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Diagnosis

The object of this study was to examine the ways psychiatrists conceptualize their views in practice, and to relate these views to how psychiatric science and society have described and viewed the objects of psychiatry. From the first exploration of diagnostic practice, we gained an impression of the differences between somatic medical diagnosis and psychiatric diagnosis. The four main philosophical positions identified in diagnostic practice were theoretical pluralism, causal dualism, values-oriented pragmatism and clinical realism. Arguably, the most influential difference springs from the nature of the objects of psychiatry: the phenomena of psychopathology themselves. Whereas in somatic medicine the targets have, for the most part, been described and anchored to recognized and accepted pathophysiological etiologies, psychopathology is moored to heuristic semantic groupings reflecting current and historical ways of sorting the phenomena. The features of these groups are not so rigid to deny practitioners the room to construe the phenomena of practice in different ways. What we saw in practice is that practitioners do follow the shared categories of psychiatry, the tried and tested symptoms of psychopathology and the DSM taxonomies, but they also employ different theory-based categories and concepts in their understanding and exploration of the case: the DSM is not the only taxonomy they are tied to. In fact, the DSM, to them, is less appealing than theory-based conceptualizations, which are cognitively efficient and offer localized predictive value. The DSM was seen as valuable as one touchstone for organizing inductive knowledge, but in diagnosing patients, the practitioners are also aiming for deduction in service of prediction, and they apply meaningful reasoning to acquire idiographic knowledge to this end. Concepts from various psychotherapeutic theories aid them. A second striking finding was a further twist to this theoretical flexibility: psychiatrists proved to apply such theory-based understandings of the phenomena in a pragmatic manner, aimed at getting whatever best results applied at the time, whether it was enticing the patient to remain in treatment, to provoke them into reflecting on their own identity, or to just keep taking the pills. The explanatory flexibility (here connected to the concept of ontological scope) offered by the phenomena afforded them the room to push the explanatory story in a direction they saw as valuable. This space was not limitless, but bounded by the perceived nature of the phenomena and their relationship to the understanding as a whole: certain groups of phenomena, and diagnoses, are more strongly tied to notions of material causation than others. The causal dualism already apparent in the literature was also on display here, as those symptoms or syndromes thought
to be more material, were generally also thought to be less psychologically or socially caused; inversely, where psychiatrists could not rationally or empathically understand the reasons for the phenomena, they were more inclined to see them as biological. We also saw that this was associated with degrees of alignment of cause, ontology, and treatment: material in cause, implies material in nature, implies material treatment, to put it (too) succinctly. Interestingly, alignment also involved their professional role exemplified by the ‘doctor’s perspective’, wedded to the material point of view, an understandable notion from historical perspective. Meanwhile, it was also apparent that the malleability of the psychiatrists’ perspectives was also curtailed and/or influenced by the local institutional structure and the entailments thereof, most tellingly described by the participant who said: “We don’t get to do real talks here, that’s the arrangement.” These initial findings raised questions: if psychiatrists are being pragmatic and allowing values, albeit therapeutic values, to influence the way psychopathology is construed, is this legitimate? Is it a good thing, or is this just the ill EBM and the DSM are targeting: combating idiosyncratic practice and diagnostic unreliability? Such practice seems at odds with the general scientific project of psychiatry, to describe the features of mental disorder, relate them to fundamental research, and feed the results back into practice. And here we have a practice where not only is the DSM not front and center, but its objects are actually being destabilized by pluralist pragmatism.

Classification

If we were tempted to see this contrast as a tension between the pragmatic desires of the therapeutically-focused practitioner versus the reality-describing nosologist, the historical exploration of psychiatric classification showed us that such tensions are inevitable for a classification, since a taxonomy functions as a transducer between the general and the particular. Modern classification of psychiatry was initially rooted in the Virchowian lesion model of disorder, and throughout the 19th century, it was hoped the body would prove just such an anchor for mental phenomena as it had been for somatic disease. Kraepelin shifted the emphasis towards the course of the disease, but the fundamental ontological and epistemic assumptions remained in place: mental disorders were grouped as syndromes with presupposed separate underlying pathophysioologies. A view of the panoply of 19th century classifications reveals that the classification alighted on for the influential Statistical Manuals was by no means historically and scientifically inevitable: this was the age in which every self-respecting academician would publish a taxonomy, and psychiatry at the time was quite aware of the speculative nature of such classifications (though this didn’t stop the
taxonomists professing their positions with great force). However, the relatively small scale of psychiatry at the time prevented this from causing any conflict in actual practice: these taxonomies can be seen as parts of small ‘cottage industries’ of psychiatry, where the academic was also the (sole) practitioner in the asylum or academic hospital department. Also, there was no connection between the limited therapeutic arsenal available and taxonomic preference. Friction between taxonomies therefore was for the pages of the first psychiatric academic journals. The real push for unification of taxonomy came from outside the profession, from societal need for an instrument which could be applied nationally for public health purposes. At later points in time, including the ‘revolutionary’ change from DSM-II to DSM-III, societal need again was decisive, and what was also apparent was that for change to come about, not only should powerful social groups be involved, with at least a ‘foothold’ within the profession, but there should be an alignment not only of interest, but of epistemic perspective. In the case of the DSM-III, this alignment can be found in the societal need for precise demarcation of diagnosis, to allow for utility in health care rationing, and its corresponding value for researchers, in defining a stable and reliable research object, thereby returning psychiatry to its 19th-century project, but with better technique. Trouble, however, remained afoot, as history repeated itself, and the aspirations of the decade of the brain failed to supply the DSM 5 with its neurobiological revolution, leading to a current situation in which there has been a first major nosological departure from the DSM-model by the NIMH through the RDoC project, and worries have been raised about the sustainability of the DSM. In the accompanying philosophical debate, realists remained committed to the project of the DSM reflecting nature as it is, or at least converging on it. We could paraphrase the debate as between those who say psychiatric classification cannot cut nature at its joints, and those who say it just hasn’t found the means for that yet. This was also reflected in participants’ views of science and classification. However, in line with current philosophy of science, most participants in the philosophical debate veered away from the extreme positions of positivism or social constructionism, preferring ‘middle’ positions of weak realism or weak nominalism, allowing for multiple perspectives on an ontological reality, disciplined by scientific communities, which themselves are (legitimately) open to societal influences and interests. We also noted, however, how the scale and scope of psychiatry’s reach has grown tremendously since the days of Pinel and Rush, to the extent that, in my opinion, concurring with Pincus, Sadler, and Cooper, both psychiatric practice and psychiatric science have outgrown the DSM (Ralston and Swinkels 2015). Psychiatry is simply too large, its practical interests, both scientific, therapeutic, and societal, too diverse, to be governed by one classification. As has been remarked upon by its architects, the international success of the DSM caught them by surprise: it has exceeded
expectations. It has also reaped extensive benefits. But it seems it is now time to build upon this framework and allow for more scientific freedom. The philosophy, I would argue, is in place to validate such a move, and it would provide benefits for all domains: greater freedom for the scientific communities to explore psychiatric phenomena according to their epistemic framework (which is exactly what the RDoC is), an increase in theoretical content which logically should lead to greater clinical utility, and greater social pragmatic value in being more attuned to localized interests. Of course, such freedom should be balanced with scientific rigor, and to this end, a hierarchy was proposed, based on pragmatic – scientific aims, and strengthened by a democratic framework. The latter idea was inspired by Sadler's work on values at work in the classification, and the acknowledgement of the fact that scientific progress and rigor (attention to good method) in the taxonomy have not been matched with equal ethical rigor and progress (and attention to good process). The elephant outside the room of taxonomy is patients. Acknowledging the presence of values in taxonomy and the connections (alignments) between social interests and taxonomy requires an ethical stance towards the process of taxonomy. The ethical argument dictates that those affected by psychiatric taxonomy should be involved in its construction. Worries over ‘a recipe for disaster’ (Spitzer 2005) are misplaced: an ethical foundation strengthens a taxonomy rather than weakens it. The switch involved here is in moving from an ambition of just one ‘mirror of nature’, to taxonomy becoming what classification should be: an instrument with which to explore nature, responsive to human needs and interests. It is this last dimension of human need and interest that requires democratic balancing, so those persons for which the classification has actually been constructed, lest we forget: the patients, reap its benefits.

Science

This proposal for psychiatric classification has the advantage of accommodating part of the practice we observed in diagnosis: it should result in better scientific grounding of pluralism in practice, since the ‘alternative heuristic groupings’ could be connected with legitimate taxonomies and related scientific communities, without going through the distorting lens of the DSM. However, would psychiatrists be ready and willing to accept such a proposal as legitimate? Also, the questions over their pragmatic and values-infused practice still remained. The next chapter on science provided more insights into the knowledge base of psychiatrists and their views on scientific legitimacy. From the literature we derived a picture of different forms of knowledge in play in practice, conscious and intuitive, codified and tacit, and imparted through different channels in medical and residency
training. Here too we saw significant values influences within the not-so-hidden curriculum, the correspondences between personality features and theory choice, and the importance of role models and practical experience in knowledge acquirement. Significant epistemic differences were noted between psychiatric training and medical training, perhaps most evident in the 'beginning psychiatry training syndrome' described, which could be characterized as an epistemic crisis: young physicians coming from a field of epistemic clarity as certainty, comfortable within a realist model, thrown into a pluralist arena. This transition requires a different epistemological perspective, which for some may instigate a crisis of professional and scientific legitimacy. Development through practical and theoretical affiliation with psychiatric theory mirrors developments described in the literature on personal epistemology, which may lead to a position of 'commitment within relativism', fitting the self-descriptions of many of our participants, who show affinity to certain theoretical outlooks, but apply others as they judge them to fit and useful. However, their views of science show exactly the same diversity we saw in the philosophical debates on the DSM: though some are clearly pragmatic and relativist about truth claims of epistemic communities, many entertain the 'received view' of science, and therefore see their own personal judgments, even where they are expertise-based, as outside of actual science. This does not, however, imply that they see such actions as illegitimate: they argue on the same grounds as taxonomic realists: we do not have the science – yet (in Fulford's terms (cf. Fulford et al 2005), we would say they are reasoning from a deficit model of science, as opposed to the values-inclusive strengths model). Therefore, in the explanatory gap that remains, it is legitimate, even mandatory, to ground their practice in the alternatives: professional expertise and the evidence base. This approach does, however, have the unfortunate side-effect of distancing (values-laden) expertise from (objective) science. In accordance with the personal epistemology and medical sociology literature, we saw clear institutional and professional influences on the 'right way' to think about science, but also individual differences on how this was navigated. Part of this was related to the development, degree of sophistication, and confidence, in a personal model of professional legitimacy, based on ideas of science, expertise, and values. With respect to the latter, there was, as we might expect, some diversity between practitioners who placed values in the center of their practice, and those who would rather eliminate values entirely from practice. The question of whether values were 'shakier ground' than science, seemed to be answered in the affirmative by most participants, but this did not imply that values-based decisions were therefore considered illegitimate. Values-based legitimacy was enacted through clinical skill: underlying all practice was a commitment to refer to the patient throughout the whole process of diagnosis and treatment, to not only check whether one has
understood what the patient has been saying, but also to identify what the patient would see as therapeutic benefit, and to get a sense of the meaningful context the patient exists in (though the extent to which the latter was possible or performed varied from context to context) in order to judge, as far as possible, what ‘benefit’ would constitute in the individual case. Following a remark of one of the participants, I termed this practice ‘being faithful to the phenomena’ by which I mean to emphasize the skill of attending to both factual and evaluative elements in the narrative of the patient, checking interpretations (in hermeneutic fashion) with patients and thereby relating them to their meaning-frameworks, and equally defining what is pragmatic and ‘the good’ of treatment in those terms. Again, a certain degree of alignment seemed to occur in the practice of the psychiatrists’ studied: hard science being associated with the ‘hard’ diagnoses: schizophrenia, bipolar disorder, autism; here there was less scope for epistemic variation, or individual values influencing diagnosis, whereas in adjustment disorders, personality disorders, or (moderate) depression, more pluralism was afforded by the phenomena, it seemed. The resulting model of practice demonstrates the factual and evaluative constraints placed on values-based pluralism and pragmatism, both emanating from the phenomena (e.g. through prompting, ontological potential and scope), the individual and contextual values of and surrounding the patient, the institutional context (local, professional) and the relevant scientific-theoretical communities.

So it seems these practitioners were willing to embrace pluralism where science simply hadn’t given them one route to the truth. On the place and legitimacy of values, there was less consensus. The question remained as to their rightful place, and more importantly, their management. EBM, for example, performs a segregation of values: they belong to the patient. In the EBM approach, diagnosis is a process of sifting through the hybrid fact/value narrative for the factual information necessary to perform a diagnosis (rooted in matter and for this perspective factual), relate it to evidence through the prescribed methodology, and return to the patient with treatment options. These are subsequently calibrated towards patients’ values-based preferences. As we saw this was not how psychiatric diagnosis progresses. But should that not change then? The role of values in the scientific approach to psychiatry was examined historically in Chapter 7.

**Professional legitimacy**

This part of the historical story focused on the development of the psychiatric profession in the Netherlands and the role of science therein. It became clear that
a simple commitment to the benefit of the residents of asylums, and their status as physicians, was not enough for asylum doctors to overcome societal resistances to professional jurisdiction over the domain of what was to become psychiatry. Professional status necessitates exclusive expert knowledge, and for psychiatry in the Netherlands, this was only obtained after it had strengthened its links to natural science by an allegiance with neurologists. Safeguarding the professional domain, under pressure from government and competing health professions, increasingly required clear demarcation towards the end of the 20th century, and to this end, the psychiatric profession in the Netherlands again aligned itself more closely to general medicine, e.g. by way of self-defining documents such as the 2005 Profile Sketch (PS). Besides commitments to the natural science model of medicine, medical practice in the PS was identified with science, proclaiming EBM as its grounding methodology. If the view of the PS is to be taken as representative of the profession as a whole at the time, the practice identified in this study would be in need of modification, and mostly, codification. However, there are substantial philosophical, ethical and practical arguments against the viability of the PS model for practice: monist and value-free views of science have largely been rejected in current philosophy of science, which since the descriptive turn after Kuhn recognizes methodological discipline and epistemic and ontological agreement within science communities as a realistic basis for science. The presence of value judgments within science is unavoidable, and does not undermine its validity, which is relative to the scientific community, the epistemic, ethical and other relevant norms within this community, and its scientific aims. The pluralism of post-Kuhnian philosophy of science in itself is not a defeating challenge to a practice reduced to EBM, but it complicates it since pluralist science should result in different evidential hierarchies besides EBM. A greater challenge to EBM comes from questions over codifiability of clinical knowledge. Thornton argued for an irreducible tacit dimension to clinical judgment, but also added that this did not detract from its validity. In fact, this argument serves to validate the importance of the role-modeling and practical demonstration content of medical education: certain information cannot be codified but must be practically demonstrated. Reducing practice to only codifiable knowledge, as the PS seems to support, would therefore result in a severe reduction of current practice and would risk disallowing valid tacit knowledge. Furthermore, it was argued that a preponderance of technical rationality and the risk of 'values blindness' would lead to negative consequences for patients, and disempower professionals in a key area of professionalism: normative attunement. The latter concept is taken from Glas’ (2012) normative practice model (Chapter 7), which was offered as an alternative framework to the naturalist science-practitioner model of the PS. We noted significant parallels between this model and the findings of this study, implying
that it holds promise as a viable model of professional legitimacy underpinning the features of practice identified in this study.

For those favoring a naturalist stance, Thornton (2007a), from McDowell (1996), brings a sense of objectivity of values as features of the world to our attention, which can issue cognitive command: we can aim to get them right, but we can also get them wrong. In the terms of this thesis: one can succeed and fail at ‘being faithful to the phenomena’, and it is possible to identify both. This is the sense of ‘getting the values right’ both in clinical practice and in science.

Following Abbott (1988), and in agreement with the NPM, we recognize that enacting and embodying professional values is essential. The NPM, as a heuristic framework, is a professional tool in itself, clarifying the normative structure of practice. In addition, a number of theoretical and practical perspectives were noted which should aid the practitioner in acquiring and maintaining the expertise inherent in the NPM. The NPM stresses action and competency of the professional not only at the ‘micro’ level of practice, but at meso (e.g. institutional) and macro (society, political) levels, all the while exercising attunement to the ‘regulative direction’, or telos, of the profession. We recognized both the outcomes of this study and the NPM as a relative departure, at least for the public face of psychiatry, from the current model, suggesting new skills and expertise are required. However, the results of a number of similar studies suggest core elements of this expertise are already present in practice, only requiring theoretical and professional recognition, organizing, bolstering and facilitating them. For science, we referred to the work in social studies of science as an empirical source for recognizing the place of values in science: again, our history had demonstrated values ‘traveling’ across the boundaries of profession, society and science. The concept of ontological and epistemic alignment arising from this study is a crucial vehicle for the transportation of such values across the borders of the therapeutic encounter, inwards and outwards. The model of therapeutic practice envisioned here is therefore dynamic and three-dimensional, with fact and value not only traveling in a two-dimensional plain between patient and therapist, but also abstracting away from the encounter and back, through alignment, to and from relevant professional, scientific, and social domains. Sociomaterial research methods such as ANT can be seen as tools for the values-aware scientist to track the presence and influence of values in science, whilst VBP offers a skills framework for the identification and handling of values at the institutional and practice level.
Chapter 10

*Mental Disorder*

Now that we had come to a position in which a pluralistic and pragmatic, ‘values in’-approach to practice, classification, and science was being proposed, accompanied by the acknowledgement and disciplined management of values in all these domains, the further question, still left hanging from Chapter 3, was: whither mental disorder? If practice (as we observed it) is performed by grouping phenomena into different, theory-based heuristic groups, and we legitimize this with scientific pluralism, recognizing the fact that different science communities can be incommensurable, wouldn’t this result in severe stress being applied to a singular, unified concept of mental disorder? To explore this matter further, we first looked at the role a concept or concepts of mental disorder played in practice. After distinguishing between two functions of the concept for practice: domain-setting, and constitutional, it became clear that the former sense was not ostensibly present in the locations examined in this study: there was no boundary conflict between participants (though it lay beneath the surface in the conditions set to practice by third-party payers). The constitutional role of the definition of disorder was present in the determinative weight the phenomena carried towards their understanding. In practice, there was no clear solitary and universal concept of disorder present, on the contrary: psychopathology was understood as disordered in different ways, not just across individuals but also in singular instances. Fitting with the tendency towards causal dualism and alignment, those disorders seen as more material were viewed as the ‘really real’ disorders, more disease-like. This however did not imply that more psychologically understood disorders were invalid, only that they were understood by the subjects to be disordered in a different way, by recourse to suffering, or the mutable bridge concept ‘dysfunction’. So there was both variance in the nature of the phenomena themselves and in how they could be understood, without –according to these participants- a threat to their validity as disorder. Conversely, this seemed to answer the question of relevance of a (singular) concept of disorder in the negative: perhaps thinking about this concept has as little import (except for in boundary issue areas) for practice as contemplating the coffee bean has for putting the kettle on.

*Disorder in action*

In Chapter 9, applying the ANT method, we examined a number of historical examples of the role of mental disorder at the borders of profession, science and society, beginning in pre-modern times. The role of society in setting the outillage mental was revealed in multiple examples, in the process revealing the degree to which psychiatry has differentiated internally and externally through society. This
also demonstrated that this differentiation didn’t seem to result in a reactive desire for a strong unifying definition to ‘rule all arguments’. Instead, discussions over boundary issues were characterized by the employment of a variety of arguments, both science-based and ethical, to argue for the setting of boundaries in a certain way. Again, we noted the importance of the power of social groups (now represented as punctuated nodes in an actor network) in determining the ontological and epistemological scope of a discussion: e.g. if the minister demands an uncontestable boundary for mental disorder, there is a big chance that precision will end up high on the epistemic value hierarchy embedded in the stakeholder discussions. The upshot of this analysis was that history too, besides practice, points to a local, contextual judgment of what ‘mental disorder’ should be. In turn this proposal was tested against current philosophical debate, focused on the issue of mental disorder as a ‘natural kind’. Though there remained space to argue for other intermediate ‘kinds of kinds’ between non-kinds and natural kinds, the consensus seemed to alight on the notion of mental disorder as a practical kind, where the pragmatism involved is taken to encompass a pragmatic sense of science which is also evident in the Kuhnian approach to science as problem-solving activity. The second argument for a local, contextual judgment of mental disorder rather than a unified one, was normative, related to the necessity of relating any (constitutive) explanation of disorder to the meaningful world of patients, thereby necessitating an understanding relative to this individual background, and the recognition of the translation of values from society through mental disorder concepts, and the ethical requirement of being sensitive to such values and the implications they have for patients. This is a product of the historical work in this study which repeatedly demonstrated values crossing domains which are conceptualized, from the traditional, received view of science, as either value-laden or value-free. The hybrid nature of mental disorders require a normative sensitivity to the manner in which disorder is being construed in practice, and this can only be done in reference to the meaningful context of the patient.

Where has all this brought us? The picture painted is of a pluralist and pragmatic practice on the lines of suggestions recently described by Brendel (2006), but this study adds an empirical picture of the dynamic interplay of fact and value at ‘ground level’, offering an opportunity to flesh out a legitimizing framework for such practice. The implications from this study may have less impact on the way we handle putative facts than on the way we manage values. Central to this view is the notion that it is both philosophically untenable and ethically unwise to segregate facts and values into separate domains, together with separate disorders, science communities, and professions. Neither is any reduction towards one (uncontestable) epistemic perspective likely. Instead, scientifically and
ethically legitimate ways of managing hybrid and dynamically interacting facts and values in classification, science, and concepts of mental disorder, are possible, without damaging validity. In fact, as in the case with the alternative proposal for classification, an infusion of theory and democracy may serve to bolster validity. The more general framework for psychiatry as a profession will be presented in the following, based on the main conclusions of this study. First though, we will address the limitations and possible criticisms of this study, and implications for further research.

10.2 Limitations and further research

The most obvious limitation of this study is its relatively small-scale, qualitative nature. The final group of psychiatrists interviewed, was skewed towards males and a higher age demographic. The influence of changing educational traditions, socioeconomic effect on treatment practices, or character formation prior to entering medical school, might all lead to a different picture for younger psychiatrists. Add this to the fact that this study was wide-ranging in its philosophical interest, and it is obvious that similar research focusing on different professional demographics, and different domains, would be valuable, as would more focused studies. Clearly, the complexity of (mental) health care requires reticence in generalizing these findings to other areas of the field. Nevertheless, an argument could be made that the difference may be more of degrees and relative emphasis rather than a full-scale overhaul of the themes recognized here. The DEF (Developing Explanatory Framework) model was purposely constructed to accommodate practitioners with differing theoretical and epistemological perspectives. If, as we might hypothesize, younger generations of psychiatrists, having been trained more extensively in the culture of EBM, apply more actuarial reasoning in practice, this is readily recognizable in the DEF model. The related scientific community is also identifiable. And in this state of affairs, question on the translation from the general to the particular, the navigation of patient values, the presence of value judgments within EBM at various levels, are all involved. Further empirical research too is required to explore the products of qualitative studies of clinical practice in relation to the clinical reasoning literature (Chapter 3). The emerging actions of strategic conceptualization and alignment, for example, require further study in order to determine whether they may be robustly generalized, and if so, what their impact is in diverse clinical settings. Again, the proposed model does accommodate limitations in such impact based on narrower ontological scope, and stronger connections between observed phenomena and patterns on the one hand, and theory- or evidence-based interventions on the
other. Nevertheless, the findings suggest a significant departure from models of reasoning primarily grounded in description and identification. The structure of the encounter may be correspondingly different as well. The DEF model itself is open to further empirical testing with respect to more finely-grained analysis of the interactions described, such as ontological power and scope.

The tensions between professional practice, scientific and social legitimacy, in which we identified different philosophies of science at different levels, raise questions about how practitioners navigate such tensions, to what degree philosophies are stable or context-dependent, and which factors are most influential in this process, all questions open to empirical and experimental study.

The QR was conducted by a small team of professionals. This also could be varied and expanded, as the professional interests and values of this team may have affected the framework analysis, since QR remains an interpretative endeavor. The study could have been strengthened further by focus group discussion of the findings, however practical constraints prevented this.

This study was purposely focused on the contributions of the psychiatrist to the encounter, and was initially termed ‘the philosophy of psychiatrists’. As the degree to which both practice and education of psychiatrists proved to be permeated by ‘external’ factors, there seemed little alternative but to refer to philosophy in psychiatric practice. The study was conceived as the first of a series, the next being aimed at patients. Clearly therefore, as a study of the philosophy of psychiatric practice, this work is incomplete, and the definitive article had to be removed from the title, hence ‘philosophy in psychiatric practice’. A similar study from the patient perspective would be a stepping stone to longitudinal studies incorporating both perspectives and examining interactions and developments over time.

The same empirical perspective applies to the dynamics of mental disorder conceptualization, both in practice and at institutional and social levels. On the historical front, combining philosophical field work with the ANT perspective will be fruitful and much can be learned from this perspective. What methodological issues might we expect here? Obviously, the ones applying to ANT: its ontological problem, and its boundary problem. We may argue that both can be, at least, curtailed through a modest ANT approach, though then it must also be argued how ANT differs from a social network approach. What must be noted here is that the lines in a network are not of equal ontological causative nature: a connection in a network may be lawlike, but it may also be meaningful, or social. So a two-dimensional network suggest an equality of relations that is not the case in reality. This is the point of the explanatory power of ANT: care must be taken to separate
its descriptive power from causal claims, which themselves should be examined. ANT gives us a bird’s eye view and suggestions for areas of interest, which themselves should be scrutinized further.

10.3 Proposals derived from the study

1. The legitimacy of the psychiatric profession should primarily be grounded in its normative assignment.

The most fundamental legitimacy of the practice of medicine is normative (Jochemsen & Glas 1997): it is aimed at a sense of the good. All other aspects of professionalism, i.e. core values, privileged knowledge, educational and legislative structures etc., are all conducive to this end. This good, however, is not independent of the practice of medicine, it is enveloped in the related concepts of illness, disease, and disorder, and in medical methods. Therefore, one could term it the ‘medical good’, where medical is to be understood in the broad, socially defined sense of the area of health care rather than the ‘medical model’. By setting the aim of medicine as a moral endeavor rather than a set of techniques aimed at changing a state of affairs (this state being illness or disease), the emphasis in this proposition lies on the ethical core of medicine, and claims of legitimacy are less strongly tied to finding a foundation in the validity of a concept of disease or disorder, a question which has troubled psychiatry for decades. According to this definition, ethical expertise is a fundamental ingredient of professional legitimacy for physicians. One main conclusion of this study is that values cannot be segregated into just one area of practice: they are not only present in the narrative of the patient, but also in medical concepts, theoretical frameworks, epistemic commitments, and institutional arrangements. The traditional way of managing these values was by segregating them, defining a value-free area within the domain of science, and organizing a scientific framework around it, to which the physician refers, and from which she derives professional (scientific) legitimacy. This created the unfortunate side-effect of professional legitimacy being tied to the ‘reality’ of mental disorders viewed from one singular epistemic perspective. This approach has been extensively criticized in this study, which shows that a robust alternative is possible, once the commitments to truth correspondence and carving nature at the joints are replaced by a more pluralist approach. The fundamental legitimacy of practice should be derived from its normative assignment. Such legitimacy accords with the philosophical positions (pluralism, causal dualism, normative pragmatism, clinical realism) found in diagnostic practice.

However, in order to replace the bedrock of reality as a foundation, the normativity
of practice must be based in methods that are methodologically rigorous. For practice, there are two main implications: firstly, if there are different, legitimate, scientific communities with ‘paradigmatic’ methods, these may be legitimately applied to practice in accordance with these methods. It is the professional responsibility and expertise of the practitioner to judge which scientific knowledge is relevant to the clinical encounter, based on (primary) clinical knowledge and expertise in the individual and context-bound encounter, and equally grounded in normative expertise: attunement to the professional telos. Secondly, such expertise can be theorized on, bolstered by the heuristic framework of the NPM, studied, and trained. Knowledge from domains of values-sensitive study (e.g. empirical ethics, sociomaterial studies, ethnographic studies) can be applied to practice, again, with reference to appropriate methods of assessing rigor. Together, this results in a foundation for professional legitimacy in which scientific and clinical knowledge inform clinical expertise and judgment, which comprise of the judicious use thereof towards the aim of the ‘medical good’.

2. The phenomena of psychopathology comprise an ontologically heterogeneous category, comprising dynamically interacting factual and normative properties.

Another main finding of this study is that of the nature of disorder in practice: we cannot discern one unified linguistic definition active in practice, nor in society. Rather, there are different senses in which the general concept is construed, and these are relative to context and interests. A minimally sufficient conceptualization for mental disorder is that of a practical kind. The same pluralism applies for scientific and taxonomic approaches. In clinical practice, within science, in local interactions between individual practitioners and institutions, and in interactions between profession, science and society, fact and value have proven to interact dynamically. This does not preclude identification and tracking of such interactions, both at the individual level of the therapeutic encounter, or through sociological and historical study, boosted by methods such as actor network theory and values-based practice. Pluralism does not equate to relativistic eclecticism, and should be constrained by science, ethics, and clinical judgment. Professionals, therefore, have a responsibility to partake in debates in which social and political boundaries are set on disease and disorder concepts, and to derive their arguments therein from their normative assignment (the professional telos). Furthermore, the social dynamics of the translation and stabilization of MD concepts demonstrate the role of diverse social and political interests. It is incumbent on the profession to advocate for patients’ interests and to promote democratic representation of patient values in such sociopolitical processes.
3. The relationships between the concepts of fact and value, science, society, and profession are not dichotomous but gradual, interacting, and dynamic.

The studies included here demonstrated interactions between fact and value and multiple levels in psychiatry, both in practice and in professional, scientific and societal transactions: fact and value traverse such borders (as the process of epistemic alignment has shown). For both the individual practitioner and the profession, this implies the requirement of a sensitivity to the ‘openness’ of the domains of practice, science and society. Segregating fact with science, and values with society, or splitting the professional-as-person from the professional-as-scientist, risks a failure of ethical rigor. As noted above, the requirement for professionally recognized rigor in managing values should be set just as strongly as for the management of facts. The model of the encounter developed here implies adding a different perspective for locating values to the traditional approach: as with EBM, for example, it is the patient’s values that are the prime focus of attention. Good practice should also entail a practitioner being aware of her own personal moral prejudices. To this two-dimensional skill a third is added, abstracting away from the encounter, and following the vectors towards the relevant knowledge domains. These may lead towards the scientific sphere, but also the social, legal, economic, political spheres at meso and macro levels. This action should also take into account the value properties embedded in concepts, theory, practices, and institutions, and relate them to the value context of the professional encounter, thereby necessarily involving the meaningful context of the patient and the aim of the medical good. An addition to the NPM from this study is to not only focus on relations between humans, but between humans and objects, concepts, and texts, and also to be open to the historicity of ‘objects’ and the values embedded in them and/or in their related and entailed practices. This dimension is required due to the manner in which fact and value intermingle in practice coupled with the apparently porous nature of the clinical encounter to ‘outside’ influences on the epistemic and ontological development within the DEF. This approach is consistent with the abovementioned proposal for the practitioner to profess his or her own values and to engage with relevant moral communities. The scientific, institutional and professional domains that the practitioner is involved in, are also moral communities, and the practitioner has a responsibility, as a feature of ethically grounded practice, to recognize values embedded in these communities and to bring them to bear on the clinical encounter and to relate them to the patient’s values and priorities. The concept of epistemic injustice (Fricker 2007) is relevant here: one central aspect of the Recovery movement in psychiatry is related to the experience of lack of involvement of service users in the production and stabilization of concepts and social meanings in mental health care which affect
them, an example of what Fricker terms *hermeneutical marginalization*. One conclusion from this study is that it is incumbent on the professional to be aware of the possibility of epistemic injustice within relevant science communities, and to address this as part of the opening up of said community to the practice level.

This is not to say this is a simple task. An example of such action can be found in a recent public debate in the Netherlands on the concept of schizophrenia (van Os et al. 2015). A number of high-ranking professionals, including a former president of the Dutch Society of Psychiatry and the president of the Royal Dutch Federation of Physicians, published an article in a national newspaper with the title: “Let’s forget the diagnosis of schizophrenia”. The first line of this article was: “Schizophrenia does not exist.” Their argument for replacing ‘schizophrenia’ with ‘sensitivity to psychosis’ (a dimensional concept) was based on a mix of statistical/epidemiological and moral/pragmatic reasons, the latter consisting of the argument that the concept of schizophrenia is laden with essentialist and pessimistic expectations relating to severity and course, leading to (self-)stigmatization, a lack of hope and perspective, and reduced opportunities for treatment and recovery. In a response a number of equally high-ranking professors criticized this argument (Sommer et al. 2015), also employing both epidemiological/statistical and moral arguments, the latter consisting of the charge that van Os et al. were trivializing the suffering of patients with schizophrenia. Interestingly, throughout the debate, both sides mix arguments from the scientific, individual-ethical, public-ethical and clinical spheres. They do not, however, recognize this, and this leads to talking at cross purposes. This underscores the balancing required for the approach proposed here: attunement does involve opening up to other spheres but is not a license to ignore the norms of a (scientific, normative) community. Attunement and negotiation cannot leave from any other position than respect for such norms. Equally, reflection on the translations occurring to the concept of schizophrenia as it moves from one sphere to the other are crucial to inform these negotiations.

This form of reasoning at the ‘macro’ level of public and scientific debate finds its parallel in this study at the ‘micro’ level in practice where practitioners reflect on the use of certain linguistic concepts within the DEF based on their pragmatic use towards the betterment of the patient. Though this debate clearly involves an attempt to address issues of social justice connected to the scientific term ‘schizophrenia’ as it travels in society, a further action from the perspective of epistemic injustice would be to ensure service users’ voices are heard in this debate, rather than limiting it to members of academe.
The analysis of science and legitimacy in Chapters 5, 6 and 7 and the concept of alignment derived from this study point to the benefit of social studies of science and social epistemology (Bluhm and Borgerson 2011) for this activity: where values are encapsulated in concepts which travel between society, science and practice, and have a bearing on patient values, the practitioner requires tools with which to track their course, translation and transformation. Social epistemologists analyze the social structures relevant to the knowledge-productive capabilities of particular communities (ibid.). Manning’s analysis of Dangerous Severe Personality Disorder (2002) serves as a clear example of such research, dissecting an attempt at translation of political values from the macro level to the micro: had this attempt succeeded, we would now see persons carrying a ‘diagnosis’ of DSPD. In this case, the profession acted with sufficient agreement and ethical integrity to contribute to the failing of this enterprise. Actor-Network Theory, it has been argued here, is another tool in aid of ethical awareness traversing traditional dichotomies and segregations.

The skill involved in managing the ‘mangle’ of values and facts (Pickering 1995) traversing the permeable boundaries of practice is an enriched conceptualization of clinical judgment, a fundamental property of professional expertise. This also leads to a revised conceptualization of clinical expertise, which encompasses both scientific and ethical sensitivity and practice. The examples of psychiatrists taking into account the effects of possible explanations for the self-worth, or attitude to treatment, of patients, offer a sense of what is involved here. The ‘ontological shifting’ seen in this study, could be legitimate, but it could also be flawed; again: this should be argued for based on sound science and sound ethics. I would argue that such practice fully accommodates EBM, and bolsters it with an improved ethical methodology.

4. In relation to privileged knowledge, medicine and psychiatry should adopt a pluralist stance.

With respect to psychiatry, an influential historical narrative has held that the field has been dominated by a struggle between monolithic scientific, therapeutic, and philosophical perspectives: natural sciences versus the humanities, psychoanalysis versus biological psychiatry, or realism versus postmodernism. However, scientific, societal and philosophical developments have opened up psychiatry to society at all levels, and now, perhaps, if we were to aim at characterizing psychiatry in binary terms, we might prefer the tension between centralizing and decentralizing forces, so apparent in the debates on the DSM and on EBM. This study argues for recognizing and managing the pluralism in practice, bolstered by an equally pluralist and (ethically laden) scientific pragmatism, which in my view
both accords with practice and is philosophically justifiable. Bluhm and Borgerson (2011) note various forms of methodological pluralism in an argument against the monistic values hierarchy of EBM e.g. Petticrew and Roberts (2003), Muir Gray (2001) and Bluhm (2005). They also note Upshur et al.’s (2001) model of evidence aiming to capture different meaningful evidence types and their interrelationships, without imposing any hierarchical order:

<table>
<thead>
<tr>
<th>Type of evidence</th>
<th>Characterization</th>
</tr>
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<tbody>
<tr>
<td>Qualitative/personal</td>
<td>Narrative, socially and historically context-specific, individualized</td>
</tr>
<tr>
<td>Qualitative/general</td>
<td>Social, historical, general</td>
</tr>
<tr>
<td>Quantitative/personal</td>
<td>Quantitative, individualized</td>
</tr>
<tr>
<td>Quantitative/general</td>
<td>Statistical, general, impersonal, quantitative</td>
</tr>
</tbody>
</table>

Table 10.1. Evidence types (Upshur 2001)

EBM falls in quantitative/general category, but exclusive focus on this one category, they argue, is unjustified. Medical professionals, besides requiring expertise in assessing the intermingling of value and fact, also require critical skills and expertise in plural knowledge frameworks. The high values diversity, localism, and pluralism in this study revealed in psychiatry in this study perhaps imputes a higher responsibility on psychiatrists in this regard than in other areas of medicine, a responsibility, if taken up, which Fulford (2013) has argued may allow psychiatrists to invigorate their professional status as leading the way with regard to the recognition and management of values and ethics besides facts and science.
5. Enriched clinical judgment and expertise form the bedrock of professional legitimacy.

This proposition argues for the prioritization of clinical expertise and judgment above other sources of professional legitimacy. It is founded on a value principle that is so seemingly transparent that it is easily missed: the basis of the profession of medicine is grounded in the benefit of the patient (proposition 1). Therefore, the professional’s legitimacy is dependent on the degree to which he or she is capable at effectuating this and the manner in which this is done. If this is the case, then the patient is necessarily involved in professional legitimacy, since his or her values are necessarily involved in the assessment of whether or not suffering has been alleviated or removed (clearly situations of reduced competence challenge the latter proposition. Nevertheless, in such cases societies have designed legal representation and advocacy procedures designed to safeguard the patient’s interests and well-being). Professional knowledge and expertise are subservient to this goal. The openness of the professional situation sketched in this study again works both ways here: the professional should strive to ensure that patient values are well-represented in societies’ conceptualizations and operationalizations of ‘betterment’ within mental health care.

Enriched clinical judgment and expertise
The sense of clinical expertise as involving the skill of being ‘faithful to the phenomena’ stems from the consideration that the factual and normative elements of practice are present at multiple levels, from the phenomena themselves to the sociopolitical environment, and all in-between. We start at the phenomena as they are presented by the patient. Phenomena presented should be judged as to their nature in relation to the relevant scientific, professional, social communities, but this must also be done in relation to the pragmatic aim of the endeavor at hand, in which pragmatism is taken as value-laden, as it is related to the ‘medical good’ of the patient. This is not just a question of relating relevant knowledge to the problem at hand as prescribed by EBM, but taking note of the fact that diagnosis is both identification and construction, and therefore factual and value-related issues permeate the process of diagnosis and the development of a shared rationale. Sadegh-Zadeh (2011), with the aid of Austin (1962), views diagnosis as a speech act and a social act, the speech act including not just a declaration but a notion of what needs to be done, a performative (pragmatic and normative) component. One aspect of ‘professing’ is enacting and embodying the ‘regulative direction’ of the profession in diagnosis. This therefore does offer scope for the explanatory and narrative negotiations in the DEF, which from the NPM perspective can be seen as just the kind of normative attunement that fits the model. But, lest we forget: this
can be done well or badly: the relevant communities are normative and prescriptive. The DEF framework in this study might serve to aid in the description and tracking of these actions. Sadegh-Zadeh concludes that logical pluralism (i.e. plural formalized reasoning systems) is the most appropriate stance in medicine. Judgment involves the adequate recognition of the relevant facts and values in play, and expertise involves the adequate management thereof in relation to the benefit of the patient. The Cambridge Model of mental symptom formation (Berrios and Marková 2006, Berrios 2014) also underlines the mutability of the presenting phenomena (here also seen as ontological hybrids: entities and acts, resembling the ANT perspective) as the biological signal is (prelinguistically) configured by cultural influences, and the ‘dialogical negotiation’ (from Gadamer 1989) between sufferer and clinical interlocutor.

As we have seen, phenomena have their own potential to elicit certain ontological and epistemic relations, and we should, a priori, view such phenomena as hybrid, factually and value-laden. Therefore, we cannot prejudge the relevant epistemic community, e.g. by allocating understanding of a certain heuristic order to one scientific community. For example, if a patient describes hearing voices, and being disturbed by these experiences, this may evoke a relationship to the ‘biological’ scientific community, but to apply this community simply on this basis is to prejudge the matter. In the terms used in this study (see Chapter 3): prompting and alignment are mitigated by methodical reflection. If the patient hearing voices is disturbed by these voices because he is being called out to daily by his recently deceased wife, a psychological/meaningful knowledge community might be judged to be more apt. However, if the patient has entered into the encounter saying he just needs some sleep to get through the next week, a biological perspective would again be relevant. The nature of ‘voices’ in each of these perspectives is slightly different, as they are connected to different values and science communities. Applying the correct perspective (and form of reasoning) is determined by clinical judgment, which can be seen as comprising technical and humane judgment (Downie and MacNaughton 2000). These are not separate judgments relating to different elements, but expressions of two essential features of the professional role of the physician: the scientific and humane attitudes. The former is associated with a sensitivity to pick out patterns which deliver pragmatic advantage from relevant science communities (natural or human science), whilst the latter encompasses ‘ethical sensitivity’ to the normative phenomena present, the skills to be able to explore these, and relate them to ethical methodology. Technical and humane judgment are then the expressions of these dispositional attitudes. The dispositions of the humane and scientific attitudes, and their expressions in scientific and humane judgment, are one cornerstone of professional legitimacy. Just as scientific skill can be developed in identifying phenomena related to
scientific heuristic groupings (e.g. DSM diagnoses), the appreciation of relevant scientific evidence and the application thereof to the individual case, so can ethical sensitivity to the values present within the phenomena be practiced, and taught, based on ethical methodologies. Emphasizing the parity of importance of both these skills in practice, medical training, and CME, and the necessarily local and contextual nature of clinical judgment, are conclusions of this study. As remarked before, there is a strong framework in place for dealing with more factually-laden phenomena. Relatively speaking, the normative framework requires further support in order to make ethical knowledge and method available to the practitioner.

Finally, we can now apply these findings to current debates on professional legitimacy. We shall review main points of these debates, current professional strategies for ensuring legitimacy, and suggest possible avenues for calibrating these strategies if we take the above propositions into account.

10.4 Conclusions: The profession of psychiatry

The professionalism movement in medicine and psychiatry

In the past two decades, an international consensus appears to have developed in which the profession of medicine is seen as besieged. Though the details of the challenges to the profession may vary locally, significant recent reports testify to similarities across international borders. For example, in the introduction to the Charter on Medical Professionalism, published simultaneously in the Annals of Internal Medicine and the Lancet, Sox notes that changes in health care systems in industrialized countries ‘threaten the values of professionalism’. The Charter itself refers to an ‘explosion of technology, changing market forces, problems in health care delivery, bioterrorism and globalization’ as examples of such changes, requiring a professionalism ‘activist in reforming health care systems’ (ABIM et al. 2002). Bhugra, then president of the Royal College of Psychiatrists, wrote of psychiatry and other medical specialties being ‘under attack from a number of sources, including government and policy makers’ (Bhugra 2008). Several authors have remarked on the historical parallels with the situation in the US that instigated the Flexner Report, which together with the efforts of its author provided a strong impetus for the professional development of medicine in the early Twentieth Century (Irby, Cooke and O’Brien 2010, Hafferty & Castellani 2010, Duffy 2011). In Flexner’s report, professionalism was a necessary countervailing element in opposition to commercialism. In latter descriptions, professionalism is seen as a ‘third force’ between those of state and market, perennially defined by its
altruistic, public aims. Increasingly in the past two decades, medical professionalism has been positioned as a means through which the profession can (re)gain a degree of social legitimacy and power, to be exerted towards its public remit: the profession’s gain should be the public’s benefit. This wording already points towards a common streak within this new professionalism literature: it is strongly normative and value-laden. Though professionalism is a concept that may be subject to conceptual debate (which we will not enter into now), the possession of a set of ‘shared’ and/or ‘core’ values binding and defining professionals is a universal property of conceptualizations of professionalism. A major strand in the new professionalism movement consists of multilateral efforts to define and profess such common values. In his presidential address, Cohen (1998) cited ‘a small set of overarching attributes that characterize the qualities must possess to meet societies’ legitimate expectations.’ These attributes included altruism, compassion, empathy, trustworthiness, truthfulness, scientific knowledge, skill, and the ability to collaborate. The abovementioned charter is grounded in ‘common themes’ expressed in three ‘fundamental principles’ and a set of ‘definitive’ professional responsibilities: the primacy of patient welfare, the principle of patient autonomy, and the principle of social justice, coupled with responsibilities towards professional competence, honesty towards patients, patient confidentiality, maintaining appropriate relations, improving access to care, just distribution of finite resources, scientific knowledge, managing conflicts of interest, and professional responsibilities. One problem with this approach is immediately apparent in the lengths of these lists and the fact that they are heterogeneous, the supposedly overarching attributes of empathy and compassion not having found their way into the Charter. We will return to this point later, here we note the orientation towards a set of common values as a first main feature of the new professionalism movement.

In the Netherlands the processes above have developed in a similar fashion: the incoming president of the Dutch Association of Psychiatry asked, in his inaugural address:

“Who is the psychiatrist? The care manager, the administrator. Thank heavens we have been granted directorship, we may sort things out, we’re the lucky people where the buck stops, we can fill in the administrative requirements and be accountable. We’re the symbol of a certain amount of DRGs, we sign off on things.”

https://www.youtube.com/watch?v=Fu463zh4aUw

Borleffs, Mourits and Scheele (2016) remark upon the changes in the newest edition of the influential CanMEDS model, in which the place of ‘leadership’ as a new core competency is the most eye-catching. The change from ‘manager’ to
‘leader’ is a reaction to social developments, requiring the physician to assume the role of a ‘change agent’ (Frenk et al. 2010), with an emphasis on action with a systems perspective: physicians should function as “individual care providers, as members of teams, and as participants and leaders in the health care system locally, regionally, nationally, and globally” (Frank, Snell & Sherbino 2015). The effort to implement and sustain ‘medical leadership’ in the Netherlands is apparent through medical educational reform, the formation of formal professional platform (http://platformmedischleiderschap.nl/) and the installation of a dedicated professorship. In the platform’s Vision Document, the move to Medical Leadership is motivated chiefly by increasing complexity:

“Health care is becoming more and more complex. Nowadays, as a physician, one is also confronted with complicated legislature, political developments, and current social issues. Physicians are expected to play a coordinating and assertive role. You must also be able to bring both your care team and patients on board with your medical decision-making…. Finally, the fading of borders within Europe and the easily accessible communication with the rest of the world requires placing our medical practice in an international perspective.”

The expanded scope expressed in this document pertains chiefly to skills involved in navigating systems complexity, either at the individual professional level, at the level of (local) organizations, or at general health systems levels, with an aim to exert influence at all levels. The second main feature of the modern professionalism movement is, therefore, its (added) systems orientation.

A third feature may not be apparent in all instances of new professionalism, but is a common feature in the sociology literature on the subject: the framing of the narrative of professionalism in terms of loss, rediscovery, and recommitment (Cohen et al. 2007, Hafferty and Castellani 2008, 2009). The fall in professional status is attributed to the loss of professionalism as a core occupational attribute; its solution the rediscovery thereof and renewed commitment thereto. The principle locus of this activity should be medical schools and training, and its method is a change on culture of medical education. An example of such a narrative can be found in Swick (2000) in which the author decries the rise of ‘expert professionalism’ in recent decades accompanied by a loss of ‘social trustee professionalism’ leading to a loss in its sense of public and social purpose:

“In recent years, professionalism in medicine has gained increasing attention. Many have called for a return to medical professionalism as a way to respond to the corporate transformation of the U.S. health care system. Yet there is no common
understanding of what is meant by the word professionalism. To encourage dialog and to arrive eventually at some consensus, one needs a normative definition.” (Swick 2000)

The narrative is shaped in terms of loss, the solution in terms of recovery, and the focus here lies on a set of shared values within the profession.

Though this ‘modern professionalism movement’ has gained substantial footing on both sides of the Atlantic, it is not without criticism. Hafferty and Castellani (2010) cast doubt on the historical accuracy of the ‘professional loss’ narrative. Referring to the Flexner Report’s depiction of a medicine in the early Twentieth Century as a nascent profession ‘not fully socialized’ in terms of fulfilling its ideal values of altruism, minimizing selfish motives and resisting the corrupting forces of commercialism, the narrative of loss implies that somewhere between the 1920’s and the 1980, the profession did attain, or come close to, an ideal of ‘altruistic grace’. If that does not prove to have been the case, we should conclude that this story is ‘more hyperbole than historical fact’. The loss narrative, they propose, suits just one of a number of empirically grounded forms of medical professionalism, namely ‘nostalgic professionalism’. In their article, the authors distinguish seven different forms, based on different values hierarchies. In nostalgic professionalism, for example, autonomy, altruism, interpersonal competence and personal morality are valued highly, whereas in ‘entrepreneurial professionalism’, commercialism, autonomy, technical competence and professional dominance take precedence. Meanwhile, ‘activist professionalism’ values social justice, the social contract, altruism and personal morality highest. Besides a previously recognized diversity on the understanding and conceptualization of ‘professionalism’, another layer of diversity, namely in the selection and prioritizing of values, is apparent within the profession. Kinghorn et al. (2007) also criticize the assumption that there is or may be a universally agreed upon or latent set of core professional values, arguing that the need itself for such documents as the Physicians Charter betrays the fact that apparently not all such values are shared by physicians. They argue that professional virtues are dependent on particular moral community traditions, that the aforementioned statements fail to acknowledge this and therefore forfeit power, and that medical education in professionalism must be openly pluralistic, thereby embodying the particular moral communities in which the virtues can flourish (ibid.). The attempt to prescribe, through consensus-based documents, a values hierarchy fails to acknowledge both the diversity of values within society and local communities, and the problem of, even where there may be a values consensus in theory, of enacting and prioritizing these in practice. For the latter, the localized values systems within moral communities are highly relevant.
Students of medicine and medical professionals alike have been reared in various moral communities, of which medical school and a mental health institution are but two examples. An appeal to some essentially medical, internal shared value core, e.g. the Hippocratic Oath, cannot solely provide a moral legitimacy for the profession, since certain elements of the Oath are clearly not shared universally within medicine today ("abstain from abortion and euthanasia, do not charge a fee for medical education"), and those that have survived, it is argued, have done so to being sustained by external moral systems ('living moral communities').

"Medical care has existed in a particular cultural milieu and has been profoundly influenced and directed by the prevailing moral community traditions of the broader culture. The experience of physicians in caring for the sick can inform and influence these broader community traditions, but it cannot supplant them." (Kinghorn et al. 2007)

A further criticism of the modern professionalism approach is the possible discrepancy between professing and enacting professional values. If the distance between ideals such as 'always putting the interests of the patient above your own' or 'avoiding conflicts of interest' are in marked contrast to the actual behavior of role-model physicians, residents are exposed to models of compromised ethical integrity, and may develop professional cynicism and a 'chameleon-like' approach to professional ethics (Brainard and Brislen 2007). Professional values, in other words, must not just be stated, they must be professed (Montgomery 2011, Sabin & Steven Moffic 2011, Swick 2007) and enacted. A related argument is that this discourse puts the onus on the individual practitioner to comport himself or herself in a manner according with these professional ideals, without sufficient notice of the systemic forces she may be exposed to (Hafferty and Castellani 2010).

This debate can be reframed in historical sociological terms. As mentioned above, Flexner pitted the moral core of professionalism (with its core value of altruism) against the corrupting forces of commercialism (with the core value of self-interest). Historically, the medical profession enjoyed a period of negative freedom (freedom from the intrusion of professional autonomy by others) throughout the first half of the Twentieth Century (Montgomery 2011). A mix of wider sociopolitical and socioeconomic forces resulted in a general diminishing of professional autonomy from society. Depending on political leanings of the society medicine was operating in, this resulted in a greater role of market forces and commercialism in medicine (the United States) or of the state (Britain until the gradual privatization of the NHS). The modern professionalism movement attempts to bolster professional autonomy by (re-)establishing core values and putting them on display, for society to see, and by enacting these in practice. In
doing so, at least part of the movement performs a segregation (criticized in Hafferty and Castellani 2009) of ‘core values’ intrinsic to the profession and to explicit curricula (mostly aligned with the values hierarchy of nostalgic professionalism), whilst assigning ‘threats’ to these core values as external: within system pressures of market forces, state-driven cutbacks, or insidious ethically corrupting forces in the hidden curriculum. This picture though proves to be an insufficiently differentiated representation of the values distribution within the profession, and without. The morally ideal but besieged professional may be an inspirational and heroic image, but probably, it is false. To quote Kinghorn et al. (2007):

“Is it possible that the true “threat to medical professionalism” is not market forces, insurance companies, trial lawyers, or managed care, but, rather, medical students, residents, and physicians who are inadequately formed in any substantial moral tradition that would help enable them to withstand these pressures?”

Montgomery argues for a foundation of professional legitimacy based in a concept of positive freedom: freedom to. An emphasis on professional autonomy and negative freedom has been shown to be overridden by state and/or market forces, and is susceptible to ‘short term goals, consumerism, and giving society what it thinks it wants’ (Swick 1998). Montgomery identifies both the risks of a profession one-sidedly dictating its values upon patients and society, and the risk of consumerism: which he sees as fundamentally amoral, reducing the physician to an ‘unreflective responder to consumer desires’ (Montgomery 1996). The alternative, based in positive freedom, is enactment of professional values and engagement. This perspective is consistent with Kinghorn et al.’s proposal to engage with moral communities, be they social, institutional, or scientific. It is probable that a global survey of professional medical values would deliver a logical geography of such values, in which we might be able to pick out ‘core values’, but is equally likely that when enacting these values, we will need to engage in local circumstances and we will be challenged by situations leading to values conflicts both between internal and external values, and between internal values, leading us to question our own values hierarchies. Therefore, we should agree and conclude that professional values should not only be made explicit, be professed, and be enacted, but also, they should be in dynamic engagement with relevant moral communities. It should be noted that the normatively reflective perspective on relevant facts and values on the part of the practitioner in such interactions mirrors the third level reflection thereon in the clinical encounter.

This conclusion is consistent with the findings of this study, in which one of the main findings is the lack of segregation of values, and the way in which values are
deeply and dynamically involved in diagnosis and treatment. This has implications for the skills required of the psychiatrist in awareness and management of such values. In the following, I shall argue that this requirement should be met by changes in medical and residency training in psychiatry, in its professional profile and ‘caching out’ of the social contract, and in practice itself.

An open profession

I will now move on to set out a view of legitimate professional practice for psychiatrists. This view is grounded in the main findings of the study. Before sketching this approach though, the deeper question of what kind of thing professionalism should be grounded in should be addressed. Following the above discussion and literature, one would tend to conclude that the medical profession’s primary legitimacy is normative, resting on values, whether these are an enduring and possibly essential set of core values, or a more mutable and historically/socially relative set based on a (temporary) social contract. In Loughlin (2013), a number of authors discuss Values-Based Practice as a legitimizing endeavor for psychiatry. In this debate, the merits of foundationalism versus anti-foundationalism are discussed with respect to a normative foundation (in this case VBP, but the discussion can be applied to the approach suggested in this study. Miles (2013) points out that there is a risk of replacing one debunked hegemony (EBM) with another singular epistemology, now values-based instead of facts-based, only to foreseeably realize in the future that any singular approach must fail, since the very nature of medicine entails epistemological and ethical pluralism. His anti-foundational approach is termed Person-Centred Clinical Care. Little (2013) responds to Miles with a fork: what motivates the ‘centering’ on the person if it is not some value or set of values? Either this should be acknowledged, or PCCC fails to motivate why societies invest so many resources into health care. Little’s own proposal describes a set of more general foundations, pre-normative values, argued from an explanatory rather than a prescriptive perspective, and fundamental for human societies: survival, safety, and flourishing. In the concluding chapter, Fulford and Little exchange views on the question of foundationalism, and Hume’s regression problem: beyond each foundation a further question for grounding beckons. This is not a debate that is likely to be resolved anytime soon, therefore they conclude that models based on different positions on this question may peacefully coexist and provide guidance. I am in agreement here: whether we see certain core values as pre-normative essentials or as historically contingent concrescences is, metaphorically speaking, as relevant to such highly embedded values as the mouse’s opinion of the ontological status of
the elephant: the latter carries a lot of weight irrespective of the mouse and the mouse does well to tread carefully. Whether or not we agree with ‘foundations are not to be had’, the shared moral should be that, to ensure survival, the profession should both invest in mapping its own (temporary, contingent) values geography, and mapping and engaging with those of patients, communities, and society. This also includes mapping the internal geography of varying hierarchies of professional values as demonstrated by Hafferty & Castellani (2010), which should invoke deliberations and negotiations as to their legitimacy, scope, and jurisdiction. Just as we saw heterogeneity and local solutions to the problem of ‘mental disorder’, it is conceivable, even plausible, that varying hierarchies are enmeshed in and appropriate to different local contexts.

The medical profession has invested substantial resources into developing a methodology of knowledge management that is science-based rather than authority-based. Given the fact that subjectivism is already a worry attached to normative deliberation, grounding professional legitimacy strongly in normative practice may expose it to renewed objections of paternalism or authority-based practice. Therefore, as mentioned above, the methodology and reflective practice related to values for psychiatrists must be substantial and rigorous. The recognition thereof within philosophy of psychiatry has provided us with new resources to meet this challenge. Resources, knowledge and training should be directed at the aim of increased normative expertise in practice, the performance of which should be assessable. This is a crucial point: one worry of the ‘values list’-approach in modern professionalism, as mentioned above, is the possible discrepancy between what is professed and what is practiced. Schmutzler and Holsinger (2011) point to the risk of double standards if students and residents witness faculty members, attending physicians and residents behaving in an unprofessional manner. Sabin and Steven Moffic, in the same collection (2011) echo this warning, noting the risks of statements of professionalism as ‘pious platitudes’, ‘powerless ideals’, or ‘hypocrisy’ if stating and professing values are not backed up with action. In a scheme reminiscent of Hafferty & Castellani’s (2010) micro, meso, and macro levels and the NPM, Schmutzler and Holsinger also take a systems perspective to the ‘striving for values throughout the professional lifetime’: this should be done not only at the individual level of the physician-patient encounter, but towards the healthcare system and society. The realization that physicians should engage at these levels is apparent in the systems approach within the modern professionalism movement, however I will argue below that both for medicine generally and for psychiatry, so far this new professionalism, though having recognized the importance of values as a central feature of health
care and professional legitimacy, has not yet sufficiently adapted training and professional declarations to the aims it has derived from this recognition.

A question related to the ‘foundations debate’ is whether it is possible to derive essential values from within health care, as Pellegrino (2006) has attempted, or whether, necessarily, one must appeal to morals from outside the domain. The latter might awaken worries of relativism. This can be overcome in accordance with arguments put forward in Chapter 7 on science: to ascribe ‘anything goes’-relativism to a moral grounding is a subjectivist stance. Though values may be required to be negotiated, and are relative to time and place (as in the normative practice model), it is just the set of agreements, the agreed-upon moral base, that grounds them and wards off relativism, whilst they are enacted and intrinsic to practice, embodied primarily in the physician-patient relationship. Therefore, I agree with Kinghorn et al. (2007) in their emphasis on professing and engagement. This is not to say, however, that the production of formal charters and professional statements has no value. Just as it should be possible to derive a logical geography of current professional values, such a project could also be performed from a historical perspective for medicine, and psychiatry (see for example Grob 2015). Whether we see such charters as temporary historical concrescences or essential elements of the profession is less important than recognizing their role in the here and now, defining, integrating, and professing the current values of the profession towards society. In terms of social contract theory, society will accept or resist such a charter, and will set its own set of values against it. It is highly likely society will not fully endorse any charter, just as likely as it is that health professionals themselves may possess different core values or values hierarchies. And again, local circumstances will necessitate debate and negotiation on which values should take precedence in a given situation. Conversely, certain values will have a longer and more stable track record than others, and have been written into national or international (health care) law and internal professional regulations. It is altogether possible to recognize on the one hand the presence of a set of core values and on the other the diversity of values hierarchies both within and outside of the profession (cf. Hafferty and Castellani 2010).

**Ensuring ethical expertise**

There are, of course, many resources available for values-sensitive methodology relating to practice. Substantial overviews hereof can be found in Sadler, van Staden and Fulford (2015), Bloch & Green (2009), Dickenson & Fulford (2000) and Robertson (2014). Awareness of values, their nature, how and where to recognize them, and how to attune them to the clinical encounter at hand are foundational
elements of professional expertise. This currently generally involves taking a reflective stance towards one's own practice, facilitated by peer consultation, peer-to-peer coaching, case meetings, and suchlike. These forms generally, but not always, relate to one or more methods. One conclusion of this study is that these practices should be transparently grounded in recognized method. An example of such a practice in the Netherlands is that of the 'Moral Council' (Moreel Beraad, cf. Molewijk et al. 2008), which specifies a theory and method of approaching and analyzing value features in practice. With regard to consciousness raising, and managing of values in practice itself, Values-Based Practice has been noted (Woodbridge and Fulford 2004). Besides offering a clear theoretical framework, an advantage of VBP is its pragmatic, and practice-based approach: it has substantial ease of use (Crepaz-Keay 2015, Fulford and van Staden 2015).

An approach not mentioned in Chapter 7 (as it was primarily aimed at the relationship between science and practice) is that of virtue ethics. This perspective is one way of addressing the problem faced by a principle or rule-based approach to ethics of coping with local diversity and pluralism. Radden and Sadler (2010) have argued for a role for virtue ethics from the specific nature of the ethical challenges involved in psychiatry as opposed to all of medicine, and the presence of 'unruly values' which cannot easily be captured in terms of rules and principles (there is a parallel here to Thornton's arguments on tacit knowledge being objective, valid, and nevertheless not susceptible to rule-following). A centrist approach, espousing professional core values connected to entailed principles and rules, risks either a lack of coverage, or an overemphasis on rule-following, overly constraining practice (and, depending on societies' approaches to assessing professional ethics, bureaucratization). Combining deontological with virtue ethics offers some balance: in the Virtuous Psychiatrist, Sadler and Radden argue for key virtues required of the professional psychiatrist (besides those connected to the medical profession), related to the specific features of the domain of psychiatry (table 10.2).
1. Trustworthiness  
2. Humble Propriety  
3. Gender Sensitivity  
4. Empathy and Compassion  
5. Warmth  
6. Self-Knowledge, Emotional Intelligence, Self-Unity, and Integrity  
7. (Hopeful) Patience, Fortitude, and Perseverance  
8. Unselfing and Realism  
9. Respect for the Patient and the Healing Project  
10. Moral Leadership and Moral Integrity  
11. Authenticity, Sincerity, and Wholeheartedness  
12. The Metavirtue of Phronesis

**Table 10.2. Virtues for Psychiatrists (Radden and Sadler 2010)**

The strength of this virtue approach is that it combines both accountability (it is possible to assess virtue through varying methodologies) and flexibility in taking local values geographies into account. To these methods, I would like to add a specific ethical approach described in Robertson (2014), because it, in my opinion, captures the third dimension of ‘openness’ of practice to values from the social and science domains.

Robertson provides two ethical perspectives which offer resources for dealing with values connected across different science-society-practice domains: social contract theory and communitarian ethics. He invokes *social contract theory* to describe the relations between the profession of psychiatry, people suffering from mental illness, and society. The professional social contract imposes a dual role upon psychiatrists: they have a responsibility both to the individual patient and to the community. These responsibilities most clearly come into conflict in debates surrounding involuntary admissions and forensic evaluations. In these contexts, significant numbers of individuals see the actions of psychiatrists more to their detriment than to their advantage, and primarily for society’s gain. Balancing the interests of individual patients and society also manifests itself in different ways: psychiatrists, just as other mental health care workers, frequently act as advocates for patients in their relations with social institutions. How far may such advocacy legitimately extend? Critics have pointed to the presence of ‘double dependency’
implied in such advocacy relationships: the patient not only ‘suffers’ the power differential inherent in the medical relationship, but where this extends beyond the borders of the hospital, the dependency extends within his or her social sphere. In another domain, with regard to health care rationing, similar questions over advocacy may be raised. In the previous chapter, various organizations were involved in a high-level government discussion over demarcation of the mental health domain. It may be argued that the professional organizations have a legitimate place there in view of their experience and knowledge of treating mentally ill persons, and because any decisions will affect their practice, but to what degree are they also representing these persons and advocating for them? Recall the ethical arguments related to duty of care. Can these professional bodies truly be said to legitimately represent the needs and interests of persons suffering from mental disorder? If so, what form does such (democratic?) representation take? In what way can the profession be seen to be advocating patient values within such policy debates? Such issues are akin to those addressed by Sadler with regard to the DSM process, discussed in Chapter 4. It is reasonable and justified that there be a divergence of opinion as to where the boundary lies where advocacy becomes inappropriate. Robertson proposes an ‘onion skin model’ where there is a core of professional expertise and actions related to this are incontrovertibly psychiatric, as in ‘clinical intervention’. Further out lie questions of community attitudes and public policy, and the debates become less ‘psychiatric’ and more sociopolitical; this implies that as one travels further out from the ‘core business’, the less substantive the role of the psychiatrist in advocacy should be. As psychiatry has grown, so it also has differentiated. This implies that the form, rules, and obligations of a social contract will vary across sociocultural settings, including those within one national domain. Therefore, psychiatric ethics, according to Robertson, “is a network of interactions between the individual morality of the psychiatrist, and the relationship between the psychiatric profession and broader society.”

To the perspective of the social contract Robertson adds that of communitarian ethics. Communitarianism, according to the Oxford Companion to Politics (Etzioni 2001), is a social philosophy that maintains that societal formulations of the good are both needed and legitimate. Communitarianism is often contrasted with classical liberalism, a philosophical position that holds each individual should formulate the good. Communitarians examine the ways shared conceptions of the good (values) are formed, transmitted, enforced and justified. Communitarian ethics is grounded in Aristotle’s view that the community is the source of the good. Liberal individualism, exemplified by the American Declaration of Independence proclaiming the individual’s right to ‘life, liberty and the pursuit of happiness’
emerged in the 18th century, and was criticized by MacIntyre (1998) for having emphasized the value of the individual over all others. This individualism, according to MacIntyre, ignored the dependence of justice and moral reasoning on group traditions, promoted the atomization of man, allowed the individual to be at odds with the group, and ignored the fact that some groups can predominate over others, thus compromising the philosophy as a basis of the good life. Taylor (1989) added to this criticism that liberal philosophy focuses on what is right to do, rather than what it is good to be. Taylor put moral evaluation at the center of human identity: people understand who they are by making evaluations about what is good and how that understanding will affect their lives. Moral choices are made from individual experience, but must be set within a framework of society, nature, and history. Callahan (2003) related communitarian ethics to psychiatry using an ecology metaphor of bioethics: if one introduces a new species into an ecosystem, one must consider the effects thereof on other species in the system and the system in general. Liberal individualism, by contrast, focuses on the effects on the individual species. Robertson summarizes with four points: first, that humans exist in a network of other people and within the social institutions and culture of their society, second, that no sharp distinction can be drawn between the public and private spheres of moral life, third, that communitarianism begins with the welfare of the society as a whole, and finally, that the historical context of moral systems is important. The highly contextual nature of the psychiatric profession, which has been a main feature of this study, accords with such an ethical approach. Therefore, communitarianism is proposed by Robertson as an ‘ethical prism’ through which quandaries in psychiatric practice should be viewed: by not only attending to the values that can be identified but also to the influence of history, societal values, the law, and culture. Robertson applies these principles at ‘endo’ social level of the psychiatrist-patient encounter, with a form of moral reasoning consisting of a reflective phase (which proceeds from the local value features of the clinical context, to wider contextual, e.g. institutional, legal, political, and to fundamental personal and professional values), and a deliberative phase based on casuistic reasoning.

Taking the third main conclusion of this study (the dynamic and non-dichotomous nature of fact and value in psychiatry), we can apply the ‘onion skin’ approach to relevant value elements of the moral communities (scientific, professional, institutional, societal) that professionals relate the phenomena to. Their relevance is determined by the normative and pragmatic aim set by the fundamental nature of the encounter, which implies that the patient is the primary reference point of the ‘medical good’, also implying a necessary connection to the patient’s meaningful frame of reference. Robertson’s ‘onion skin’ metaphor for the gradual
relationship between professional responsibility and the patient’s own responsibility, set on an axis between profession and society, should be applied to wherever else values are located within the encounter, including conceptualizations of disorder, or the presence of values in science. Ethical sensitivity includes a recognition hereof, and a duty to relate such more embedded values to the primary goal of the ‘medical good’. In other words, psychiatrists shouldn’t only be sensitive to the facts and values in the individual context of the physician-patient encounter, but also view them on a tangential axis, outwards towards relevant moral communities, and be aware of values embedded in scientific concepts and perspectives, institutional and societal arrangements perpendicular, but relevant, to the encounter. Robertson’s metaphor, in which value judgments made in the encounter may require action at ‘outer’ societal levels, here can be seen as a vector along which values can travel in both directions.

To illustrate, a hypothetical example: a psychiatrist works on a clinical psychiatric unit. Recently, financial pressures on the institution have led to a number of measures being taken, one of which is an agreement to maximize the occupation of hospital beds, as reimbursement is tied to occupation. Part of this involves a restriction of the possibilities for patients to spend nights at home before being discharged. Previously, experimenting with day and weekend leave was a regular part of treatment and preparation for discharge or transfer to the ambulatory services. A cap is agreed of 2 nights maximum per patient. Subsequently, a situation arises in which a patient’s partner falls seriously ill. The couple do not have a social network to fall back on, and the patient, after deliberating with his partner, requests for additional leave to tend to his partner, with the secondary aim of hoping to prevent a hospital admission for her. It is immediately clear this would result in going over the agreed limit. The psychiatrists feels it would be right to argue for an exception to the rule, but her manager invokes the slippery slope argument which would finally result in major financial problems, and the advantage of this patient would lead to the disadvantage of another. There are of course, many courses of action available to the psychiatrist, and the aim here is not to deliberate these, but rather, to focus on the methods for doing so. Firstly, the position argued for here implies that it is a professional duty to take an ethical stance on this issue, related to the duty of care for the patient. The psychiatrist cannot say (on this account) that a management decision is outside of her domain or power, and she should remain ‘neutral’. Secondly, the normative stance should be backed up by relevant knowledge and method. The psychiatrist’s feeling of what would be right, indicative of a moral emotion, should be connected to the appropriate ethical domain(s) and methods, in order to inform and ground a
course of action. It is this latter point which is perhaps most modificatory of current practice.

**Implications for medical & residency training and CME**

Such ‘values-sensitive’ skills should not be seen as purely conscious cognitive phenomena, a part of ‘reflective practice’, although this is an important component. As we saw in Chapters 2 and 3, clinician reasoning is partially determined by unconscious modeling, hidden curricula, intuition and tacit knowledge. These conduits for knowledge impart both factual and normative knowledge. In other words: one’s ethical stance and judgments are not qualitatively different from fact-based judgments: they can be conscious, reflected upon, but are also embedded in action, encapsulated in ‘illness scripts’ and *intuitively* performed. Therefore, to further good practice values-related judgment and expertise should be *practiced* as a skill to be honed. This requires a knowledge base and recognized methodologies, such as those mentioned in this study, though in need of institutional support. The knowledge base required for professional values expertise should not only be imparted through medical and specialist training and CME, but also through the kind of demonstration required for attaining tacit knowledge. The practice found in studies of medical and psychiatric training of supervisors imparting their personal and professional values to students and interns is not a priori wrong, but should be motivated, and connected to ethical frameworks and methodologies described here. With respect to methodologies, a requirement for relicensing in the Dutch psychiatric profession is participating in peer-to-peer support groups, a form of peer review. Such peer review groups offer a practical opportunity to practice values-related skills. An obvious conclusion from this study is to translate the aim of rigorous ethical deliberation in practice to education, that is, to ensure that there is sufficient attention paid to this area. Applying communitarianism in this area could lead to a wider use of recent, innovative ideas and practices. Mirroring the suggestions made with respect to the development of classification, the involvement of patients and other ‘stakeholders’ within such processes is legitimate. Education too invokes epistemic perspectives and necessarily involves values. Patients, in this context often taking on the role of ‘experts by experience’, offer diverse first-person perspectives which show alternative epistemic channels, whilst also being able to attest to value entailments of otherwise unattended to, embedded concepts. An example of such an approach to reflective practice is the ‘Trialogue’ group approach described by Amering, Hofer & Rath (2002):
"""Trialogue" stands for the encounter of the three main groups of individuals who deal with psychosis and with the mental health system – people with experiences of severe mental distress, family members/friends and mental health professionals. This encounter occurs under special conditions - outside the family, outside psychiatric institutions, outside a therapeutic setting. It is the aim of the Trialogue to facilitate communication about the personal experiences in dealing with psychosis and its consequences. The participating groups strive towards giving up their isolation and lack of common language. Mutual understanding and necessary delimitation from the vast variety of the participant’s different backgrounds concerning experience and knowledge should be established. Trying to understand and share the complex and very heterogeneous subjective experiences may well lead towards establishing a common language, which implies building the basis of a culture of discussion seen to be necessary for working together effectively. It is widely argued from different areas of research that acknowledging the personal experiences of users in planning, organizing and doing practical work is necessary to improve both research and practice in dealing with psychosis (Stastny P and Amering M, 1997; Zaumseil M, 1996). Engaging in the Trialogue is the necessary training to further enhance this process."

In keeping with the ‘open’ aspect of professionalism, training should also focus on the meso and macro levels, and the transitions and applications of fact and value between levels. In new professionalism, there is a strong recognition of the requirement for professionals to acquire knowledge in the areas of health care funding, economics, (health care) law, management, sociology and political science in order to perform effectively in these spheres. Such knowledge will generally entail applications of the background disciplines to (mental) health care. This necessary translation should be combined with values-sensitive approaches, e.g. ‘Ethics in Public Health Care Policy’.

Enriched Professionalism
Along these same lines, the involvement of patients in defining the ‘medical good’ becomes a duty of institutions and the profession. Whereas a ‘segregated’ view may frame certain courses of action as uncontested, evidence-based approaches, the perspective of this study argues against such a priori prioritization: there may be, and there frequently are, good reasons for applying EBM-based guidelines. However, this choice is secondary to the general aim of the medical good, and the latter should also be determined by patients. Alternative epistemic pathways may legitimately be invoked in order to get a sense of this good. As an example, we have recently undertaken a project aimed at developing an instrument to evaluate ‘good
care’ within a closed, emergency ward setting, based on concept mapping (Nijssen, Ralston & van Weeghel, forthcoming). An important feature of this instrument is that it is being developed from a recovery perspective (Slade 2010), whereby the experiences and perspectives of patients and experts by experience play a central constitutive role. A communitarian perspective is also helpful in determining levels of action and responsibility. If we take, for example, the disputes over the CVZ report described in chapter 9, from the ‘segregated’ perspective the legitimacy of the profession in speaking out on these matters would be limited to basic arguments concerning access to care, general quality of care etc. From the perspective of this study, choosing a certain ontological view of disorder (in the CVZ case, as ‘uncontestable’) has, through translations from the sphere of government, enacted in documents and practices involving the third-party payers, which become part of institutionalized procedures, an impact on the *outillage mental* of practice. The profession should, if it is to fulfill its side of the social contract, reflect upon and take a public and if necessary political stance based on the envisaged consequences thereof for its ultimate goal. Again, the ‘openness’ principle necessitates the involvement of patients in this judgment, as advocacy is limited by principles of democratic representation: norms applying to the meso and macro levels of negotiation. What’s good for psychiatrists, the DAP’s founding statement notwithstanding, is not always good for patients. If, as we have proposed in this study, the core of the medical profession and therefore that of psychiatry is the benefit of patients, the profession would be wise to assume a collaborative position vis-à-vis patients at all levels as a feature of normative attunement. The CVZ debate is but one example of the values being examined, reflected on and negotiated from the points of view of profession and patients, towards society. The values can just as well be found in psychiatric science: the growing support for the recovery perspective in patient groups could be translated into alliances with professionals to stimulate further research in this area. And in an intersection between patients, profession, and science, such efforts could be directed at designing instruments measuring the ‘medical good’ in terms that are acceptable to the ‘third-party paying’ social groups. Central to the proposal of this work is that a professional duty rests upon the profession to, at the minimum, explore these avenues.

### 10.5 Conclusion

With this overview of the general conclusions to the study, their implications for the legitimacy of the psychiatric profession, and practical applications thereof, we come to the end of this study. The initial aim of applying an empirical approach to
practice, and connecting this with philosophy, has generated a refreshing perspective on psychiatric practice. Clearly, the empirical work within the study is open to alternative and contesting interpretations or accounts: such is the nature of qualitative study. Also, the limitations of this study precluded practicing what has been preached in this final chapter, namely, the constitutive involvement of patients in the process. If this approach does prove to be fruitful, the obvious next step would be to conduct just such a study from the perspective of the patient rather than psychiatrist, followed by a study incorporating both. One final tip of the hat to history: recent historical work has shown that the ‘father of psychiatry’, Pinel, was indebted to Jean-Baptiste and Marguerite Pussin for his ideas and efforts towards the humane treatment of the insane. Previous to the role of superintendent, Pussin had himself been treated in the Bicêtre and therefore, after a fashion, was an expert by experience avant la lettre. I hope this study contributes to a recognition of the value of collaboration between physicians and (former) patients at all levels of mental health care.
As a hybrid discipline and field of inquiry, 'philosophy and psychiatry' has great promise as an interfield study area: the 'communication gap' inherent in

advice of Philips to 'show practitioners, in their language, what might be the

and perhaps even follow their influence on practice? Can we also take Philips' further, normative step of 'sh
Summary

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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