themes emerging under science and under diagnosis, which is to be expected as these themes are inherently related where diagnosis for the profession is at least in part to be legitimized through a scientific approach.

1. Philosophy of Science
   - Pluralism vs. Monism
   - Reductionism vs. Antireductionism
   - Empiricism
   - Paradigmatic views/Social
   - Causal dualism
   - Realism/Antirealism
   - Idiopathic vs. Nomothetic

2. Legitimacy
   - Therapeutic Outcome and pragmatism
   - Scientific legitimacy
   - Professionalism and professional expertise

3. Professional Development and Theory Choice
   - Personal and professional clinical experiences
   - Personal and professional values
   - Institutional influences
   - Alignment

Fig. 6.1. Science and legitimacy framework.
6.1.1. Philosophy of Science

Pluralism/Monism
Most psychiatrists term themselves ‘eclectic’, and apply mostly partial theories to encountered problems. Only rarely was there a ‘single-theory’ approach taken within an intake, e.g. psychoanalysis, and even in those cases where a participant aligned him or herself with a certain psychotherapeutic approach, they added that they would apply other approaches to specific problems if these seem apt. Psychiatrists in this group did not self-identify exclusively with one psychological theory/therapy. Allegiance to theory was expressed in quite general terms, such as having ‘affinity with’ a certain theory or therapy, or whether a theory/therapy ‘suits them’. This corresponds with the literature on personality characteristics and world views predicting theory choice.

Pluralism can be scientific, usually expressed in a dualist form: science encompassing natural and human science, or theoretical, i.e. applying different theoretical models to different disorders and/or phenomena. It may also apply to the freedom to apply different taxonomic approaches besides DSM. A minority of participants professed an allegiance to a single theoretical approach (monism), supporting one dominant explanatory theory, including its ontological and epistemological entailments, though they generally did allow some room for the application of alternative approaches depending on the nature of the problem. Stronger affinity to a single approach increases the ‘import’ of related theoretical concepts into practice and to resistance to discrepant institutional constraints, as described in Chapter 3.

These examples come from all three settings (private, institutional, academic). Pluralism was evident in all three settings.

Psy 1 (private practice):
I: ... So you’re a bit of a Jack of all trades.
Psy 1: Yes. I've never felt at home in a small enclosed space with boundaries. That’s one of my characteristics.

Psy 2 (private practice):
Psy 2: Of course, I have a background in the analytical developmental model. That’s a background from the situation in 'City C' with X (well-known psychiatrist). That’s a background which sometimes, consciously or unconsciously, comes sailing through. On the other hand, there is the behavioral background which was also hammered in about complaints etc.
Psy 3 (private practice):

I: Sometimes it’s portrayed as a battle, perhaps back then, there was the period of antipsychiatry, but, previous to that there was the dominance of psychoanalysis. Which was a kind of dichotomy. Maybe more in the US than here, but a battle between the two, that biological psychiatry has won, to put it very briefly.

Psy 3: Yes, the funny thing is that on the one hand I’m all for integrating different faiths but on the other I find biological psychiatry fascinating. I’m a big supporter of it. Very fascinating. So, my approach is very diverse!

I: Can you integrate them, those different perspectives?

Psy 3: Absolutely. I see no opposition between them.

I: You might say, on boundaries, that there are differences. The biological psychiatrist might say: The psychiatrist should do the medical bit, he’s not there to make people happier. That’s one remark that has been made in this regard. What do you think?

Psy 3: I think that’s nonsense. Getting well has everything to do with well-being. You should hear people who’ve gotten better! They can hardly believe their eyes and ears. Isn’t that great? Working on people’s well-being?

I: My question is, what’s your perspective against the background of being a doctor, a medic, a biological psychiatrist etc. How do you integrate those roles? You have psychiatrists who say: Yes, I’m for biology – you can ask yourself: what is that, biology? And they take it to mean that they focus on the medical part, doing psychiatric examination. And then there’s the psychotherapist who does his or her thing and he focuses on the rest.

Psy 3: No, no. I’ve trained in both. Because there is good scientific research that combining pills and psychotherapy gives good results. So I have the diary method, a book on cognitive therapy I use. From my time in addiction care I was already very familiar with CBT. Behavioral modification. All those sectors I carry with me.

Psy 4 (institutional):

I: What are the things that for example point you towards the frame of one theoretical direction over the other?

Psy 4: Well, maybe it’s my own background. I followed a Rogerian training. But when I did that training, the really pure Rogerian view wasn’t around anymore. Since they called it eclectic even then. So it was a little of everything, a mish-mash, and in that training I veered a little more, you read a bit about behavioral therapy stuff, about relationship things, about psychodynamic things, well after the training I continued with the psychodynamic advanced training so that gained a lot more emphasis in my way of working, I think, than the behavioral approach.

Psy5 (academic):

Psy 5: I think I’m very practical. I’ve never been a ‘School’ type myself [referring to
the psychotherapeutic schools] You can also say, I’m pragmatic. I think that if someone should be treated with psychoanalytical psychotherapy, we should do that. It should be carefully considered, but that’s true of all treatments you give. That goes for all therapeutic perspectives. So what I’m saying is: I’m not principled. I can live with a lot of different solutions. Good idea, why not! I tend to see the positive side of things.

There was a minority of participants who chiefly identified with one theoretical/psychotherapeutic position:

Psy6 (private practice):

**Psy 6:** I trained as a psychoanalytical psychotherapist and have been one since 2010. I have a private practice in which I try to work psychodynamically as much as possible. Unfortunately, that isn’t always possible, but it is what I aim for.

Later in the interview, Psy6 describes how his choice for psychiatry developed:

**I:** So you could say you had a number of qualities as a person and a certain way of working that appealed to you. But there is also a certain step to say, Okay, I want to practice this profession, to specialize. What prompted that choice?

**Psy 6:** Quite simple. I ran into problems myself and underwent psychotherapy, without knowing what it entailed. Before then I had little affinity with psychiatry. I was interested in it and did well at it, but I still thought very mechanically, like a doctor, someone in internal medicine. I’m from a family of doctors, so you take some of that along naturally.

**I:** You describe it as mechanical thinking?

**Psy 6:** Yeah, you know: disease, causal, like that. When I did my psychiatry rotation I was mainly occupied with how the brain works, how medication works, the receptors etc. I was well schooled in the hardware and got an 8 out of 10, while the resident that supervised me thought I wasn’t too good with patients, ha ha! He thought that was a laugh too. Anyway, later I got some problems. I went into therapy with a psychoanalytically schooled psychiatrist. I kind of identified throughout the therapy. With the person and with the therapy. Maybe more with the image of the person sitting there. I internalized it in this way, and specialized in it besides my psychiatric training.

Note how a clearly meaningful personal therapeutic experience prompts affinity with the theory and practice. Also, this excerpt shows another example of metaphysical alignment: doctor-mechanical-disease-causal.

Psy6 also demonstrated pragmatic pluralism:

**I:** So you went into [residency] training and you were already very interested in
In this period, you encounter all those other theories. What does that mean if you put it into the perspective of your personal development previously and you view it from the perspective of theories that you use in practice. Rogers, CBT, systems therapy, all theories on how things work. How did that develop in that period? Did you make choices, or not?

**Psy 6:** No, I didn’t make choices. You are presented with very many different theories and backgrounds. What you do then naturally is... I was interested analytically but wasn’t in training to be an analyst, then. So you’re trained eclectically, at least in various directions. I still have, in my work... my framework is, in principle, dynamic, especially when I’m thinking diagnostically. But in my work, in treatment, I also do CBT bits. I also work systemically if I think it’s necessary. In fact, I’m sometimes working eclectically because pure analytical processes can only be applied to a limited number of patients. So, I’m someone who works pragmatically and sees how things go. Also, within analysis there are also many schools of thought..... So there isn’t one frame of thinking. It’s important to realize that. The point is to be aware of what’s out there and to know very well when a patient will benefit from a certain approach. That requires a certain sensitivity and experience.

This example illustrates the fact that even where psychiatrists self-identified with one theoretical model, they did so against a (training) background of theoretical and therapeutic pluralism with a pragmatic foundation for practice, fitting the ‘right approach’ to the problem.

Reductionism/antireductionism

Participants differ in the degree to which they tend to reduce ‘surface features’ such as symptoms noted during the intake, to underlying mental or physical processes. In other words, this dimension describes the strength of their essentialism. Some participants link descriptive questioning to establishing a ‘surface diagnosis’, assuming the disorder under examination is ontologically either present or absent at a deeper, material level and if present necessarily manifests itself through symptoms. On this assumption, all that is required for diagnosis is descriptive assessment of the symptomatology. Antireductionist participants differed on the prospects for future reductionism: some viewed reduction as being limited by current technical possibilities, others viewed reduction from meaningful to factual as principally impossible.

In this example from an institutional setting, the intake discussed in the interview concerned a psychiatric examination aimed at determining the presence or absence of ADHD. In the coding, the relative use of descriptive, closed questioning was noted, and subsequently discussed in the interview. In the interview, the
psychiatrist described himself as a biologically-thinking psychiatrist.

**I:** Do you have a causal theory of ADHD? General thoughts on its causes and where they lie?

**Psy:** Yes, on ADHD I can be brief. I think it is primarily genetically determined. You can see that. I’ve been working with ADHD for eight years now. Ten to one that a patient has someone in their family tree who has it too. So yes, of course it is exacerbated if it is present in statu nascendi, by the effects of upbringing or by another sibling, or by parents who can’t cope with it.

When the interviewer brings up possible environmental causes, the response demonstrates material reductionism:

**I:** That’s clear. So you’re saying it’s a disorder that can be localized within the individual. Let’s take the example of a relationship problem. That, we could say, is an interactional phenomenon. And a depression that is heavily determined by social circumstances, you might localize somewhere between the individual and society, in where you locate what is making someone ill. But with ADHD you say it is strongly within the person.

**Psy:** Yes, whilst it is never, it’s always both. Ten to one the children have been bullied at school because of their ADHD and were marginalized. I think that this also exacerbates the ADHD.

These passages portray ADHD in a reified manner, even when being discussed within the social sphere. Behavior does not constitute ADHD rather it affects it.

In the following example of causal reductionism, in the coding it had been noted that the psychiatrist made a relatively early (compared to other participants) move to descriptive, quantitative questioning. Questioned on the motivations for her interview technique, this academic psychiatrist professed a preference for a view of mind and brain in which moral norms could be eliminated through knowledge of physical processes.

**I:** Okay. On this topic I’d like to ask you a few questions. You started by expressing your interest in the brain and neurosciences. Can you tell me wherein the attraction in these fields lies or lay?

**Psy:** The creative part on the one hand, the analytical side that you need to use and that is always fulfilling. Also, it’s one of the great mysteries that are still around: ‘How does the brain work?’ It’s very influential in daily life and it’s very interesting to understand more of it. Also because you can neutralize a lot of things this way, taboos, religion, that kind of thing.

**I:** Can you explain that to me?

**Psy:** For me, everything a person does, thinks or feels, has a biological substrate. So in this regard I have a physicalist approach. So it’s to understand more of all this
mystery that is going on out there, where there is a lot of religion and taboos, difficult things between people. They still exist but are more easily explainable. Do you understand what I mean?

I: So in the material world norms and values don’t exist, and everything is neutral? Psy: Yes.

The psychiatrist clearly attested to viewing disorder as fundamentally physical, including a concept such as grief-induced depression. The participant also noted that the state of current science precluded a fully reductionist approach to practice at this point in time, though she had faith in its promise for the future.

Psy: Not everything is based on an RCT. That’s impossible. How I respond to the patient in the intake, that’s personal of course. That hasn’t been proven by an RCT whether that is the most effective intervention she needs. You notice that as a therapist, due to the fuzzy scientific information on this kind of interactional subject, you make decisions based on your own experience and insights, at this micro-level. For one person, you make the judgment that a CGT-approach will be the best way to tackle a problem. For someone else, you will view it more from a psychodynamic/psychotherapeutic perspective, and for someone else, you might combine the two. You judge which approach gets the best response. You’re performing research in practice to ascertain what gets the best result. That’s what I define as the best.

For an example of antireductionism, this psychiatrist worked in an institutional setting, a polyclinic for adults. In describing his early professional development, he touched on reductionism:

Psy: I started working in practice and I worked for a year at a classic Riagg\(^{15}\) in Amsterdam. A neighborhood ambulatory service with people who’d worked there for decades. The team welcomed me and I seriously meant what I said, that I discussed with them, that I maybe didn’t think that talking was that important. I thought we should just influence the brains. Through medication, generally. They laughed heartily at that. That was an enjoyable, formative year! I learned then that talking is also important. That was interesting. That psychotherapy is effective.

Later in the interview, reductionism was discussed directly. The reasoning shows the psychiatrist developing from a dualist to a more monist (or as he would say holistic) stance during his professional career, and in the process, questioning reductionism.

I: This idea you had at the Riagg, was it connected to an idea on mental disorder? You

\(^{15}\) Riagg: Regional Institutes for Ambulatory Mental Health Care, established in the Eighties in the Netherlands and now mostly extinct, having been swallowed up in institutional mergers.
said it was a kind of a biological psychiatric idea, was it connected to those major mental disorders.

**Psy:** No, not really. It was mostly the biological perspective. Can you explain mild complaints with disruptions in neural networks or lack of activity here or there.

**I:** So a causal explanation?

**Psy:** Yes.

**I:** So the thinking goes: mild complaints too have a physical causal base.

**Psy:** Yes.

**I:** About that causality. Do you see that differently now?

**Psy:** Yes. Sometimes I read those popular books and I find myself agreeing more and more with the criticisms thereof. It’s a bit of neurobabble. It’s always ‘well mirror neurons ensure we can do this and that’. I keep thinking: don’t separate these things. It’s just... we are all of this. It’s whole and cannot be separated. The complicated issue of ‘we’ve found where it is, it’s here and you can see it on a scan when you experience this and this’. That’s become more complete and more integrated in my head.

Another example, from an institutional setting. The discussion was on competence and responsibility for one’s actions.

**I:** For example, I can’t blame someone who’s highly psychotic for the wrongs he’s done caused by the psychosis, since his will is disrupted at the time.

**Psy:** Yes. I’m thinking of autism too. One the one hand I’m against reification but on the other I do think there is something there. That there is something wrong with the connections in the brain.

**I:** Would you, from this perspective, say too that that makes it a real disease? That the problem is fundamentally at that level?

**Psy:** Whether that is by definition necessary?

**I:** Yes.

**Psy:** Then it’s about the question, does someone have real symptoms or real dysfunctional behavior. Your question then is, can that always be found at the level of neurobiology, if you can find out all you want to know about it?

**I:** Well, I actually mean, in a related thing, since you said, you thought there was something wrong with the connections, that sounds like for the pathology, that is the most important level. That doesn’t mean to say there’s something wrong with other levels, just that at this level you say: “Yes, this is where the problem is!”

**Psy:** No, it isn’t the most important level. I once heard the comparison: what is temperature? If you only describe it in terms of the speed of air molecules then you describe it in a basic, physical manner. But that doesn’t tell us what we experience as temperature. Warm or cold. That is temperature too. I don’t believe the one is more important than the other. I think you should pay attention to both. Those two levels.
And that both can be helpful to understand and to do something with it. So both meaning and the physical level.

Sometimes antireductionism is motivated from pluralism. In this example of a psychiatrist from private practice, who self-identifies as a Lacanian psychoanalytical psychotherapist and psychiatrist, the psychiatrist had previously criticized the current state of psychiatry as being narrowly biologically focused. The discussion moved to science and pluralism. The interviewer sketched the realist ambition of discovering a pathophysiological cause.

I: There is a tension in the sense that it is very important to find the right level, that given by nature. There is a reality out there and we must attempt to approach it, to describe it. That is what science is. And that is what psychiatry should do. This is an argument to practice a certain form of science. An idea of science and progress. On the other hand, you might propose that psychiatry should stay very pluralist and shouldn’t be forced into singular or plural causal specifications. But this is based on the idea that it would be impossible to find a singular cause. For the spectrum of psychiatry that proposition would be unlikely. Some people say that that reduction is, in principle, possible, others that it is impossible. In principle. What’s your idea?

Psy: Impossible. The reduction towards one area that you’re focusing on, where of course something’s going on and where you can find something concrete or pathological, to derive it from there. It’s one expression, that you can say. But if you reduce it to that then I think you’re not only letting down the patient but you’re letting down science too. If you limit yourself to that and lose sight of other things. As if an epidemiologist would only look at diseased cells and not at the way in which the virus is transmitted from one person to the other. From a pragmatic perspective too, it would be very bad.

In the previous examples, the psychiatrists supported explanatory and perspectival pluralism. A neutral position on reduction can be found in strict application of evidence-based medicine, wherein empirical findings are related to one another based on statistical evidence of correlation, without causal assumptions being made. Though most psychiatrists confirmed they applied evidence-based medicine in their practice, mostly with regard to pharmacotherapy, actual practical examples of application of EBM were mainly apparent in the academic group, and most evident in intakes which were formally described as second opinions. These were the only sessions in which the psychiatrists actually mentioned research evidence to their patients in the sessions themselves.

This academic psychiatrist consciously structured his encounters around evidence-based medicine, which he had wedded to an active approach of and by
his clients.

**Psy:** [In my practice] the people who come to me, if it's not about diagnosis, then we're in a pharmacotherapeutic perspective, always or nearly always according to the guidelines and if not, then we're consciously deviating from the guideline and it's always discussed. So the perspective is evidence based medicine whereby the second perspective is that the patient knows what we are doing. So he's not just sitting there and leaving with a prescription in his pocket and then we'll see what happens. He knows why we're doing this or why we aren't doing it. Why we are putting something up for discussion or why I want to know something. I also ask them to prepare things at home or find things out. You could call that a kind of activating behavioral therapy.

**Empiricism**
This is the view that knowledge is derived from sensory experience. This represents the common support for empirical research into effectiveness of treatment, epidemiological research, and fundamental scientific research. This was further expressed in a reticence with regard to (causal) conjecture in written reports, in other words, to not go beyond describing phenomena correctly and applying the correct diagnosis and classification. This was demonstrated in the difference found between the causal and meaningful connections made within the DEF, and the relative lack of such explanatory statements in written reports.

Example (institutional setting):

**I:** What would the ideal form of science be for psychiatry?

**Psy:** That's a rather general question. What do you mean exactly?

**I:** How should we best acquire more knowledge about mental disorder. How should we do that, ideally. Take it any way you want to, I'm purposely leaving this open for you.

**Psy:** By continuing to study the questions that are there. That's in the epidemiological research that points you to relationships. The whole area of genetics where there is much to study. Things like imaging studies. The effectiveness of treatments. All kinds of psychodynamic and psychological explanations are harder to study, I think. But it's very important still to keep studying the effectiveness of treatment methods. A form of psychotherapy or which factors in psychotherapy contribute to the result. I think it's especially important to study all areas. Both psychotherapy, fundamental biological research and epidemiological studies. I think you have to do all of this.

**Paradigmatic views/Social**
This encompasses acknowledging and being aware of the relevance and
importance of social, economic, and political factors on science. Some participants voiced support of paradigmatic views of science and resistance to progressive realism. Participants were also aware of conceptual connections under the ‘Alignment’ theme, e.g. connecting ‘market values’ & materialism, and might take an ethical stance therein.

Example paradigmatic view: an academic psychiatrist.

**Psy:** ...Basically I was much influenced by X and Y. They were the heads of the department where I followed my residency training. This led to me taking a psychodynamic perspective and also being a supporter of the biopsychosocial model.

**I:** Those two things you mention. Can you say what they mean for your daily work?

**Psy:** The psychodynamic approach determines how I talk to patients, how I view them, which things I emphasize. It’s also a way to translate emotions to manageable concepts for treatment. It makes it understandable to me and places it in a framework enabling me to discuss it with the patient in such a way as to develop a rationale and whether that rationale is true or not doesn’t really matter. Whether patients can use it productively to me is the most important thing.

**I:** Whether it’s true…. that doesn’t matter?

**Psy:** Not on my account. The truth isn’t demonstrable, so far. We don’t know how it all works, yet. Currently, the biological approach has priority. But those are also models. Everyone seems to feel as if that is the truth or reality but in my view, that’s doomed to undergo the same fate as psychoanalysis.

**I:** What fate is that?

**Psy:** That people say, at a certain point: “it’s not actually like we thought it was,” and then a new insight occurs. When I was in training psychoanalysis was unassailable. It was the truth. That’s how you viewed patients and if you couldn’t you’d be excluded. And slowly that paradigm has shifted to biological psychiatry.

**I:** Being excluded, do you mean this as a social process too?

**Psy:** Yes. A psychiatrist was, where I was trained back then, a psychoanalyst. But that was limited to that city I think. At least, it was very clear there. And in [city Z] directive therapy was coming up, half way through the Seventies. Slowly, van Praag rose to attention, the whole biological psychiatry boom. That is now what is the truth and is where most scientific successes are claimed and that has to do with... I can say what I think right? The paradigm is not just determined biologically but epidemiologically. As long as we can count we have the idea we can approach the truth. I think that’s a mistake.

**Causal dualism**

Already noted in practice in Chapter 2, this was readdressed here.
Causal dualism and essentialism: Psychiatrists tend to view causes of mental disorder in dualistic terms: causes are either material, frequently termed as ‘biological’, or psychological/social. There are clear connections between causal essence and choice of therapy: where a disorder is seen to be materially caused, or to have a material essence, the psychiatrist will think of pharmacotherapy, conversely, in psychological causation/essence she will tend towards psychotherapy.

Example (private practice):

I: Is my impression correct that you’re saying: “I’m eclectic but I do think that I make a different mix for different disorders”?

Psy: Yes.

I: What determines this?

Psy: A disease concept. I think of schizophrenia as so clearly biologically determined. And then I don’t think, sixties-like, that’s it’s all due to society. Whereas ADHD, well that’s one narrow example, but I think there’s a large social factor involved there.

I: So for different mental disorders...

Psy: Yes, they’re very different in their genetic or biological substrate.

I: So you’re saying, that I should replace the term ‘biological’ by ‘physical’?

Psy: No. I mean: less determined by social and environmental causes.

I: What then is the biological other than environmentally determined?

Psy: You can’t cure schizophrenia with psychotherapy. You can improve it, but not cure it. You can cure a depression with psychotherapy.

I: So things you can’t treat with psychotherapy are biological?

Psy: No, but it does play a role in the treatments you choose. If someone has a Pervasive Developmental Disorder or Schizophrenia I’ll much sooner start with a biological treatment. I’ll have much more faith in a biological treatment in these cases.

I: And this has to do with a biological cause. So you connect cause and treatment to each other?

Psy: Yes.

In this fragment, we not only see dualist reasoning and the connection between conceptualizing a disorder as biological and biological treatment (generally pharmacotherapy), but a hint of backwards reasoning from the effectiveness of a certain treatment to this conceptualization: why is schizophrenia biological? Because you can’t cure it with psychotherapy. This is consistent with alignment of psychopathology into material disorders with material treatment, and psychosocial disorders with psychotherapeutic treatment. Pluralism and pragmatism can be consistent with this approach, in the sense that multiple
therapeutic frameworks are available for psychosocial problems and disorders, and pharmacotherapy is legitimized on a combination of empiricism (within EBM and RCTs) and an instrumental form of pragmatism (choice of treatment determined by foreseen benefit).

Realism/antirealism
Taken here as the question of whether scientific theories reveal literal truth vs. the belief that we cannot determine final truth value of scientific theories from an external point of view. Antirealism encompasses positions such as paradigmatic views of science, or research programs. Causal indeterminacy providing a legitimacy is a realist defense of pragmatism in practice. Views on this issue were most readily apparent in discussions on diagnosis and the DSM, since in delivering a diagnosis and pronouncing a classification, the question of the truth value of both is relevant.

Example (institutional): at this point in the interview, we had been discussing a case in which the participating psychiatrist had found diagnosis difficult, and still had his doubts.

I: In the end you make a diagnosis both for autism and for depression. But you also kind of play it down, right at the end when you talk about your view of the problems. You say: “I distinguish two things. The situation has lasted 7 years in which the concentration has gone and is very low, a feeling of uselessness, failure, and fatigue. That is something that fulfills the depressive features and a serious burnout and depression are not always easy to distinguish from each other.” The patient then says: “Someone said to me, I think you’re depressed, I said yes but I don't experience it as depressed in the sense of negative but as passive.” You say: “A kind of anesthesia of your emotional life. Could very well be a depressive trait.” You gave an extensive explanation. But just now you said you’d do things differently in hindsight?

Psy: I’m glad to see I put things in perspective. I do downplay those classifications a lot. Which actually makes it (offering a diagnosis) easier. With ADHD that is of course the case. What we too often do is that something is really SOMETHING. That’s when a description becomes an explanation. Conjuring a rabbit out of a hat that you put in there earlier. If you see a classification as a description of something your patient is telling you without saying that it is already “something” that has been explained, then you can classify more easily. Then you’re putting the classification much more into perspective. That’s how I see ADHD too.

I: Right. That’s interesting. That’s in the questionnaire too. There are different directions there. One is a kind of a constructionism and corresponds to what you’re saying: diagnosis, that’s a way of organizing things, a way of organizing our
observations. Without talking about ‘things’.

**Psy:** I usually make a diagnosis because it is a working hypothesis that has utility, not because it is The Truth. If I think that someone will be aided by the diagnosis as a means to a treatment plan, then I make the diagnosis.

Example Realism, from an academic psychiatrist. Previously in the interview, the psychiatrist had remarked on the remarkable progress made in the science of psychiatry, and the benefits this had accrued in the sense of data on which kind of treatment works for which problem (this psychiatrist also self-identified as a pragmatist). On the subject of mental disorder, he viewed disorder in general as being defined as ‘brain disease’. This was explored further.

**I:** What’s your reason for prioritizing the brain?

**Psy:** And...not...something else?

**I:** The whole body, for example..

**Psy:** Ah, that’s very clear, I think. The brain of course is connected to the whole body through the autonomic nervous system and the hormones. Of course, people feel their mental complaints in the body, by definition. They’re not carrying on, it’s really there! But it is generated centrally.

In this excerpt, this psychiatrist connects the reality of mental disorder to the reality of the scientific discoveries relating to the brain. This points to a correspondence theory of science: through empirical research the theory corresponds to real objects in the world, and therefore, the content of theory reflects empirical truth.

Another example of realism, from an academic psychiatrist, on the relationship between science and mental disorder. The discussion centers on the normative nature of disorder:

**I:** There are people who say that a dysfunction is not something we can define at a material level. In the end it’s a normative thing.

**Psy:** But surely there is a lot more research that seems to prove the biological substrate?

**I:** The argument goes that the deviation from biological statistics is dependent on a previous normative judgment.

**Psy:** Which brings you back to the question of boundary setting. That quantitative area, right?

**I:** Yes, that’s related, it’s about the essence of disorder.

**Psy:** But if you quantify it, you can stay very neutral, can’t you?
Again, the psychiatrist connects the reality of disorder to the reality of material observations, based on (quantifiable) empirical science.

**Idiopathic vs. Nomothetic**
With respect to the attention to knowledge from idiopathic versus nomothetic perspectives, again there was support for applying both perspectives. In practice (see Chapter 3) participants generally prioritized adequately and accurately representing the meaningful communications of the patient within the DEF. As far as nomothetic knowledge has bearing on the DEF, it should accord with such representations. Again, the perceived relative lack of nomothetic knowledge for clinical decision making entails a default prioritizing of the former, as it is seen as giving better guidance, with greater individual predictive power.

Example (institutional):
**I:** How do you choose between scientific theories? Do you say one is better than the other, or?

**Psy:** During residency, you do have this tendency. You search and have periods when you think, nonsense, all this overcomplicating, medication has a clear effect... and then you backtrack... to get into a different perspective. But it remains a difficult search. I have never succeeded in writing off one of those perspectives or theories. But I also think they're insufficient, the theories. I tend to look for common factors. Attention, patience, seeing the person, the delusions, the delusions of the person, paying attention to the movement. These are all aspects that I think are all important and effective, but not specific to one theory. But I force myself to not be more assured than I am entitled to. I could make things easy for myself... but I wouldn't be doing justice to reality.

**I:** So if you want to do justice to reality, you say, you don't have a good foundation on which to write off a theory.

**Psy:** Yes. It's a struggle. It doesn't make the profession meaningless though. These people have burdensome complaints, and I think, to put it simply, that people are most helped... maybe that's a kind of theory, a view of my profession... that you do your best with your best reasoning, the best application of different theories... Our profession then is bit of pulling and pushing. And you often find a way through. You needed be ashamed of that. It often works. Pulling, pushing, a little of this, a little of that. I think that's the best you can do.

**I:** So it's a very practical profession, grounded in pragmatic practice.

**Psy:** Yes. But I also have a kind of ideological idea that I... The interplay between experience and values I think is very important, very essential. The person-centred approach, whatever complaints someone has, I think is very essential. Maybe more
than others. Keeping an eye on what is troubling someone, has in himself, how he as a person is going about things, that is often much more important than trying to change the person.

In this excerpt, the participant connects the pragmatism involved in choosing a theory that is optimally applicable to the presenting problem(s), with special attention to the particulars of the person and the problem(s) at hand: the person-centred (idiographic) approach is essential, connected to the importance of (personal) values and experience. Here epistemic values are clearly in play, supporting the idiographic perspective.

Example (institutional setting): the discussion has been focused on the value of current and future neurobiological, etiological findings, and the status of psychiatric science.

**Psy:** In somatic medicine, it’s sooner clear whether someone needs a certain operation, I think. Though it’s not all cut and dry there either. But see, you have certain basic data. Your antipsychotics for psychosis, though that also isn’t that clear by the way! (Laughs) Because they’re given for different things now. But let’s say: we have a fairly clear system for pharmacotherapy, and its indications. It’s wise to adhere to those recommendations. And if you do your work with reason and a warm heart, then you generally do it better than if you follow the rules to the word.

Later in the interview, he added these comments on his own professional values:

**Psy:** The first thing that springs to mind, I’m not sure whether it’s a value, it’s very guiding for me... that you see a person as he is. At least, you try. That you don’t judge someone, categorize someone, that you don’t project your own hypothesis over someone. That’s very difficult, by the way! But that you really try to hear what someone is saying and you try to understand that in their context. And that you assume that the patient is speaking the truth, and that what they say demands respect. I’m very focused on the patient as the center of things. As information, information of the truth which you have to work with.

In these excerpts the participant supports the aspiration to base practice on nomothetic knowledge (inductive or deductive) but also clearly reserves legitimate space for the idiographic perspective.

### 6.1.2. Legitimacy

**Therapeutic outcome and pragmatism**

In its most superficial sense, this relates to the basic charge of the physician, to act
as an agent towards improvement. Most participants’ highest value, unsurprisingly, is whether or not their patients get better. The products of science are tools to that end, not ends in themselves (as shown previously in the primacy of pragmatism over truth value: ‘if a rationale works, it need not necessarily be true’). The professional charge or remit may demarcate/limit Level 1 (e.g. ‘help request). Outcome is seen to have a necessarily ethical dimension. The importance of therapeutic outcome of the patient also mitigates downward penetration of institutional values/concepts or personal theoretical perspectives which are seen as or prove to be incompatible with patients’ or professionals’ views of good outcome. Therapeutic pragmatism can have a deeper foundation in a philosophy of science perspective in which absolute knowledge claims are viewed skeptically, and there is reference to changing paradigms, cultural and temporal influences, as shown above under the ‘paradigm’ theme.

The previously mentioned acknowledgement of the limitations of practical scientific knowledge in psychiatry leads to a form of legitimacy for eclectic, pragmatic forms of practice. The sense of pragmatism used here is in relation to ‘good outcome’ for the patient. The leeway that scientific uncertainty affords also leaves room for personal and professional values in guiding practice, which will be discussed later.

Psy1: this participant works at the polyclinic of an Academic Hospital. The discussion is on science and legitimacy.

**I:** Your practice. Do you see what you do as a scientifically guided activity?

**Psy 1:** Can you specify that question a little?

**I:** It’s about the foundation of what you do, why you do what you do. So how you treat people, pharmacotherapy, intakes, everything that may be grounded in science.

**Psy 1:** I think it’s a hard question to answer. From a very technical perspective I’d say yes. But my interaction with patients is a result of who I’ve become. How scientific am I then? So I don’t know.

**I:** Let me put it differently: “Not all my actions are a result of scientific analysis.”

**Psy 1:** Not everything springs from an RCT, that’s impossible. How I respond to a person in an intake, that’s very personal of course. That is not something that has been proven in an RCT or may be the most effective intervention that he or she needs.

**I:** What are your views on the perspectives in psychiatry, as a therapist who is involved in personal contact? If I say that at least part of what you’re doing can be captured in an RCT, in a more general way, not at the micro level.

**Psy 1:** Not at the psychodynamic level we were discussing. Of course, it would be very nice if that could be the subject of scientific research. But if we must prioritize there are other areas, like neural networks and substrate conditions... I think are more
important. A lot of that interaction will prove itself in practice or be rejected in practice.

I: Does that imply that you could conclude: the strictness with which you ground your practice in science should be mitigated based not only is reasonable, but also measurable?

Psy 1: Can you give me an example?

I: Let’s say you apply psychodynamic theory. Then I could suggest that psychodynamic theory is unfalsifiable. There may be some research supporting the effectiveness of psychodynamic therapy but at the level of micro-interventions or understanding I could advise against its use. The theory is unsustainable: it uses unproven and unprovable concepts. Now you might say such criticism is radical...

Psy 1: What’s the alternative then?

I: Don’t do it. Talk to people, but don’t use the theory. Use something else.

Psy 1: So you’re implying it could be harmful?

I: Yes. I’m taking a strong scientific position and saying: you’re paid by the community, you’re a scientific professional so you’re obliged to use concepts that have proven themselves. CGT, for example. No more talking of transference, talk about cognitive schema’s.

Psy 1: Yes, you notice that as a therapist, given the fuzzy nature of the scientific information on this kind of interaction subject, you make decisions primarily based on your own experience and insights, at this microlevel.

I: Yes, but are you saying that...

Psy 1: In one case it’s your personal judgment that a CBT-like approach will have a better effect for a certain problem. In the other you might view a situation more from the psychodynamic/psychotherapeutic perspective. And in another you’ll combine the two, maybe. You see what approach gets the best response. You’re doing research in practice by observing what gives the best response. The latter I define as the best.

Psy 2: a briefer example, from private practice, that is representative of the participants:

I: Do theoretical ‘schools of thought’ play a role in your practice?

.. (discussion on what is meant by schools of thought)

Psy 2: Hmm, what would have inspired me? I think I use things from diverse schools. Sometimes I make a dynamic interpretation if I notice it helps. I use, I think, behavioral approaches pragmatically. I think I try to integrate a lot of things. I don’t think that a biological perspective alone is fruitful.

I: But are these conscious choices or has this been more of a gradual development?

Psy 2: I’ve become acquainted with different things and have formed my opinion of them. I’ve formed my own totality.
I: And your guiding concept is what is ‘effective’.
Psy 2: Yes. What helps, what in the end helps your client to move further.

Such remarks were made by psychiatrists from all three groups.

Psy 3: [academic setting]:
I: Psychodynamic theory, and its assumptions, what’s your opinion of it, as a theory?
Psy 3: I don’t know. I don’t have a fully-formed opinion on the matter.
I: Is it important to have an opinion on this question?
Psy 3: I don’t think so. I can do my work fine without it.
I: Well, it’s about an explanatory theory, it’s one example. If psychiatry is an applied science, then it should develop scientific theories, test them and their etiological theories. So a psychiatrist should have an opinion on these theories, whether they are good or bad. But you haven’t got an opinion.
Psy 3: It’s not my aim to test theories. My aim is to understand the patient.
I: Explain the difference to me.
Psy 3: You’re asking me whether I have an opinion, as a scientist, on psychoanalysis. As a scientist, I have no opinion on the subject, and I haven’t delved into it. But if you were to ask me for an off-the-cuff opinion I’d say it can’t be based on evidence (at least, the psychoanalytic theory). Being involved in psychoanalysis hasn’t actually established a theory in my mind. It’s established a way of working. The curiosity of exploring together with the patient how it’s all put together.
I: But do you think psychiatry should be accountable for the scientific standard of its causal theories? Evidence, for example. Applying theories in practice that are supported by facts? Or, if I understand you correctly, the theory you apply, you might apply some aspects of psychoanalysis, that helps me to understand the patient. If that works well, then that becomes apparent in practice, and that’s good enough. A different way of legitimizing oneself to society is through the effectiveness of one’s treatment.
Psy 3: That’s certainly the most important...
I: Yes, but there are people who say that’s all fine that you want an effective treatment, but they don’t think it’s enough because the medical profession should use the scientific method, and that includes testing the theories you use. So not doing that is too relativistic and that raises the question: how scientific is psychiatry. People might as well go to a quack selling snake oil and making them feel better. So, what kind of science should psychiatry be?
Psy 3: Medicine exists to treat patients. That is the final arbiter. I think a well-proven theory can be very useful to practice medicine but it is not absolutely necessary. If you have a method that demonstrably (through scientific research) works but you don’t know how it works, I wouldn’t care. Of course I’ll remain interested in how it works,
but in the end I’m applying it already. What the theory is, is not necessary in order to treat the patient. It is handy to have and to improve your therapies and to understand why it helps one person and not the other. But a theory is not a necessary condition. If it were, then we wouldn’t be allowed to practice psychopharmacology since we don’t really understand why antidepressants work. If we weren’t allowed to practice things we don’t understand fully then a lot of what works in medicine would be forbidden. And especially in psychiatry!

This last example, taken from an academic psychiatrist, clearly sets the aim of treating patients as the central value of medicine. Therefore, (scientifically proven) effectiveness is essential, scientific theory as to how or why something works, through which etiological pathway, is secondary. Note the alignment in the responses, pointing towards traditional models of science, it being associated with RCT’s, biology, evidence.

Scientific Legitimacy
The scientific legitimation of practice was related to both natural and human science, though the alignment of professional scientific legitimacy was stronger towards natural science than to human science. As stated previously, causal indeterminacy was a frequently reported argument for granting room for pragmatism and the application of clinical judgment. A common connection to the primacy of therapeutic outcome is the generally held belief that the effectiveness of treatments should be empirically supported, conforming to EBM. The primacy of therapeutic outcome was also present in the seemingly paradoxical satisfaction with etiological uncertainty and uncertainty on the validity of psychiatric and psychotherapeutic theories.

Example (academic setting):
I: Can you say what you base your practice on as far as scientific theories go?
Psy: I feel the urge to say: NOT, but that’s not entirely possible. But if you ask me whether there is one... If I look at how I filled in the questionnaire, probably not. I think I’m very eclectic.... (expands on residency training and experiences with different psychotherapeutic approaches).
I: How does this relate to science, your development, and that of other psychiatrists. It's a very different image than that of a classic natural science training, like chemistry or physics, where you learn laws. Like relativity theory. Every physicist knows it as should know it. But that doesn’t go for psychiatry.
Psy: Thankfully not.
I: Thankfully not? But what is the case then? Can you say something about theory development in psychiatry. Is it scientific or not? How should we see this?
Psy: Thankfully not, because that’s the biggest challenge there is. I’m sure that’s the best there is.
I: What does it yield for you... that you can discover?
Psy: It gives me a palette of possibilities. No corset, no structure I’m stuck to, I can switch where necessary. The disadvantages: opponents might say: “Yes, but then you can’t fully exploit the resources of one theory.” That is certainly true because I don’t know myself. Switching between theories, including biological theory, is part of this. I think the patient, and myself, we both feel most comfortable with this.
I: Could you say, instead, that you do apply some corset of theory, in the sense that you base yourself on knowledge, but from different domains? Biology, psychological theory, but different forms of knowledge, not leading to one single theory being so dominant in practice that it becomes a corset?
Psy: In fact I only have one theory, and that’s all directions together, that is the theoretical foundation I use.
I: Kind of a foundation for eclecticism?
Psy: Yes.

A theme mentioned by most participants was the acknowledgement that science hasn’t actually, so far, delivered many findings of practical relevance to psychiatry. Though all participants are supportive of evidence-based medicine and show evidence of using this approach in practice, they note that there are no uncontentious etiological theories in psychiatry, and no theories with such predictive power that they are prescriptive of actual practice. In the above excerpt, the participant says “Thankfully not,” indicating his satisfaction with the ‘palette of possibilities’ the lack of scientific evidence pointing towards one singular approach affords him. This ‘deficit legitimacy’ was echoed by a substantial number of participants, and is connected to a traditional view of science: psychiatry either comes up short from the natural science perspective or is a ‘young science in a highly complex domain’. The main domain in practice where scientific research is relevant, is in pharmacotherapy. Sources of scientific knowledge from the EBM perspective are (mandatory) professional guidelines, scientific literature, and (to a lesser degree) symposia. A number of participants mention applying knowledge from basic (neural) science to their pharmacotherapy approach, modulating the EBM perspective in this manner.

Examples.

Psy 1: A participant from the academic group. This example puts the above ‘deficit legitimacy’ succinctly.
I: What role does science play in your practice?

Psy 1: As in practice and as legitimation you mean? I’m tempted to say that science is of substantial importance. If something has been well-researched then that is very helpful. And I also believe that evidence-based medicine tries to ground itself in that science. Besides that there is a lot that science has no answer for so you’ll have to improvise. A very large part of our practice is improvisation or intuition or feeling things or doing things. There are also a lot of specific factors going on and something can be said about these from a scientific perspective. From a different domain, I think that you have to make sure the therapeutic relationship with your patient is good, even if it’s about pharmacotherapy, that’s a scientifically grounded strong factor. Which is sometimes overseen in scientific discussion I think. In academic centers, I sometimes have the idea that there is a strict focus on this is it and what it should be with regard to medication, so quite strict, a protocol that becomes a bit narrow. So my idea of science is as helpful from many angles...

Psy 2 (private practice):
I. Okay. A different subject. Science. Can you tell me how you use science in your practice?

Psy 2: I use what I read. Professional literature. That’s where I read about the state of science and I take my things from that.

I: And does that work well for you, with this psychiatric science?

Psy 2: Hmm, tough question. If you look at the way I’ve been describing my views of the profession then I think regarding science, it doesn’t help me.

I: What doesn’t help you?

Psy 2: Scientific information, or maybe I read the wrong books or magazines, but I read what on average everyone reads which is articles on imaging studies, pills and biology. What helps me most, but what I in fact don’t read enough, is magazines on forms of therapy or psychotherapeutic practices. I do read them, but not enough psychotherapeutic magazines.

I: But how do you explain this discrepancy then? You literally said that what you read isn’t helpful. Why read it then?

Psy 2: Well, I read the magazine Psyfar (journal focused on pharmacotherapy). I prescribe quite a lot of pills so I feel I should stay up to date, and it also gives me points [this refers to re-licensing, AR] so I don’t have to go to symposia. I hate symposia.

I. Why do you hate symposia?

Psy 2: On this kind of subject, pharmacotherapy, it’s all about trial this and trial that, that’s unappealing to me, and hardly informative. I’m reading an old book now about
difficult clients. I really like reading that. I also read a lot about Acceptance and Commitment Therapy. You might call this science. Contemplative works.

In this excerpt, the participant laments the orientation of most psychiatric literature, noting his own preference for more therapeutically-oriented works, and criticizing the science approach of EBM. A substantial number of participants supported more pluralist views of science (see under pluralism/monism) and for them, pragmatic pluralism was not a ‘deficit’ position, but philosophically defensible.

Psy 3: The science on etiology has produced much less. That’s why I think I scored lower on the biological side (MAQ). I view it still as of very little relevance to clinical practice. I don’t mean medication but more the neurobiological processes or the HPA axis etc. It is still the case, and that’s very unfortunate, that you don’t need the pathophysiology of our disorders to understand a disorder and to understand and treat the patient. In the other medical professions that’s different. Much more directly linked.

Most participants’ views of science are of natural empirical science. When thinking and speaking of science in psychiatry, they refer to evidence-based medicine, clinical trials, imaging studies, pharmacotherapy. As mentioned before, a conceptual complex is involved in which a certain view of science (natural) is connected to classification, material objects, material forms of treatment (pharmacotherapy, ECT) and a biological view of mental disorder. Coupled with the view that the science of psychiatry hasn’t provided many clinically relevant findings, this may result in a certain degree of scientific humility in participants. This was certainly the case with regard to etiological knowledge, as evidenced in the reticence to make pronouncements on etiology in written reports. However, most participants were upbeat about the scientific development of psychiatry and especially its ‘turn’ to descriptive and natural science from the Seventies onwards. Many participants were hopeful of future scientific discoveries being able to offer a more robust foundation for psychiatry, and showed evidence of progressive natural science views, but equally there were many who were skeptical or had principled objections to such a development. A number of participants was aware of the division between natural and human sciences and wished to ground psychiatry in both.

Here two examples of the optimistic, naturalistic perspective.

Psy 1 (academic setting):
I: I’m interested in your views on the development of science in psychiatry. How has it gone and where are we now?
**Psy 1:** Well, where are we now? Firstly, we have made a tremendous step forward (I always compare it to the time when I was in training [this was in the early Seventies]), it's unprecedented. There is fantastic scientific research being done, we know a lot more about which treatments are effective and which aren't. Less – more. Of course, there is still much that we don't know but if you look at the bright side then I think we have made a large step forwards. On the side of diagnosis, I think we now have structured diagnosis which may have gotten a lot flatter (the DSM, the classification) but is has supplied unicity. And that's very valuable. But you have to move further.

**Psy 2** (academic setting):

**Psy 2:** I see psychiatry as a medical discipline in which natural science clearly is at the forefront. So when I talk to people I think in terms of functions, functions of an organ, the central nervous system. If that doesn't function well, as with depressed people which can develop due to stress and prolonged exposure to external difficult circumstances, circular flows develop in which certain areas of the brain are less active or overactive...that's how I view it. That's the medical approach to my profession. The functions of the brain.

An example of a participant with a wider view of science, from an institutional setting:

**I:** How do you use science in your practice?

**Psy:** Define ‘science’.

**I:** Okay, start with that question then! (laughter)

**Psy:** Well, measuring is knowing. But knowing is also experiencing of course. There are different degrees of knowing. Some say that the highest form of knowing is that coming from randomized controlled trials but the problem is that those are always about patients that aren’t your patients. They're never the same kind of patients, they're a selected group. I mean, what person or family lets himself be treated with a placebo antidepressant if he’s really depressed? There’s something strange about that in the first place.

...  

**I:** So what’s the current state of science in psychiatry?

**Psy:** To a large extent it’s a human science. It’s not just natural science. And the state of it today? I think that it’s pretty good that we, together, not on an island, generate questions and that you study these as well as possible, you publish and discuss these. That’s of value. But what then also becomes apparent, and I think that’s typical, is that non-specific factors in encounters are the most important. What method you apply, that’s far less important. I think that’s a very important finding. That kind of
puts me...If you practice with a warm heart and a cool head, you won’t mess up too quickly! Then science will not be able to prove you’re doing it wrong!

**Professionalism and professional expertise**

If the professional role is that which requires legitimacy, it is logical to expect the adequate fulfillment of this role to serve as legitimizing. Related to this category were such features as clinical judgment, expertise, professional and personal ethics. An aspect easy to overlook is the primacy of the professional charge: the legitimacy of the professional charge has primacy over other forms of legitimacy. That is, fulfilling the duties assigned to the profession are the hierarchically highest legitimizing factor for participants, over such things as scientific legitimacy (evident in the view: it’s more important for something to work than whether it’s true) or good outcome (as this may depend on extra-professional factors). The previous section on scientific legitimacy already pointed to a slightly hierarchical relationship between professionalism and science: either through ‘deficit legitimacy’ or through philosophical pragmatism/pluralism, it was the professional him- or herself who was required to make a judgment of the applicable theoretical perspective. The notion of sovereignty of this judgment, described in Chapter 3 as clinical realism, underlies the legitimacy of this judgment. The profession of physician is conceptually aligned with material-biological-neurological concepts. But as shown previously, personal views on legitimacy are broader: both theoretically (eclecticism and pragmatism) and philosophically pluralistic (encompassing both human and natural science) notions feature strongly. This may lead to tension between the personally held view of professional expertise (from the embedded practice perspective) and the explicit or implicit legitimacy held up towards society of the profession.

Example of a psychiatrist working at the time both in his own private practice and in an institutional setting:

**I:** So my question to you is: How should a psychiatrist legitimize himself to society?  
**Psy:** Yes, he should. But he shouldn’t do that at the expense of everything and at the expense of his own identity. If so, you lose yourself. What I do see is the other side. The ‘scientification’ of psychiatry. In my view, it has highly deleterious effects. I see the young people I encounter, especially emphasize this. And they’re always going on about results and spin-off and diagnosis has a prominent role and attached to that without a doubt there has to be one direction, one line and a maximum number of sessions connected. That’s how it goes. It’s almost a calculation, a scientific calculation that is done. I know the managers sitting there have that even more. They share that with the people entering there. They didn’t do it to me since it’s apparently
pretty hard to find psychiatrists these days. You’re a scarce commodity and then you have more freedom. I know the oppositions. I avoid confrontations. What I actually do is the idea that is the most important in therapy, that you meet people and you talk to them. If I see with others there’s a discussion like, how should this be done? I tend to say: “Well, go talk to them and see where that leaves you and don’t focus too much on the result.”

I: Can you tell me what the negative consequences of this development towards science are in your opinion?

Psy: The main thing is that symptoms, that people present with and are troubled by, have to be removed as soon as possible and that the meaning of those symptoms has hardly any value. It’s like a disease. You have to remove the disease as soon as possible to get the patient better. The whole mechanism of how the symptoms arose is skipped, so to speak. That’s of tertiary importance and should be gone as soon as possible. I notice this very strongly where I work. I always try to say the symptoms aren’t there for nothing. If you take them away I don’t know what has happened. Because, someone has produced them with a kind of logic behind them which has brought forward this symptom, which you must respect. You can look into this and examine what has happened. See whether or not there is a different way to express the conflict or the trauma underlying it. Other than simply removing it with medicine or with behavioral treatment.

As a standard part of the interview, participants were asked not only whether the intake was representative of their everyday practice, but also to what degree the practice shown conformed to their ideal of how practice should be. This question served to open up tensions between their personal professional ideals and the constraints within their respective settings. Sometimes participants spontaneously offered their views on professional ideals, as in the following example.

Example, institutional setting:

I: We saw this intake was aimed at performing a personality examination/diagnosis and we have two questions here. Firstly, what does that entail for your approach? And secondly, is this representative of your daily work or do you get different questions and follow a different approach?

Psy: This is representative of what I like to do. Not of what I’m always able to do. It depends on the kind of question, what kind of diagnosis. Because sometimes that can be a lot more psychiatric. I note that in this intake I miss that aspect. Since the question also involves bipolar disorder and my conclusion is that I don’t have indications for that. Probably not but that isn’t apparent from the report. Since I didn’t ask a lot about facts. Are you sleeping badly, are you busy... So it kind of
depends on the question involved and the time I get for it. That is a tension these days. That you don’t get as much time any more to perform a psychodynamic investigation like I learned and the way I would like to do. Which is much more about biography but taken in a certain way, namely more towards an adult attachment interview, in which language again is very important, and in which you try to interpret what a patient says and how he says it.

... 

I: So you began to say that this is an example of how you like to practice. It was demarcated by the kind of question you receive but also by the amount of time given by the organization, which has said you get a maximum of so much time for this question, and so much time for that question. 

Psy: Yes. It’s not as if it was said aloud, that you can’t take more time, it’s more of a vague pressure you feel. About how much production you’re making, and this can’t be done, psychiatric examination what is that exactly? My impression is that these are two different things, psychiatric examination or what I’m doing. But in my experience, they’re not that different.

Professionalism involves the practical application of scientific knowledge. Previously, we saw how pragmatism and pluralism featured strongly in motivations for applying certain theoretical approaches consciously, whilst aligned theoretical understandings may function in a more passive manner. Participants however also described a hierarchy and certain requirements of the clinical situation as necessary conditions for the application of knowledge.

Example, academic psychiatrist: 

I: You have incorporated knowledge from many areas. But when you then go to work as a psychiatrist, what knowledge do you need and use then? 

Psy: It starts primarily with making contact, with conversation skills. That is the basis for everything. Making contact with people, mastering your conversation technique, having a repertoire at your disposal with which you can be succinct and to the point, or receptive and patiently attentive. That’s how you build things. That’s the basis of our profession. Mastering as many of these things of the palette as possible. Also, the dynamic that develops between you and the person or the system opposite you, mapping that. Once you’ve mapped that, you build towards the condition. You have techniques for that. Besides that you assess very well whether someone is clear of mind, whether there aren’t any strange cognitions. Once you’ve done all that you see whether someone’s ill of healthy. And if you think someone’s ill, what do you find there? Are there neurological diseases, or endocrine diseases? That’s how I build my story.
This example demonstrates a sequence of events that the participant describes as a set structure, one in which ‘making contact’ is seen as a condition to provide access to other facts. Again, practical knowledge and expertise is prioritized over theoretical grounding. The same was true for most participants, who stressed this primary requirement, one that requires professional expertise. This aspect is closely connected to the feature of the shared nature of the DEF noted in Chapter 3: it safeguards the general requirement of ‘contact’, a term used by participants to denote expressing agreement with respect to the DEF and other positive aspects generally subsumed under ‘therapeutic alliance’. A further aspect of professionalism is that one of its outcomes is that the patient should feel understood. The implication hereof is that the legitimacy of the meaningful mode of reasoning is primarily grounded in professionalism and the pragmatism of striving towards good outcome, rather than in science (a majority of participants associated science with natural science rather than the human sciences). The hierarchical nature of individual professionalism versus scientific legitimacy suggests applied knowledge, including the expertise to judge which theoretical knowledge is applicable and fruitful for the individual case, operates as a more basic grounding of practice than the scientific validity of related theory. This underscores the tension between the personal, professional legitimation professed by these participants, and the historical precedence of the ‘natural science perspective’ as a dominant legitimation for the profession of psychiatry. Meanwhile, however, there are signs of tension between the room for professionals to make such choices, and institutional constraints (see below).

6.1.3. Professional development and theory choice

*Personal and professional clinical experiences*

Whether through observing the practice of others, or practicing themselves, participants throughout their professional development evaluated treatments and therapies both on their effectiveness in treating patients, and on their own personal capability to treat patients through these methods. It was notable that generally speaking, they did not reject certain approaches on scientific grounds, mostly because even those theories which were seen by some as being scientifically questionable (such as psychoanalysis) were also seen as being effective (the primary value and legitimacy). Influential personal and professional experiences could be positive or negative. Some participants pointed to specific ‘exemplar’ experiences which affected their preferences for one or another approach. In psychiatry, explanatory theoretical views are often connected to treatment approaches (as in the ‘psychotherapeutic schools’). This connection
proved also to connect practical experiences in this category to support or disaffection with theoretical/therapeutic approaches. Psychiatric theory, therefore, from residents’ perspectives, is evaluated from a practically engaged position.

An emerging theme within this theme was ‘affinity’, a term regularly used by participants to express support for a theory/therapy approach. Affinity we defined as a positive, reciprocal influencing and reinforcing of personal-professional values, evaluation of validity of theories, and personal and professional experiences surrounding a theory/treatment/therapy. The term captures this sense of being both supportive of the theoretical and the practical merits of the approach: it is not only the experience of the effectiveness of therapy, but also an experienced capability or expertise, in the sense of being able to practice well within an approach. The latter also confers a sense of pleasure, and the phrase ‘liking’ a therapy was used by a number of participants. This sense of liking can be embedded in practice, in the sense that many practices can be enjoyed, in which ability and affinity may converge: you enjoy playing tennis, you practice more, you improve. But there is also another sense of affinity, which lies in agreeing with certain tenets of the theory, or with certain values that are implied or explicit in the theory.

In the following, some examples of formative personal, professional experiences.

Psy 1 (institutional setting):

**Psy 1:** When I was 18, straight out of middle school, I started studying medicine. I finished it in the allotted time. After that I started on doctoral research, very briefly. That was in X. Biological markers for schizophrenia. I did a stress test. I thought this was just the thing for me when I was studying medicine. I thought: I’m gonna be a biological psychiatrist. All very interesting. First maybe a neurologist, and then go into psychiatry. But on my neurology rotation I thought it was a bit dull. I really wanted to be involved in the higher cortical functions and it turned out that that was more a psychiatrist’s work than a neurologist’s. That’s how I arrived at psychiatry. But after a few months of my research I found that there were a lot of questionable assumptions involved, and to cut a long story short we agreed that I would terminate my involvement. I went into practice and worked for a year at a classic Riagg in Z. This was an ambulatory neighborhood team. This team welcomed me and I seriously meant what I said, when I told them, that I maybe didn’t actually think that talking was that important. I thought: let’s just influence those brains. Medication, generally. Well, they all laughed heartily at that. It was a fun and formative year! I learned that talking is also important! And that was quite interesting. That psychotherapy is effective.
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The contrast described by this psychiatrist may be an example of the ‘epistemic jolt’ described in the previous chapter: the participant, in the space of one year, and based on clinical experience and peer relationships, moves from a reductive materialist view towards a pluralist (‘talking is also important’) perspective.

Here an example of personal experience outside professional training or practice, from a privately working psychiatrist. The excerpt follows a discussion in which this psychiatrist explains being inspired by a supervisor to follow a psychodynamic perspective.

I: You can say that he as a person had certain qualities and a certain way of working that appealed to you. But then there is a certain step to say for yourself: Okay, I want to do this profession, specialize in this. What made you make that choice?

Psy 2: Quite simple. That has to do with the fact that I had some problems myself and went into psychotherapy, without knowing what it was exactly. Before that I had little affinity with psychiatry. I was interested in it and I was good at it, but I still thought very mechanistically like a doctor, an internist. I’m from a doctor’s family, so that kind of thinking you acquire naturally.

I. You describe it as mechanistic thinking?

Psy 2: Yes, just like disease, causal. Like that. When I did my psychiatry rotation I was mostly occupied with how the brain works, how medication works, etc. I had an examiner for my rotation, I was well versed in the hardware, and he was quite impressed so he gave me an 8, whilst the resident who was supervising me thought I wasn’t very empathic with patients. Ha ha ha! He thought it was really funny! I enjoyed that rotation. But anyway, after that I had some problems, that I won’t go into, but I started psychotherapy with a psychoanalytically schooled psychiatrist. And I kind of identified with him after a while. Both as a person and in the theory...these things overlap. Not the person himself, because he was there as a therapist, but more with the image, the figure sitting there. You create it of course. I met him later and I was a bit disappointed, when he was speaking normally. But that’s logical because you make something of it yourself in the dynamic. He worked from the analytical tradition. I integrated this in this way, and specialized in it besides my psychiatric training. Yes?

I: Certainly. So you had a clearly meaningful personal experience in which a certain identification occurs. And also because of this you’ll have a certain affinity with the whole way of thinking and process of analysis

Psy 2: Yes, I started to appreciate the body of thought of psychoanalysis. It also becomes part of yourself because of the long process.

I: So in fact you could say, the formation of theory and the personal process can’t be separated from each other.

Psy 2: In fact not, no.
**Personal and professional values**

These include therapeutic outcome, but also such things as autonomy, understanding, faith, personal growth (for the patient). They may also include, for the professional, academic curiosity, enjoyment of practice, and therapeutic success.

Besides professional role models and personal experiences, sometimes a certain overriding ideal or value could be highly determinative of theory choice, such as in this example of a participant (institutional) who explicitly stated that his general model was pragmatic.

**Psy:** In recent years I’ve been working with solution-focused therapy. Supervening above diagnosis, you could say. And partially inspired by this approach we have modeled our ‘front door’ and supported by management we really do perform stepped diagnosis, you could say. So, you don’t have to know more than is necessary. Necessary for the patient to be satisfied with his or her care. So for example you can start with the solution-focused approach and then you don’t know in advance what should come first. If people leave satisfied after three sessions then we’re happy too.

...  
**I.:** And what do you focus on in such an encounter?  
**Psy:** Can I find relevant things for treatment that help someone to advance? What can help? Always strongly focused on: is this of benefit to someone?  
**I.:** How does this differ from other encounters? It sounds like a general pragmatic principle, very general. It would probably also go for other encounters?  
**Psy:** Yes. I try to make a broad assessment of what could be the problem. But really a kind of a scan of all areas... and in later encounters, that’s all been decided. Then I’ve looked at it and we’ve thought this and that and we’ll carry on further on this track for now.  
**I.:** So in different encounters, I imagine, if I try to put myself in your solution-focused approach, you put less energy into exploration, then you much sooner move to pragmatically attempting to intervene and seeing what that delivers in the sense of progress?  
**Psy:** Yes. What helps or could help. The big difference is that in a classic psychiatric examination I’m the expert and in the solution-focused approach the patient is, in principle, the expert. What’s helped you before? Where are your strengths? What are your talents? What do you like doing and if you really think about it, what exactly helped you back then? Etcetera. So you’re putting the client in the center.

This participant’s pragmatism also extended to guidelines for pharmacotherapy:

**I.:** On the subject of pharmacotherapy. Do you follow the guidelines which are linked to DSM-categories?
**Psy:** In principle I do. Sometimes I’m pragmatic in this too. Guidelines don’t entirely exclude pragmatism. If people remain depressed with a first SSRI then I sometimes tend – if there are sleep disorders and if a little weight gain isn’t an immediate disaster – to add mirtazapine because it has a quick effect and instead of switching the one for the other of which I suspect a bit: Well, is this actually the case? So I explore the boundaries a bit. And I’ve quite often seen that it helps. There is some evidence for it, and it’s not in the guidelines yet, but let’s do a combination treatment of antidepressants. I think it works better. There is some stubbornness there.

Academic psychiatrist:

**I:** Can you tell me something about important influences on your perspective of the profession and your own professional practice?

**Psy:** I think I have something in my character (already had) throughout my residency training which was more directive than in X [city where P was a psychiatry resident]. I still have that in my approach to work. I’m not a long-talking, chronic patient doctor and good at psychotherapy. The psychotherapies I do, they’re mostly quite short, directive and combined with hypnosis, strongly focused on symptoms, no more than 6 or 7 sessions. Then people have to have recovered quite some bit. That’s different to my colleagues working at the day clinic. They think in months and years.

**I:** You say it has something to do with your character and in part with your training. Values can be of importance there, choices you make. Can you say something about why this direction attracted you?

**Psy:** I like it when people, where possible, quickly take responsibility or keep responsibility. I’ll seldom agree to taking over someone else’s responsibility. A little sweat never hurt anyone, not for me, nor for my patients. I tell them that too. “If you want to stay with me then you’ll have to do stuff.” A little running otherwise it doesn’t take. So, a little touch of the resolute. I also don’t like moaning and whining and that’s a bit of a taboo in our profession. It works quite well for me, and if some people want a different doctor, that’s fine. Most of my patients are very thankful. Even the patients that struggle to improve would like to stay a bit longer, even if they do get a bollocking every so often.

Another academic psychiatrist:

**Psy:** I don’t accept patients dropping out. I really want people to come in and then we’ll talk about it. If they don’t want to come then I want to have talked about it. Maybe we’ll stop treatment or choose something else. But I want people to understand that I’m involved. That sounds very forceful and in some cases, it is. But I do it on purpose because I think it’s very important.

**I:** In what sense important?

**Psy:** That people don’t feel they’re a number. That it does concern me.
I: Is it important for their healing process or do you think it’s a general human value?

Psy: I hope both. I think it’s important that it goes like this because I’d prefer to be treated this way too.

.....

Psy: I see it more as something from myself. I think I’m a person that does that generally. People think I’m nosy too. You could call it that too. If I see something in the street that I think is funny, I’ll go over there and ask what’s going on. If something happens to someone on the street I’ll ask people for help. I don’t have to do that either.

I: So your personal values and professional values correspond to your personal and professional style.

Psy: Yes. And I try to teach my residents this too. I sometimes miss this in my colleagues.

A recognizable feature of personal and professional values is a values hierarchy: the relative prioritizing of certain personal/professional values over the other, in a trait-like manner. This leads to ‘import’ affecting the structure of the encounter (see Chapter 3): e.g. high valuing of autonomy leads to a ‘following’ approach in the development of the DEF. Personal values appear to influence the way in which professional and training experiences are interpreted. Forms of professional practice demonstrated by supervisors may be valued or disvalued based on personal values and preferences, modulating the ubiquitous ‘role model’ influence:

Example (institutional setting):

Psy: My first supervisor had a very important influence on me. She was, in my opinion, a very engaged human person who had an eye for the person and was also very knowledgeable in many facets... A very capable and respectful, human psychiatrist. She gave me lots of motivation to do this. There have also been quite a few psychiatrists who gave me the motivation of: “Oh, right... that’s definitely NOT the way I want it.” My first supervisor certainly was the way I wanted it.

I: And can you say what made you appreciate this, a kind of agreement, distinction in good things, or less or not at all in others?

Psy: I don’t want to say others don’t do anything right but I also know psychiatrists who work very biologically and talked to patients for three minutes, didn’t talk to the people but just to the complaints... performed their practice in a very technical way. I don’t want to do that, I don’t like it.

I: So treating the whole person and the person-centered approach, that was something that appealed to you, good and important?

Psy: Yes. So things like patience, the calm attention in there, that appealed to me in my first supervisor. I strive for that too. I took that with me and hung onto it.
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This connection of shared values between the individual and the supervisor, or between the individual and values within a theoretical approach (for this example, in person-centered forms of therapy) is a feature of the category of ‘affinity’ mentioned previously. Note also the use of the concept of enjoyment as a motivator for preferring a certain way of working. This underlines the valuational aspect of such choices.

_Institutional influences_

‘Institute’ here refers to both educational institutes, the institute where one works, and professional institutions) including role models, dominant culture-carriers, and time-dependent local cultures. Local and national practices with regard to division of labor influence the professional remit of psychiatrists. This is the main area in which the three groups of participants differed (private, institutional, and academic). As was described in Chapter 3, both the professional responsibilities and the time constraints differed between these groups. These differences affected both the psychiatrists’ approaches and their way of thinking. Also included in this category is the _content_ of the codified knowledge represented in books, articles, guidelines etc. These are included here as the selection of such knowledge in respect to professional development, is first done by academic and professional institutions such as universities, teaching hospitals, professional organizations, or government overseeing bodies.

Examples:

Psy1 (institutional):

_I_: Can you tell me about your views on mental disorders, their nature, how you generally see this.

_Psy1_: Yes. This has obviously developed in the last twenty years that I’ve been in practice, and I think that in recent years I’ve tended to think but also practice more in the direction of biological psychiatry. And that practice mostly is due to the fact that we psychiatrists, I think, don’t have time anymore to do psychotherapies.

Psy2 (institutional): In this example, the intake consisted of a series of encounters between the patient and different professionals, in which a psychologist or social-psychiatric nurse did the first encounter and the psychiatrist subsequently (at a later date) performed a ‘psychiatric examination’. This division of labor was standard for this institution:

_I_: This was a pharmacotherapy consultation as part of an intake. What does this imply for your approach?

_Psy2_: I only have a limited time, and what I’ve read about the biography I won’t
repeat, so I skip a part of what I would do in an intake. I think I’m more businesslike than I would be in an intake. People generally know why they’re visiting me, so I usually don’t explain that unless I get the impression they don’t understand why they’re here.

I: What do you yourself see as the main difference between an intake and a pharmacotherapy consultation?

Psy2: Well, it’s more goal-directed.

I: What goal?

Psy: Well, checking whether the diagnosis is correct, judging whether I think there is an indication for medication, and if there is, giving information on the medication if there is still time left.

Previously, in chapter 2 we already drew attention to the fact that notwithstanding institutional constraints, individual views could result in diverging practice. Institutional arrangements can also correspond with psychiatrists’ preferences:

I: I want to get back to the constraints in a medication consultation...

Psy: I think it’s also me as a person, because I like to structure things, and I’m to the point, so it’s not just the setting and the client, but it’s also my own style.

I: It’s a style you’re comfortable working with, but there could be a view on diagnosis behind it.

Psy: I think it’s a combination.

I: What’s your view then?

Psy: That we have little time. But I think that if we did have more time, I would find it important to get a sense, quickly, of what’s going on and what has to be done. And yes, it also gives me something to go by.

These are examples of local institutional constraints. But participants also experience professional pressures to think in a certain manner. This fragment is taken from a discussion on ‘brain dysfunction’ in different disorders:

I: Someone with an antisocial personality disorder could have a brain dysfunction...

Psy: He does have a brain dysfunction, and maybe something happened at birth...

I: But why then is this seen as a being less of a brain dysfunction than in schizophrenia?

Psy: Well, then… it’s completely arbitrary. Completely.

I: So how do we get ourselves out of this?

Psy: We don’t. Ha ha ha. It also has to do with the pressure from science from outside. It used to be the case that your upbringing and society ruined you, but now it’s in the brain. You don’t make a good impression either, if you say that too much, that developmental idea, so I conform a little bit.
I: Is there a social pressure to think in a certain way with regard to causation?
Psy: Yes. Yes, I do think so. Absolutely, especially in our profession, yes.
I: And this influences you in actual practice?
Psy: Yes. Certainly.
I: And if there wasn’t this social pressure?
Psy: Then I would treat the material and the immaterial equally.

Institutional constraints can have a more abstract, academic character. This psychiatrist worked at an academic polyclinic:

I: Can you tell me what role your scientific views play in your practice?
Psy: Hmm, difficult. I think that in the hospital I wear the hat of my residential training: meaningful, existential, descriptive, but I’ve had to depart from that. Because the other, the natural science – biological model, obviously is so central today. If you look at psychiatric training after the turn of the century, it seems to be only the DSM. It’s become so descriptive. At the polyclinic, I try to use my old model from my residency period [related to meaningful understanding and existential concerns]. That is my frame of reference. Just numbering depressive complaints, etc., I find very reductionist. At the polyclinic you can give a more analytical description. I do notice some frustration in working with residents. Just descriptive work and then they’re finished, but the background often is missing. That bothers me. It’s difficult. I try to give them some sense of it but sometimes there doesn’t seem to be much interest for it. And it isn’t fostered by the training climate. Our professor is a very DSM-minded person. So.
I: So you could say that part of your practice is actually influenced by the view, and in fact the philosophical views, of a professor, who partially determines the training climate.
Psy: Yes, that reductionist model is far more reductionist than I would prefer. On the other hand it’s a challenge to do something with it from my point of view.
I: What do you mean exactly by reductionist?
Psy: Maybe the natural scientific, the biological, the descriptive. Identifying psychiatry with a sort of description, and that’s it. But there is a person sitting there. It’s not just a depression, there is a person behind it and who is that person then?

Finally, a different manifestation of tension arising from different epistemic values between clinical practice and institutions, was apparent in the analysis and discussion of intake reports and notes, in which it was notable that, compared to the codings of the intake, reports were primarily descriptive (See also Chapter 3).

Example, private practice:
I: Okay, we’re going to take a step here, because one thing we noticed in our analysis
was that in the encounter itself, which was coded, by adding a qualitative label to your interventions. So, for example, if you ask a question related to the experiential world of the client, then we code experiential, and if your remark is simply aimed at having the client carry on with her story then it’ll be coded as narrative. And what was notable, if you compare the verbatim report of your encounter with your own report and the letter to the G.P., was the relative proportion of medical codes. In the encounter itself they’re about 50-50, between more experiential/narrative remarks and descriptive-medical ones, the letter to the G.P. contains mostly medical codes. So I’m wondering why that is.

**Psy:** Because the G.P. expects that kind of letter.

**I:** OK so you’re saying...

**Psy:** He wants a brief, businesslike letter and a diagnosis.

**I:** Okay, he just wants a diagnosis. A medical diagnosis and prognosis. So the letter is clearly written from a pragmatic perspective.

**Psy:** Yes. Which doesn’t interest me at all. I’d just as easily leave them out, myself.

**I:** Right, just as easily.

**Psy:** Don’t care a jot.

**I:** Okay, those things have a purely communicative function for you then.

**Psy:** I do it because it’s expected of me.

**I:** How do you know that’s expected of you?

**Psy:** Because that’s the way health care works. They never asked me to.

**I:** No. Okay. Because you know the way health care works.

**Psy:** And everyone does this. And you’re asked for this all the time: DSM-codes and things.

In this excerpt, the value of the content of the report to the G.P. is clearly disparaged by the psychiatrist, who later in the interview aligns her professional values with intuition as a legitimate epistemic perspective. This not only emphasizes the discrepancy, but also demonstrates the esoteric quality of institutional influences: they are embedded in different areas within health care, all representing a certain (descriptive) epistemic valuing. The epistemic expectation does not need to be put into words: the psychiatrist simply knows how health care works.

**Alignment**

This is the feature of correspondence of personal, professional, institutional, role model, and theoretical values, ontologies, and concepts, increasing chances of top-down penetration of associated theory, concepts, and values (including epistemic values). E.g. interest in meaningful explanation, idiopathic understanding, and psychoanalytical theory/therapy versus opposed scientific views.
Different modes of reasoning identified at level 1 in Chapter 3 are conceptually linked by participants to different epistemes, and associated with different professional roles and professions. The descriptive approach, aimed at atomistic phenomena, symptoms, and complaints, is associated with psychiatric diagnosis, the DSM, and natural science. This conceptual complex is associated with the medical professional role.

Psy1, from private practice:

I: Sixty percent of the interview is about these things [narrative], after about three-quarters of the encounter a chain of questions on illness, weight etc. follows [shows transcription]. Then there is a number of psychiatric examination questions, and then you focus on medication. It looks like a switch in the conversation.

Psy1: Yes, yes.

I: Like you’re changing tack. Is that something you recognize?

Psy1: Yes, and I also put sexuality in there, because I think it’s an important subject, but because it’s a first encounter and it’s better in this phase, I put on my doctor’s hat.

I: Why is that a ‘doctor’s hat’?

Psy1: Because it’s very specifically the somatic side. And my legitimation towards the Inspection, attention to medication, that you really attend to the physical side, yes.

Psy2: in this example the connection between questions related to psychiatric examination, pharmacotherapy and physical aspects are seen as conceptually aligned with each other and with the professional role as physician.

I: In your report of the intake you see the same mix of life story and medical facts. In your conclusion you offer an explanation that stays close to the patient’s explanation, namely immense sorrow for her father. You choose to emphasize that aspect. Besides that you list a number of psychodynamic causes. In the encounter itself your own therapeutic contribution is pharmacotherapy. Is that down to division of labor?

Psy2: Yes, yes, that’s a very complex problem. I have to legitimize myself in order to be allowed to see her and that goes by way of medication (laughs). So if I don’t give her medicine then I can’t see her again (laughs).

Psy3 (institutional):

I: Can you say what your view is. That idea of paradigms that haven’t completely developed. Can you identify those in psychiatry? You just said: biological psychiatry and its assumptions, it says something about the relationship between mind and body, and according to you makes strong statements on where the cause lies or at least in prioritizing a causal level. Are there other rounded narratives in your opinion?

Psy3: Most obvious is the psychologist who doesn’t want to know much about biology. That everything is explained psychologically. The brain is quite static and maybe there’s free will, influence, and… I don’t know if this is relevant but I do often notice
when I’m working and trying to think in certain directions, inspired by books on solution-based theory, then I think that I should see something more as a doctor because it’s a bipolar pattern. Maybe it’s mild but it’s clear. Mood changes and such. Then I always feel a kind of a transition, a switch. Thinking: this is like a transition to a different story.

I: What kind of story?

Psy3: More biological.

Alignments are not just a one-way street, from local or professional institute to professional. Psychiatrists are aware of the role science plays in their professional identity and societal role, and they take up a position vis-à-vis the pressures traveling along the alignment vectors. In the following example, the psychiatrist (academic setting) connects a certain scientific perspective both to the identity of the psychiatric profession and to political debate on division of labor (between psychiatrists and psychotherapists).

Psy4: Sometimes we think we know something about neurotransmitters and that psychotherapy can influence neurotransmitters and that should be our way of thinking [of psychiatrists], that we should examine and stay interested in, and follow, even if it doesn’t pan out. But still, it’s our way of thinking. In this way we differ from the theologian or the psychologist... otherwise I don’t see the difference.

I: Yes. How we distinguish ourselves from other professions.

Psy4: Yes, I thought it was very strange that we wrote a letter to the Ministry together with the psychotherapists. I thought: that’s stupid! Then you’re saying that in fact you’re doing the same thing! In fact you have to say that a psychiatric psychotherapy, that’s not the same as psychotherapy. A social worker or psychotherapist can do that, they’re the same. Anyway, those are relevant discussions. That’s where science is a governing mechanism, together with all the limitations of schools of thought and scientific criticism...

The concept of alignment derived from the material is crucial to understanding one manner in which philosophical assumptions may travel to and from the psychiatric encounter. Time and time again participants spoke in terms of ‘in DSM-mode’, ‘the doctor’s hat’, ‘the biological, descriptive perspective’, connecting entities at different levels of abstraction from practice to each other based on shared epistemic commitments associated with these entities. The attachment of epistemic attributes to certain concepts and their use in practice ushers in the related epistemic commitments. However, both the dynamics involved in the development of the DEF and the hierarchical precedence here afforded to professional expertise, provide room for the professional to judge which
alignments will be involved in the encounter, and the degree to which they will affect it.

6.2. Summary

An informative way of ordering these findings is by conceptualizing the application of science in practice as taking place within a dynamic interaction between the phenomena themselves, the theoretical notions and applications of the psychiatrist, and the pragmatic goal of treatment. The theories participants mostly refer to are psychiatric theories, and these psychiatric theories are derived from biological, psychological, and psychotherapeutic theories. In practice, the theory is often connected to a form of therapy. The overall impression is that these psychiatrists’ psychological theoretical frameworks mostly consist of psychotherapeutic theories. These theories are partially judged on their face validity, consistency, empirical grounding etc., but equally, psychiatrists evaluate the practical validity of theories by practicing them and experiencing their results. This underlines the goal-directed emphasis of knowledge in psychiatric practice. Personal experiences, mostly but not exclusively in practice, were frequently noted as important influences on personal professional development. The concept of affinity captures the combination of critical theoretical acceptance, positive personal and practical therapeutic experience, and personal value alignment that seems to contribute to adherence to one or another theory. Given that affinity is also a dimensional concept, it captures the eclectic nature of theoretical allegiance in psychiatrists.

There is clear support for explanatory pluralism linked to clinical judgment and pragmatism focused on which approach will offer the best results. This judgment is affected both by the apperception of the nature of the phenomena themselves, in which we see evidence of causal dualism and causal essentialism, and pre-existing theoretical notions on the part of the psychiatrist, with respect to reductionism (in either material or mental/social directions) or degrees of affinity with a psychotherapeutic school. There was some variation pertaining to science views: a majority of participants equated ‘science’ with natural science, whilst a significant number also included human sciences, though retaining a perception of natural science as ‘real’ science. The aspiration to ground psychiatric practice in science received wide support, though there was some skepticism as to the feasibility of a naturalistic reduction. There was universal acknowledgement, however, of the limited scope and applicability of natural science knowledge in current practice. For most participants, EBM was also seen as having limited
practical utility as science stands, with the exception of the domain of psychopharmacology, though there were a few exceptions applying EBM in a broader and more thorough manner. Where a scientific knowledge gap was deemed to be present, legitimacy was sought through what was generally described as non-science based (but nevertheless professional) expert judgment, aimed at the central value of improvement. The scientific gap was also filled by personal, professional, and institutional values. For participants, this state of affairs doesn’t imply a lack of legitimacy: where science is present, it should be applied, but where it isn’t, their recourse is good clinical practice, which involves value-based judgments. One corollary of these attitudes is a conspicuous lack of causal/meaningful explanations in written reports to referring G.P.’s: these are generally characterized by descriptive language.

The latter is also an example of the negotiation and navigation of professional values versus institutional influences. There was evidence of the presence of factors akin to those represented by the ‘hidden curriculum’ concept in institutional settings, professional guidelines, and professional socialization. Prioritizing professional expertise affords room and power to the professional to mediate and modulate the effects of such factors, depending on their own professional values and convictions. Alignment is one of the ways in which concepts travel in and out of the encounters, or to put it in terms of the DEF, alignment is the vehicle for prompting (bottom-up) and penetration (top-down), the former emanating from the phenomena themselves, the latter constituted by the theoretical resources applied to the encounter by the psychiatrist, in turn partially populated by external epistemic values, imported via alignment. Psychiatrists may be more, or less, aware of these processes, and more, or less, conscious in their positioning towards these influences. In brief, in Chapter 3 we became aware of diagnosis as a dynamic, temporal, complex process, and here we see that the role of science, values, and applied versus theoretical knowledge is just as dynamic a process, again strongly grounded in personal, practical experience, and strongly guided towards the ethical goal of ‘good outcome’.

6.3. Discussion

6.3.1. Theory choice, development and practice

These findings accord with the literature on the sources of knowledge for clinical development described previously: knowledge is imparted in codified and non-codified ways, personal values and views are relevant to theory choice, role models and personal experience are highly influential (Arthur 1998, 2000, Buckman and
Barker 2010, Broadhead 1983, Gabbard 1985, Germer et al 1982). There is much support for pluralism and pragmatism, though in a substantial number of participants this was grounded in a ‘deficit legitimacy’ related to the ‘traditional view’ (Fulford et al. 2006) of science. In this so-called ‘received view’, facts and values are allocated to different epistemological domains, and a ‘values out’ picture of (natural) science is dominant. Naturalist psychiatrists seeking a firm scientific founding of their practice may espouse clinical expertise, tacit and intuitive knowledge, but see these as ‘second-best’ foundations, hopefully to be supplanted in the future by science-based recommendations. However, a number of participants also supported a ‘commitment within pluralism’ epistemology fitting a more advanced stage from the developmental personal epistemology perspective (Louca et al. 2004). The methodology of this study does not allow us to differentiate on the precise causes of the observed differences, though repeatedly academic training centers were connected in a general fashion to certain epistemic perspectives (e.g. describing the academic climate of the center as ‘leaning towards the DSM’), suggesting a role for context dependence in the development of personal epistemology (Hofer 2001). Especially in view of the pluralism espoused by most participants, the development of personal epistemology of psychiatrists seems like a very promising area for further study. With regard to the specifically medical grounding of psychiatrists, the association of medicine with natural science is also clearly expressed in this study, both in participants’ views of ‘real science’ and in the conceptual associations apparent in alignment: the ‘doctor’s hat’ is associated with description, RCT’s, EBM, DSM, biology, materialism. This accords with the findings of developments in medical training (e.g. Broadhead 1983, Woloschuk et al., 2004). We observed a tendency towards alignment of the scientific, ‘doctor’s perspective’ on the side of ‘real psychiatric diseases’ which were viewed as ontologically material (see also Chapter 3). Though we are reticent in proclaiming ‘models’ based on the research here, the consistency of conceptual alignments in this area are suggestive of Marcum’s (2008) biomedical and humanistic models, mirroring Jaspers’ classic distinction. Notwithstanding all the previously mentioned local and developmental dynamics, the distinction still seems relevant today. Epistemic legitimacy for these material phenomena (as worthy of being under the medical and mental health domain) was derived from science, and associated with a value-free judgment. Phenomena outside the ‘real psychiatric disease’ category could also be included within the domain, if connected to suffering and dysfunction, and if there seen to be a pragmatic value to offering help from the domain of health care. Clinical expertise was deemed adequate legitimation for this assessment. So when, through alignment, the professional is operating from the perspective of natural science, guidelines and transparency are required through various professional and institutional norms, whereas in the
‘clinical judgment domain’, legitimacy is derived from the expertise of applying the correct analysis to the phenomena, conducive to ‘good outcome’, and achieving good understanding of the patient. The former abstracts from the encounter, the latter stays within it. A possible further tension is between those professing an objective, descriptive approach to a phenomenon whilst actually invoking pragmatic considerations in the construction of explanations, as we observed in Chapter 3.

If we take the concept of the hidden curriculum in its descriptive, non-pejorative sense, then it can clearly be applied to institutional factors and pressures bearing on the professionals and on the professional encounter (cf. Hafferty and Castellani 2009). From the responses here, we would expect such factors to vary, according with the findings of Rabow (2014).

The relative lack of applicability of scientific findings mentioned previously does not seem to plague the participants: though they generally support (natural) science aspirations, they seem quite happy to rely on clinical expertise where the science isn’t ready at hand. In fact, Cartesian science/clinical skill dichotomies may be helpful for such a view: if the facts aren’t available, there’s room for ‘mere’ clinical expertise. But this is also supported by the view that the integration of scientific knowledge with the unique features of the clinical encounter is a specific and crucially legitimizing feature of professional expertise.

We noted in Chapter 3 that there was a tendency to create segregated and aligned associations of disorder (or symptom collection), causal essence (dualistically conceived) and therapy. Conceptualizing the phenomena in this way may help in issuing a sense of clarity: These two ways of knowing and practicing are sometimes consciously demarcated as we have seen, as different roles within the encounter (the ‘doctor’s hat’). The alignment between the role of the physician and the more material domain of psychiatry is, for many participants, a natural association, though frequently institutional arrangements are noted which determine this, and there is resistance to a reduction of the profession to just this one perspective. Though their view of science may prioritize natural science, their view of diagnosis and professional practice is broader and does, necessarily, involve the attempt at meaningful understanding. For many participants, (meaningful) understanding was seen as a foundation upon which other modes of reasoning, including the descriptive, could be built, and was seen as an essential part of the practice of diagnosis. Most participants, therefore, aligned their epistemic perspectives: natural science with description, human science (or individual qualities such as clinical judgment and intuition) with clinical understanding. This was seen as sufficient legitimation, especially combined with the overriding pragmatic aim of
therapeutic improvement. Psychiatrists see clinical judgment and expertise as a central foundation of their practice. These concepts are akin to applied knowledge (Khushf 2013) and phronesis (practical wisdom c.f. Dunne 1993, Sadler 2010) representing significant elements conveying legitimacy in the face of scientific uncertainty on etiology and theory comparison. Nevertheless, an internal tension ensues, as what is seen clinically as most important (understanding) has a lower position with respect to scientific validity: precedence is generally given to the ‘hard sciences’. Participants’ self-critical assessments of the scientific status of their practice reveal naturalistic views of science, whilst with regard to scientific aspirations, opinions seemed divided on whether a future reduction towards natural science was feasible and desirable.

But perhaps the chief finding here is the centrality of professional expertise, and the implication of a hierarchical relationship between applied knowledge above theoretical knowledge, as a central form of legitimacy, connected to the normative and pragmatic aim of good outcome. It is the space created by this appeal to a normative/pragmatic founding that allows professionals to take a position towards both the bottom-up pressures of prompting and the top-down pressures of epistemic views either embedded in institutions or traveling into the encounter via alignment. This is not to say all participants are equally conscious of this space and strategy and are equally successful at dealing with it. Sentiments akin to those in Donald’s work (2001) expressing dissatisfaction with the tension between professional ideals and local circumstances, and references to struggles with institutional constraints, mirroring the findings of Luhrmann (2001) elsewhere, were apparent (relationships between profession, society and science will be the subject of chapter 7). The activities of the psychiatrist in the DEF can also be seen as a set of philosophical negotiations aimed at ‘good outcome’: between the ontologies and epistemologies emanating from the phenomena presented in the encounter and those present not only in the psychiatrist’s repository of relevant theories, but also those embedded in the immediate and relevant institutional and social contexts that the encounter takes place in, and those that the patient travels in. Psychiatrists apply theories, causal stories, but also concepts and phrases pragmatically and sometimes strategically towards this aim. Pragmatic conceptualization is not limited to the spoken intake, but also takes written form, as evidenced by the psychiatrists’ frequent referral to the DSM system as ‘mostly used for reimbursement purposes’. A methodological by-product of this study is the finding that the written reports of psychiatrists need not represent their actual (epistemic) beliefs: they themselves may be products of the negotiation between the clinical encounter and embedded institutional epistemology, as evidenced here in a report that, for the psychiatrist who wrote it, was uninteresting and irrelevant,
but geared towards informing the GP in an understandable and again, pragmatic manner. In deriving philosophical assumptions from professional texts, therefore, this should be taken into account.

How improvement is defined is another matter, and here personal preferences, values, and judgment come into play, consonant with findings on personal traits in psychotherapy orientation (the ‘internal factors’ described by Buckman and Barker 2010). For many participants, an overriding value of patient autonomy and professional commitment to the patient’s welfare implies that it is the patient who should primarily define the sense of improvement being aimed for. Together with the frequently professed pragmatism of fitting theory to the problem, which accords with the ‘client fit’ model, and subscription to EBM where applicable, the factors described by the authors are recognizable in this study.

With respect to pragmatism, the question of ‘whose values’ are in play is relevant (Woodbridge and Fulford 2004). The preferences of the patient were sometimes overridden in this study, as in the case of the academic psychiatrist who, based on his understanding of the scientific evidence, constructed his intake as a form of motivational interviewing with the explicit purpose of motivating the patient to continue taking his medication, or in the case of the psychiatrist who transformed a simple question on the (dis)continuation of medication into a reflection on identity, based on a professional ideal of getting patients to think about themselves and their life (his version of improvement). Personal value hierarchies apply here and raise questions on the ethical legitimacy of practice which is legitimised so strongly by outcome and expertise. In other words, whose values are involved in determining ‘good outcome’? Are they made explicit, and if so, how? This study was not specifically geared towards elucidating these question, but it appears to be a crucial area for further research.

The perceived nature of the phenomena presented (as described in the working of the DEF in Chapter 3), combined with such pragmatic and value-driven goals, were prominent determinants of the chosen epistemology in this study. Such a finding also accords with the research on personal epistemology, in the sense that these could be examples of context-dependent epistemology. The fact that at least in part, such choices seem to be made unconsciously, fits with the idea that tacit, practice-based learning may include not only the adoption of certain ways of practicing and knowing, but also a metacognitive stance, in this case, of pragmatic pluralism. In other words: epistemic values may be transmitted both explicitly and implicitly (Sadler 2005, Gascoigne and Thornton 2014). Also, training effects on causal explanations were also apparent: peer pressure or the social/professional hierarchy of an academic division were mentioned as determinants, in actual practice, of ways of causal thinking. If we hark back to Eraut’s statement (2005) on
‘theories relating to the professional ideology’, the connection between the way the profession defines its ‘expert knowledge’ with regard to the social contract, and the implications this may have for actual clinical practice, becomes apparent. In other words, the implicit or explicit epistemology embedded in the public justification of the profession of psychiatry will find its way into the psychiatrist’s office through alignment and social channels, as a form of Eraut’s ‘cultural knowledge’.

6.3.2. The constitutional role of values

Values are present at multiple locations within practice. Most ostensibly they are in view in the centrality of pragmatism in practice, implying a value-laden understanding of ‘good outcome’. However, we saw in Chapters 3 and 4 that pragmatism was shown to play a deeper role in the construction of explanations and the selection of explanatory theories conducive to the psychiatrists’ understanding of ‘good outcome’. This chapter adds to that description a grounding of this practice in the legitimacy of professional expertise. This allows room for professional values relating to general goals of practice to influence lines of questioning. Add to this the role of values in professional knowledge development, whether at the personal level of professional and personal experiences of ‘good’ and ‘bad’ practice, or at the level of cultural knowledge and embedded epistemic values delimiting the scope of questioning, and it becomes clear that with regards to attitudes to knowledge and the use thereof, values not only play a highly central role, but also a role that goes deeper than previous models suggest: taking the model of evidence-based practice as an example, it suggests a distinction between objective evidence and patient values. However, the degree to which the practice of these psychiatrists is permeated by values deviates strongly from this model with values-based reflection stretching so far as to legitimize the choice to suggest, in the DEF, an explanation aligned ontologically in such a way as to promote the likelihood that the patient would choose a favored course of treatment. This underscores the necessity for a normative framework constraining such deeply constitutional values in practice, which may require a different view of the relationship between science and ethics to that espoused by the traditional ‘values out’ view of science (Fulford et al 2006). If values are constitutive of causal pathways and diagnostic constructs used in psychiatric practice, then ethics should apply to this area, an area currently (arguably) seen as primarily an area of technical expertise involving, primarily, identification rather than construction (Philips 2008, Philips et al. 2012d). This makes the inner tension between practiced science philosophy (applied, pluralist) and cognitively held philosophy of science (naturalist) all the more relevant.
Professional development, involving practically embedded knowledge acquisition and assessment, in which personal experiences and relationships with peers and supervisors were influential, is equally shot through with values. Epistemic values based in personal epistemology were recognizable in theory choice, but evaluations of theory and treatment proved to be inseparable from experiences of therapeutic effectiveness and personal competence. Actual enjoyment of practice is a factor not often noted in such developments (but mentioned here), but captures the confluence of the experience of performing one’s task well, successfully, and in accordance with one’s own values. The concept of affinity developed here aims to integrate this accordance of personal, professional and epistemic values, together with a critical acceptance of the related theory. Relating this back to the literature on knowledge and professional development in the first part of the chapter, these findings offer a suggestion of how explicit and tacit forms of knowledge interact in practical experience, demonstrating altogether different routes to acceptance and adoption of certain theoretical and therapeutic approaches than in natural science disciplines. Rather than theories having demonstrated their value through proof of the validity of their pathogenetic claims, as is common in other areas of medicine, in psychiatry the emphasis is on demonstrable outcome, which is assessed both scientifically through support for the EBM approach, and in practice through observations and experiences with therapeutic approaches connected to said theories. This latter point is supported by empirical, pluralist, and pragmatic philosophies of science, but also by the other branch of legitimacy, that of professionalism, where personal expertise, positive professional experiences of effectiveness, and shared values of the individual and the theoretical/therapeutic approach are relevant, expressed in the concept of ‘affinity’. The fact that participants do not assess psychiatric theory in a neutral, objectively scientific manner, does not imply that theory selection in psychiatry is unscientific: there is a substantial academic and institutional effort to study not only the effectiveness of psychotherapeutic approaches but also their etiological claims, and the same obviously goes for biological psychiatric approaches. These find their way into the codified knowledge which then is imparted to the psychiatrist. A central characteristic of any profession’s expertise is the local, contextualized application of such knowledge, and as should be apparent from the above, for psychiatrists, this takes place in a space that is theoretically, scientifically, and ethically diverse. The highest professional value, that of good outcome, becomes a destination towards which professional application of knowledge is aimed. According to our subjects, the current state of psychiatric science leaves a legitimate space for personal/professional theoretical affinities, intuition, and values. Framing personal values and intuition in opposition to science for some participants was evidence of naturalist and dichotomous (fact
vs. value, subjective vs. objective) views of science. Others grounded their space for pluralism in post-Kuhnian philosophies of science. As the participants selected for this study on average belonged to a relatively older age group, who in part received their residency training before the breakthrough of EBM, it would be interesting to study professionals in a younger age group.

The study of science and legitimacy in psychiatric practice underlines tensions already apparent in the process of diagnosis and brings new ones to light: where in the previous chapters on diagnosis we noted a tension between the classic portrayal of diagnosis in medicine as identification, and the practice of psychiatric diagnosis as identification and values-involving construction, in this chapter, the traditional model of science embedded in medical training stands at odds with the pluralism inherent in the applied knowledge of psychiatric practice. The tension runs within individual practitioners, depending in degree on whether their own personal epistemology allows room for pluralism as a valid scientific foundation. However, the prioritizing of professional expertise and pragmatism provides a further tension between the legitimacy of individual practitioners and the professed legitimacy of professional groups and mental health care institutions, in so far as they embrace a natural science foundation wedded to EBM, both of which mitigate against the centrality of the individual professional as epistemically privileged. Besides that, there were numerous examples of institutional pressure towards descriptive, empirical concepts which are less related to science than to managerial expediency. Given the alignment of such related values from professional, local, and governmental institutions, it is noteworthy that these psychiatrists carve out a space for professional autonomy in this manner.

Even if we have faith in the prospect of science being able to produce etiological clarity, the question how to proceed remains while we are waiting for these answers. Should psychiatry push further towards factually based practice, limiting the scope for idiosyncratic values in practice, or should it bolster the knowledge base with regard to values, as Woodbridge and Fulford (2004) have suggested? Perhaps the obvious answer is: why not do both? The problem with this latter answer, the ‘fact plus value’ alternative, is that it comes into conflict with the natural science ideal embedded in the cultural knowledge and public image of psychiatry. The tension between the natural science and human sciences view is expressed in the debate on evidence-based medicine, characterized by Falkum (2008) as a conflict between Aristotelean phronesis and techne. Veering more towards the one or the other has real-world consequences. From the point of view of natural science/techne/EBM, the practice we found would be in need of development away from the biases inherent in the knowledge acquired via
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‘mindlines’, away from individual psychiatrists’ value judgments of what makes ‘good treatment’, and towards a greater degree of implementation of the inductive knowledge already currently available through training and increased manualization. At the level of the social contract, the image of and aspiration to natural science has allowed psychiatrists to attain and defend their professional position in society. Altering the science base of psychiatry alters the terms of the social contract. With what we know of science views in society (see Chapt. 5) that might be a risky move for the psychiatric profession. Alternatively, the ways in which professional judgment and professional expertise are understood, might require alteration or enrichment, to accommodate the practices found in this study.

In his closing lines, Falkum draws attention to the connection between the ‘theoretical ideology’ and political choices with respect to resource allocation: “providers of health care may attempt to disinvest in established services for which there is no clear RCT evidence”. Since the publication of this article, the role of the evidence base in resource allocation has grown substantially. In the Netherlands, the Health Insurance Law states that treatment should proceed ‘according to the current state of science’. This was later specified to prioritize EBM (CVZ 2008). A further ethical question therefore arises: should the profession of psychiatry adopt a natural science epistemology in order to conform to governments’ preferences for naturalistic cut-off measures?

In the following chapter, we will examine this relationship between the science of psychiatry and the profession’s societal position in more detail. We will also attempt to answer the question whether it is possible to attain a philosophical foundation for psychiatry that offers legitimacy for the practice we have found in this study. In examining this point, we must make it clear that we wish to avoid the naturalistic fallacy of assuming that the practices we have found empirically are the best way forward (“no ought from an is”), therefore, a separate argument should be made for any such proposal.
6.4 Main points Chapter 6

- The dominant epistemic approach in this study is pluralist. Explanatory theories are matched to phenomena (Chapt. 3) and legitimized chiefly through pragmatism, both in relation to practice (good outcome) and science (successfully tracking world events).
- Pragmatism is supported at the scientific level by empiricism (e.g. EBM) and at the practice level by clinical judgment and practical knowledge.
- Psychiatrists tend to view causes of mental disorder in dualist terms, as either material (‘biological’) or immaterial (‘psychosocial’). There is ontological alignment between the nature of the cause and the nature of the suggested treatment.
- On realism vs. antirealism, and reductionism vs. antireductionism, a diversity of opinion was noted.
- There is a slight hierarchical preference for natural science as socially legitimizing for the profession as a whole, leading to a ‘deficit model’ legitimacy for clinical judgment. Therefore, there is a tension between privately espoused pluralist pragmatism and the centrality of professional expertise, and the sense that more monistic, materialist and scientistic views are more effective as socially legitimizing.
- During training, residents evaluate psychiatric theory from a practically engaged position. A key concept in this process is ‘affinity’: the mutually influencing and reinforcing of personal/professional values, evaluation of validity of theory, and personal/professional experiences of applied theory in practice.
- Such values affect the defining of the ‘medical good’ involved in pragmatism.
- A second key emerging concept is ‘alignment’: correspondence of epistemic and other values and/or ontology across domains (practice/institutions/society; folk language/theory/institutional and political discourse) with a reinforcing effect.
- Psychiatrists differ in their approaches to institutional influences and constraints. They are capable of identifying dominant epistemic preferences (e.g. ‘Our professor is very DSM’) and alignment (‘I put on my doctor’s hat’) and take up a position depending on personal/professional values.