Chapter 3: Diagnosis in practice.

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3.1 Introduction.

In this chapter the results of the qualitative study pertaining to diagnosis will be presented, preceded by an overview of literature on diagnostic practice. The framework analysis undertaken resulted in a perspective on practice in which different forms of reasoning on the part of the psychiatrists were dynamically applied. Psychiatrists’ implicit and explicit philosophical beliefs are described within this framework, leading to a number of questions and problems which will be taken forward in the chapters to come.

The concept of diagnosis is central to the practice and identity of physicians. Diagnosis can be taken to refer to the abstract category of diagnosis as an instance of a phenomenon referred to within a formal medical taxonomy (a diagnostic label), or the practice of diagnosis by the physician, i.e. the activities aimed at determining to which category a given set of signs and symptoms belongs. Fulford et al. (2006, p.33) identify four main purposes of diagnosis in medicine:

1. **Descriptive**: a diagnostic label provides a summary description of a patient’s symptoms, essential for communication, and the key to all other medically relevant decisions about the patient.

2. **Etiological**: diagnoses, particularly in specialized areas of bodily medicine, are often based on information about etiology or causation.

3. **Therapeutic**: knowledge of symptoms and etiology is the basis for decisions about treatment and other aspects of clinical management.

4. **Prognostic**: symptoms and etiology, together with the likely response to treatment, give an estimate of the prognosis. (Fulford et al. 2006)

They also mention a number of differences between diagnosis in somatic medicine and psychiatry, chief of which is the fact that psychiatric diagnoses are more often defined descriptively (in terms of symptoms) rather than etiologically. Such differences may be transparently related to the complexity involved in a scientific-etiological account of psychiatric phenomena, but the authors also point to the relevance of conceptual difficulties as well as empirical ones (e.g. due to being necessarily involved with experience and higher mental functions).

A central aim of the initial diagnostic interview, as presented in textbooks, is to perform diagnosis-as-practice with the aim of diagnosis-as-description as a means of connecting the local findings to the pertaining body of professional/scientific knowledge and applying this knowledge to treatment. However, the initial clinical encounter is not simply concerned with this understanding of diagnosis.
Significant attention, both in training and in formal textbooks, is given to the fact that diagnosis takes place within the setting of an encounter between two persons, within which there are multiple perspectives (cf. Glas 1997). This multiplicity is amplified by the fact that psychiatry is a highly differentiated domain, with diagnosis fulfilling different goals related to specific contexts, e.g. the diagnostic process involved in a crisis assessment at a police station will differ from that involved in an intake related to entering an outpatient individual psychotherapy. A feature of psychiatry distinguishing it (to a degree) from somatic medicine is the fact that psychiatry, when it aims at explaining the phenomena in its domain, necessarily involves both meaningful and causal explanation (Jaspers 1959). The distinction implies different relations between phenomena, necessitating different epistemologies, and implying different conceptual domains: the ‘space of reasons’ and the ‘realm of law’ (Sellars 1956). One main challenge within psychiatry generally and psychiatry and philosophy specifically is to develop a legitimate account of psychiatric practice encompassing these features. Where a purely descriptive and causal account of psychiatric phenomena arguably exclusively involves identification, the meaningful understanding of phenomena, based as it is on a hermeneutical process, requires for its validity reflection on the interpretation of meaning, a reflection to which the patient is partial. Jaspers, for example, pointed out that the ‘chaos of phenomena’ present in a psychiatric case should not be ‘buried under a diagnostic label’. The tension between reductionism and anti-reductionism (Thornton 2007b) is a further feature of this dual nature of diagnosis. As the profession of psychiatry has aligned itself more closely to bodily medicine in recent decades, the understanding of diagnosis in the narrow sense of description and identification according to the ideal model of somatic medicine has gained influence throughout psychiatry. This might influence diagnostic practice towards a prioritization of descriptive diagnosis.

Diagnostic practice 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.

Practitioners’ views on the nature of diagnosis and their professional objectives throughout the process of diagnosis in the initial clinical encounter were the subject of this part of the study. However, as pointed out in the previous chapter, the aim is also to localize and describe the structure of the encounter in such a way as to examine the question of where and how philosophical assumptions relating to the process of diagnosis manifest in clinical practice. Therefore, findings of empirical studies of the practices in the clinical encounter are particularly relevant to this study.
Chapter 3

3.2 Empirical studies of clinical practice

Diagnostic practice has been studied using both quantitative and qualitative methods. We are interested here in the manner in which diagnosis is performed: which forms of reasoning are identified, how is knowledge conceptualized, and what are the relationships between knowledge, reasoning, and practice? The following research fields will be reviewed:

1) Clinical Reasoning
2) Cognitive Research
3) Clinical Intuition
4) Anthropological and qualitative research

The objective of clinical reasoning research is to study the thinking and decision-making processes associated with clinical practice. This is a broad research field encompassing the whole of medicine, including few studies specific to psychiatry. The area of cognitive research described in the following is concerned with categorization and causation, and presents experimental studies specifically related to diagnosis in psychiatry. The research area of intuition was chosen both due to its (possible) connections with tacit and personal knowledge, and finally, since the first three areas are organized around individual conceptions and practices, anthropological and qualitative studies were selected which also attend to the role of the (institutional) context in the diagnostic interview.

Clinical Reasoning
Norman (2005) and Elstein & Schwartz (2002) have offered overviews of the development of the research field on clinical and diagnostic reasoning, respectively, describing different approaches to the field as they have developed over time. Elstein & Schwartz distinguish two main approaches, problem solving and decision making. The former encompasses hypothesis testing and different forms of pattern recognition, the latter refers to Bayesian reasoning where diagnosis involves updating information with imperfect evidence. Norman begins his overview in the Seventies when observational studies yielded the ‘hypothetico-deductive’ method, whereby clinicians generated several diagnostic hypotheses early in the encounter, and subsequently gathered data aimed at confirming or ruling out these hypotheses. However, diagnostic accuracy proved to be strongly related to practitioners’ familiarity with the content of relevant medical knowledge rather than to fluency with such a general process, whereupon research moved towards alternative explanations in the Eighties. Modeling the cognitive process
on that of chess players, researchers aimed to show that expertise was chiefly related to memory: “a matter of acquiring a large set of representative cases which can be used for analogies to a new problem situation.” (ibid.) Studies failed to back up this claim, however, and it became clear that quantity of knowledge was not related to the outcome. Researchers moved from such process-focused research towards knowledge structures (Schmidt et al. 1990). Schmidt et al. suggested a developmental model of expertise recognizing three different kinds of knowledge structures associated with increasing expertise. Early in medical training, students diagnosing clinical cases tend to focus on isolated symptoms and signs and relate them to basic science and pathophysiological concepts they have learned. In ‘thinking-aloud’ protocols, intermediate-level students tend to use advanced knowledge of basic sciences to form a causal analysis of the patient’s complaints. Such references to basic sciences are mostly absent in the thinking-aloud findings of expert doctors. This is explained by more experienced doctors relying more on encapsulated knowledge: the groupings of causal and pathophysiological knowledge are organized into higher level, simplified causal models. These concepts retain equal explanatory power, but enable increased processing speed and reduce cognitive load. With further practical experience, encapsulated knowledge is organized into ‘illness scripts’: cognitive structures containing relatively little knowledge about pathophysiological causes of symptoms and complaints (because of encapsulation), but a wealth of clinically relevant information about the enabling conditions of disease (Schmidt & Rikers 2007). Again, there is increased efficiency in this move, as it allows the physician to more quickly narrow down the likelihood of certain diseases, based on the presence or absence of such contextual circumstances. Such ‘enabling-conditions’-knowledge has shown to be acquired primarily through experience rather than being taught. The translation of such knowledge into ‘illness scripts’ occurs at varying levels of generality, from representations of disease categories to representations of previously seen cases. These exemplars are stored in memory and available for future pattern recognition. Problem solving, at least in routine cases, then becomes a process of script search, script selection, and script verification. Bordage (1994) found that the manner in which symptom representations are organized is related to diagnostic accuracy. Better performance is related to the construction of global representations of the case based on the relational structure of their medical knowledge in long-term memory. Experts’ knowledge is organized not just as simple lists of signs, symptoms, and rules, but as a rich network of knowledge. Research on experiential knowledge has shown that similarity to prior cases resulted in improved diagnostic accuracy, proceeded in at least a partially unconscious manner, and took place in the early ‘hypothetico-deductive’ phase of the encounter (Bordage 1994, Charlin, Tarlif & Boshuizen 2000).
As to which forms of knowledge lead to better performance (in the sense of more accurate diagnosis), experienced physicians performed better than novices or intermediate level physicians: they had more coherent explanations for a problem, generated more inferences from the data, and were more selective in their use of the data. Students applying causal knowledge rather than learning associative knowledge performed better, suggesting causal knowledge clarifies coherence between symptoms in a manner that simple associative knowledge does not (Schmidt & Rikers 2007).

Norman concludes:

“Although this research agenda began with the objective of revealing a reasoning process used by experts so that it could be taught to students, no reasoning process that accumulated with expertise emerged. Instead, all the research we have reviewed suggests that expert clinical reasoning is a consequence of an extensive and multidimensional knowledge base....an expert possesses superior knowledge of many kinds, both formal and informal, and any or all may be brought to bear on the solution of a particular problem.” (Norman 2000).

Norman notes that research in clinical reasoning has mostly focused on clinical diagnosis, and has been mostly related to internal medicine. It seems reasonable to expect differences in knowledge processing in areas as divergent as radiology, critical care, neurosurgery and psychiatry. Of the latter, Groopman (2008) remarked in a footnote to his study on clinical reasoning: “I quickly realized that trying to assess how psychiatrists think was beyond my abilities. Therapy of mental illness is a huge field unto itself that encompasses various schools of thought and theories of mind. For that reason, I do not delve into psychiatry in this book.” It seems psychiatry poses an added challenge to researchers in clinical reasoning.

* Cognitive Research
Experimental research in cognitive psychology has recently focused on causal reasoning in mental health professionals. One strand of this research examines the use of the DSM. The DSM famously aims to be ‘theoretically neutral’ with regard to etiology, and therefore the prescribed diagnostic approach is to search for symptoms that match the DSM criteria without presuming any causal theoretical notions of how these symptoms may interrelate and interact. In their 2002 study, Kim and Ahn found that practicing clinical psychologists draw complex causal structures when asked to specify any relations between DSM symptoms of mental disorders. They also found that in diagnosis, clinicians weighed symptoms they
deemed as causally central more heavily than causally peripheral symptoms: patients with causally central symptoms were deemed more likely to have a target disorder and to more clearly exemplify the target disorder than patients with causally peripheral symptoms. Causally central symptoms were more likely to be recalled an hour later, and clinicians were more likely to falsely recall causally central symptoms upon being presented with both causally central and peripheral (according to their own theories) symptoms not present in the original hypothetical patient cases (Ahn & Kim 2008). In other words: clinicians’ representations of mental disorders are not in fact lists of independent symptoms, but rather consist of *theory-like structures* connecting these symptoms. This tendency to represent concepts as theory-like structures is not just a feature of clinicians, but a general human tendency, related to essentialism (Ahn et al. 2006, Gelman 2005), and deemed to be of pragmatic value: it provides a framework for understanding, explanation and prediction. Ahn & Kim (2008) also noted that clinicians’ reports of causal relations among the symptoms or conditions included in the DSM were consistent across theoretical orientations (e.g., psychoanalysis; behavioral modification) and also consistent with laypersons’ commonsense explanations.

Other work from the same group (Ahn, Proctor & Flanagan 2009) focused on the kinds of causal explanation relating to mental disorder, divided into biological (material), psychological, and social causes. Their 2009 study demonstrated that clinicians conceptualize mental disorders along a single continuum spanning from highly biological disorders (e.g., autistic disorder) to highly nonbiological disorders (e.g., adjustment disorders). Also, clinicians believe medication to be more effective for biologically based mental disorders and psychotherapy to be more effective for psychosocially based mental disorders. Therefore, they concluded that clinicians make strong causal distinctions between the biological domain on the one hand and the psychological/social domains on the other, distinctions which affect their choice of treatment.

The importance of causal reasoning is reiterated in a study of clinical child psychologists by de Kwaadsteniet et al. (2010). The authors state that an intervention is effective to the extent that it “changes the causal system underlying the client’s problems such that the problems diminish”, and therefore they expect clinicians to base their predictions of the effectiveness of interventions on client-specific models that specify these causal systems. The case formulation is an example of such a client-specific model. Meanwhile though, different clinicians make different causal inferences for the same client (ibid.). Having previously found little relationship between clinicians’ client interpretation and choice of
intervention at group level, the authors were able to predict clinicians’ ranking of the expected effectiveness of interventions based on their causal models of the cases. Considering the sheer complexity of deriving an idea of the effectiveness of an intervention by taking into account all relevant variables, their causal relationships, relevance to the problem, modifiability and various feedback loops, de Kwaadsteniet et al. suggest clinicians may use simpler heuristic methods, such as basing their expectations on a general model of behavior (e.g. a psychological theory), or on disorder-specific causal models. In their study though, client-specific models seemed more likely than general models. The authors note that their methodology required them to use broad intervention categories and that clinicians may construct more detailed causal models coupled with more specific interventions. Also, they mention that intervention choices in practice will not be solely determined by expected effectiveness: temporal and financial limitations, the availability of interventions, and personal (client or clinician-specific) factors may also come into play.

Clinical Intuition
Witteeman, Spaanjaars & Aarts (2012) note that clinical intuition has an unfavorable reputation in the age of evidence-based medicine and is seen as a source of error and possible harm to patients which should be replaced by actuarial methods of simple data correlations. They believe, however, that the resilience of clinical intuition, even as the actuarial method has received such institutional support, makes it worthy of further study of its possible merits. They describe intuition as operating at least partially subconsciously and based on automatic processes relying on ‘knowledge structures acquired by different kinds of learning’. They distinguish four types of intuition:

a) Associative intuition: learned through reinforced associations and retrieved as a feeling.

b) Matching intuition: based on acquired exemplars and retrieved by comparison.

c) Accumulative intuition: memories are linked to current information in an automatic overall evaluation.

d) Constructive intuition: memories and current information are used to automatically construct a consistent mental representation.

Intuition performs multiple information-processing functions: addressing, integrating and making sense of complex information data. Such translation of repeated experience is unconsciously linked together to form a pattern and connected to action (Klein, 2003). As clinicians become more experienced, they more often apply such intuitive reasoning, though decisions remain based on a mix
of different forms of reasoning, as described earlier. In a qualitative study employing a focus group, the authors examined the value of intuitive reasoning in mental health practice and found that practitioners employ intuitive reasoning in a critical manner, aware of its pitfalls and strengths, and mostly as an instrument in generating (causal/diagnostic) hypotheses that subsequently needed to be tested. Clinicians employ both empirically and intuitively based methods, and according to Witteeman et al. (2012), both have their merits.

Anthropological and qualitative research
Some of the most influential studies of clinical perspectives in psychiatry have been oriented towards dominant theoretical models, most notably (and perhaps notoriously) in the purported struggle between psychoanalysis and biological psychiatry. Influential works (e.g. Luhrmann 2001, Kleinman 1988) attest to the framing of psychiatry as a field dominated by these two main theoretical frameworks, or their related sciences, the human and natural. These frameworks are seen as embedded within different communities: academic, professional, institutional and social. Critical analysis has subsequently focused on the associated assumptions, values, and world views entailed in these theoretical ‘monoliths’ (cf. Fancher 1995). As noted in Chapter One however, the relationship between such higher level theories and actual clinical practice is unclear.

A substantial body of research in the area of anthropology and medical sociology has examined “explanatory models” of mental illness both in the general community and within psychiatry (Bhui & Bhugra 2002). Generally, this concept is traced back to Kleinman, who defined explanatory models as: “the notions about an episode of sickness and its treatment that are employed by all those engaged in the clinical process” (Kleinman 1992). Though the terminology may vary somewhat (“health beliefs”, ‘folk explanations’, ‘language of distress”), this concept generally relates to frameworks for the interpretation of symptoms, their organization, cause, and cure or management, which display a certain degree of coherence, strength and stability within the group under study. Lay health beliefs and explanatory models have been studied in western and other societies, to a lesser degree in patients themselves (cf. Boumans & Baart 2013, Bhui & Bhugra 2002), and to an even lesser degree, in practitioners. In a qualitative study of first-time presenters to a mental health service, Williams and Healy (2001) examined the presence or absence of ‘explanatory models’, seen as a set of coherent beliefs related to a mental health or disorder concept. They found that clients actively sought explanations, and that such explanations were often tentative and temporary, sometimes contradictory and prone to amendment throughout the
process of the interviews. They concluded that such ideas were better described as ‘exploratory maps’ than as ‘explanatory models’.

Kokinov et al. (2013) emphasize this point in their study on depression, noting that static concepts such as beliefs and models have been criticized within the sociology of health and illness in favor of more dynamic concepts. They distinguish between models as defined above, maps, defined as discursive trains of thought touching on various explanatory possibilities, and illness narratives, which are characterized by their attention to the temporal development of events associated with a change of some kind. In their study they found respondents utilized all three forms in speaking of their depression, noting that all carry advantages and disadvantages: where an exploratory map suggests mutability and recovery of the depression, lack of a clear conceptualization may equally cause anxiety in some patients, whereas the clear causative picture of an explanatory model may seem restrictive for some, and comforting for others. Interestingly they found that those participants employing maps and narrative mostly associated the concept of depression with themselves, and used the “I” form when describing the associated phenomena, whereas those using more detached forms of expression, using “it” when referring to the depression, more often employed explanatory models, conceiving of depression as something external, beyond their self-world.

In a qualitative study Bhugra et al. (2011) interviewed 31 psychiatrists on their approaches to decision-making in practice. Gathering accurate information was seen as the most important process for decision making, and was described as a complex and dynamic process. Theoretical influences from training and general models (e.g. ‘medical’, ‘biopsychosocial’) were noted, though the manner of their influence was unclear. Clinical intuition was mentioned as a valuable component, mostly in diagnosis. Treatment decisions, on the other hand, were based more on evidence. Clinical intuition and EBM were seen as complementary and integrated processes. Besides these, hypothesis testing, heuristics, trial-and-error and other cognitive strategies were mentioned. Finally, uncontrollable institutional constraints and the influence of the multidisciplinary team were noted. According to Bhugra et al., these findings are consistent with current ‘dual process’ models of clinical reasoning, in which various approaches are matched to the demands of a given situation. Dual Process Theory is based on a distinction between an inferential mode of discursive, analytical thinking, and a non-discursive or intuitive mode, the latter being primarily composed of unconscious processes, in contrast to the conscious, deliberate character of the former. It is therefore a general distinction within which various approaches described in the paragraph on clinical reasoning can be placed (cf. Croskerry 2009).
Summary
Empirical research into clinical reasoning in psychiatry has moved from 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.

This literature underlines the point that we should be careful in extrapolating philosophical analyses of psychiatric theory and concepts to practice. Reasoning in practice is a complex phenomenon involving different types of knowledge organization. One aspect little attention has been paid to in the specific context of clinical reasoning, is the relationship between forms of reasoning, such as causal and meaningful reasoning, in mental health care settings. Given the general view that these have a different structure, do they in practice function in parallel, or sequentially? Do they interact? The limited number of studies in this area means these are still open questions. The potential presence of different forms of reasoning in practice was one sensitizing concept applied to the qualitative study. The literature also makes us aware that mental and behavioral phenomena observed in practice are not simply associated with a prototype. Their representation (insofar as representation is an adequate description of the cognitive process involved) is bound up in clinical experience, theoretically informed and partially tacit.

Much of this research has been done in experimental situations or on the basis of interviews, removed from the direct clinical encounter. An example from philosophy and psychiatry is from Fulford and Colombo (2004), who developed a models framework of attitudes concerning mental disorder and applied these to a case study. The authors noted that such models, derived from literature, should be tested empirically in practice for their validity. A singular-model approach to practice, however, would assume a cognitive organization on the part of the clinician that does not accord with the clinical reasoning literature as reviewed above. Therefore a first-hand, qualitative, naturalistic method was applied, uncommitted to theoretical frameworks and focusing on the practically embedded, pragmatic aspects of clinical knowing. Where clinical situations have been
experienced first-hand, mostly this has been within ethnographic methodologies (Barrett 1996, Luhrmann 2001, Messinger 2007). Our qualitative methodology also takes such a naturalistic approach (Lincoln & Guba 1985; Abma & Stake 2014). No prior assumptions on the cognitive structure of philosophical ideas were made, whether in the form of models-based representations, illness scripts, intuitions or embedded, tacit knowledge. Instead, the empirically observable linguistic and communicative expressions of psychiatrists in practice were taken as a starting point: whatever the private thoughts of the psychiatrist may be, what is said and done in the actual encounter with the patient is the expression of psychiatrists’ philosophy in psychiatric practice. Clinical reasoning, in this case, is therefore a slight misnomer, since in the following we will include actions (in the form of questions) under the category of ‘reasoning’, as expressions thereof.

The background and methodology of the general study was presented in Chapter 1. This part of the project was aimed at exploring the initial clinical encounter focusing on the process of diagnosis. We started from the basis of exploring the process of diagnosis from the perspective and in the terms of the psychiatrists themselves.

3.3 Results

As described in Chapter One, the initial theoretical framework applied to this part of the study was a division of main themes (biological, social, psychological) and relationships between phenomena (meaningful and causal). As the study progressed, the framework was adapted based on the method of iterative framework analysis including charting, mapping and interpretation, identification of emerging themes, research group discussion, and further literature study. This resulted in a final framework organized in three ‘levels’: clinical reasoning, interaction, and methodical reflection. The term ‘levels’ was chosen as the distinction that was applied pertained to different descriptive levels. The first level describes the kind of reasoning that is ostensibly visible in practice; the second level describes interactive processes between phenomena visible in the first level; the third level describes reflective features on the part of the practitioner influencing the former two levels. Therefore, these different levels should not be read as different cognitive processes on the part of the psychiatrist (or patient): the framework is simply one way of presenting the data found in this study. Phenomena observed in intakes and interviews can simultaneously be part of more than one of these levels. Within these three levels, further specific features and processes were identified. Within level two, a distinction between structure and content was made to better represent the findings, noted as A (Structure and dynamics) and B (Explanations). Fig. 3.1. shows the final state of the iterative
framework. In the following, this three-level framework will be presented in detail. We have chosen to provide extensive examples of the phenomena within the framework, as some of these may seem abstract at first glance.

1. **Clinical reasoning modes**
   - Descriptive reasoning
   - Meaningful reasoning
   - Actuarial reasoning
   - Collaborative reasoning
   - Medical reasoning
   - Unclassified, following reasoning

2. **Interaction**
   A: **Structure and dynamics**
   - The Developing Explanatory Framework
   - Dynamic elements: prompting, partitioning, binding, and perspective
   B: **Explanations**
   - Causal dualism
   - Metaphysical alignment
   - Pluralism

3. **Methodical reflection**
   - Intuition
   - Pragmatism
   - Theoretical knowledge and affiliations
   - Individual values (professional and patient)
   - Institutional values
   - Import

**Fig 3.1. Framework of Diagnosis.**

In this section, it is important to note that we will use the term ‘phenomena’ in a broad linguistic sense, referring to both verbal and nonverbal communication by patients, to observations made of the patient, and including written texts (e.g. referrals) relating to the patient. This should be distinguished from the common medical use of the term ‘clinical phenomena’ which tends to refer to single symptoms or signs of disease. In this text, ‘phenomenon’ refers to all things the psychiatrist has observed in the intake or relating to the intake. In the following, the content of the framework will be presented with extensive use of examples from intakes and interviews to further elucidate the features within the three
levels. Excerpts are taken from either the intake between psychiatrist and patient, or from the interview of the psychiatrist by one of the researchers (henceforth: interviewer). The following abbreviations are used: Psy = psychiatrist, P = patient, I = interviewer.

3.3.1 Level one: clinical reasoning modes
Clinical reasoning is interpreted here as encompassing both the cognitive processes and the actions, including diagnostic (chiefly lines of inquiry) and therapeutic actions identified in the clinical encounters. This first level contains the various ‘modes’ of questioning and reasoning observed in practice. The term mode is chosen since generally speaking a sequence of questions tended to group together within one mode. The following clinical reasoning modes were identified:

Descriptive reasoning
This form of reasoning and inquiry was characterized by being directed at complaints, ostensive behavior, and classic psychiatric symptoms and signs, questions often being asked in a closed, dichotomous fashion (e.g. “have you experienced any hallucinations”), and more likely to be of a quantitative and temporal nature (“how often?” “When did this start? How long?”) whereby the object, whether a thought, feeling, or behavior, is treated in an atomistic manner, and sequential and temporal relationships between such objects and contextual or psychological phenomena are sought.

Example: excerpt from an intake (academic setting)
Psy: Your mood is okay, generally?
P: Yes.
Psy: If a 10 is super happy and a 0 is deeply depressed, where is your average over the past two weeks?
P: A 7.
Psy: Mood swings. Are you troubled by those? Very happy or very sad or angry?
P: Not in the last 2 weeks. Before that I did have more problems with that.
Psy: And were you feeling depressed before that?
P: Yes.
Psy: So before that you were troubled by sadness and mood swings. Mostly towards the negative?
P: Yes. I didn’t have much to do just some finals. So I hardly got out of bed.
Psy: And how’s it going now with sleeping?
P: I’m trying to get back into a rhythm. I kept going to bed late and sleeping badly back then. Tossing and turning, staying awake and sleeping during the day.
P: Still there a bit.
Psy: What time do you go to bed?
P: On average... about 2 ‘o clock.
Psy: And how long do you sleep for?

Meaningful reasoning
Meaningful questioning was described by psychiatrists as serving the function of understanding both the problems and phenomena presented in the intake and the patient him or herself. Rational and meaningful connections between phenomena are examined, more use is made of open ended and ‘following’ forms of questioning, and frequent efforts are made to check whether the summaries and formulations by the psychiatrists adequately represent the meaning intended by the patient. This mirrors the circular methodology of hermeneutic enquiry into meaning.

Example from an intake, institutional setting. This patient had been referred for chronic physical complaints. The patient, a young woman, related her complaints to work stress in the early stages of the intake. She said she had tended to work too hard in order to appease her boss, and not to ‘listen to her body’. The psychiatrist asked her whether she felt supported by her bosses, to which she replied that she had not, and that she felt very disappointed by them:

Psy: When did it begin? The disappointment?
P: It started, I think about 1 ½ years ago. I was really sick at home and very disappointed about it. But I still kept going.
Psy: Why were you disappointed?
P: Because I’d really done my best for them and before I fell ill they always said ‘Good Morning’ and especially if they needed me bad, and suddenly I was a bad employee. Just because I was ill. And especially when I was back at work the last 4 or 5 months, my supervisor said: why don’t you quit. I said: I’ve done my best, because I’m ill I have to quit? I love my work, I love my job and I’ve built up my career for so long and then I have to give up suddenly?
Psy: Why is it you try so hard, that you overtax yourself, where does that come from?
P: I was very deep; my thoughts were very deep towards the future. Only I was only looking in one direction: my career, my future. I didn’t see what was happening around me.
Psy: And why is that?
P: Because I love my job so much. And I really didn’t see their bad sides. While I did
hear my colleagues and my manager say you have to give up, you really have to leave here. You don’t fit in. You are not accepted. I just wanted to prove myself.

**Psy:** And what is it you want to prove?

**Actuarial reasoning**

This form of reasoning is the detailed collection of diagnostic data with a view to connecting the data to statistical knowledge, e.g. in the form of guidelines or research literature. The form of questioning here was often highly detailed and extensive, aimed at complaints, detailing their precise nature, duration, relation to context, antecedents and consequences. Characteristic of such a form of reasoning is that causal relationships are not necessarily implied. This kind of reasoning may also involve the use of questionnaires.

Example (from an intake in private practice):

**Psy:** Do you find it difficult to begin things by yourself because you don’t have enough confidence or you don’t think you can manage it?

**P:** I often think that I can’t do something.

**Psy:** Do you go far to get support and do things you maybe really don’t want to do just to get approval?

**P:** No.

**Psy:** Have you always had an uncomfortable feeling when you were alone? Not being able to take care of yourself?

**P:** Alone at home? No. Taking care of myself in the administrative sense, I’m not good at. I’ve never been alone. I lived at home until I was 23 and was in a relationship from my 21st. I stepped into a relationship from home. I did go to England for 9 months by myself. That went well but that was all organized by the university. I lived on my own as a student and that went well. I made contact (I tried) with others. I was using Fluoxetine back then. It really went reasonably well then.

**Psy:** Imagine if you didn’t have a relationship. Would you really do your best to get one again? From anxiety or fear?

**P:** No, this is my first relationship. Hard to say. I’d be really sorry if I didn’t have a relationship. A partner is more than a relationship. We’ve been together for 10 years and we’ve been through a lot together.

**Psy:** Of course, that’s logical. That’s always so. You’re not constantly worrying about being abandoned?

**P:** No. (starts to cry)

**Psy:** Why are you crying?

**P:** If I think about it (if I didn’t have him) then I can’t go on... sometimes I get scared... I’m so unstable... He has so much more to offer... find another mother for our child... because I’m such a problem child.
**Psy**: What I’m doing now is a kind of questionnaire, to check whether there’s a personality disorder.

**Collaborative reasoning**

This comprises the conscious use of questions and utterances aimed at establishing rapport, a ‘working alliance’, or an empathic connection with the patient. It also encompasses efforts towards shared understanding of the problem(s) and working towards a consensual treatment plant.

Example intake (private practice): The patient, a young man, who had sought help for problems he initially self-described as performance anxiety. He described various social situations where he felt judged, exposed, and vulnerable. The psychiatrist referred to experiences with people who can make you feel uncomfortable, ‘macho types’ as he put it. The patient recounted similar experiences at high school of boys who would intimidate and make fun of him. He remembered he did not react actively.

**Psy**: So you felt very vulnerable?

**P**: Yes, on the one hand you’re above it, but on the other you want to act normal towards someone and not like him, but still normal. That results in a tension in your head, a conflict and you notice you’re not at ease anymore.

**Psy**: I can imagine. Is that what your faith tells you, that you mustn’t fight?

**P**: Mmm... yes, that too. But absolutely, now I think it’s complete nonsense. But back then, I grew up with it, that was part of our faith, that you mustn’t fight. So I was brought up that way.

**Psy**: Yes, me too.

**P**: In the meantime, it’s also my own conviction, that it’s out of order to fight with people. Though sometimes I do think come on... But more in an educative way. Not in an aggressive way.

**Psy**: That’s to your credit. But it requires a strong stance. That you aren’t scared of them.

The psychiatrist added, in the interview, that he had consciously revealed a little about himself to promote rapport, and giving a complement was both authentic and also in service of strengthening the treatment bond.

Another ubiquitous example of collaborative reasoning was the process of checking manners of phrasing and representing the problem with the patient, the psychiatrist checking whether he has understood the patient correctly, or checking whether certain interpretations are correct.

**Medical reasoning**

This is the mode of inquiry directed to physical health and complaints, non-
psychiatric pharmacotherapy, and use of alcohol and drugs. Often these themes were sequestered together, and discussion of pharmacotherapy could lead on to psychiatric medication.

Example: private practice. The following exchange takes place at the beginning of the intake, after the psychiatrist has collected some general personal data.  

**Psy:** What I’m filling in now is the front page of the file, and that’s where I always, I call it medically necessary data, put things, like if you have diabetes, or if you’ve had a serious disease, or if you’re allergic, then I want to know that, and I put that on the front of the file, because sometimes that’s a life or death issue. You have any of those things? Do you take any medicine currently?  

**P:** No, none at all.  

**Psy:** Nothing at all?  

**P:** No. I recently had a sinus infection and I got a nose spray for it, and that was..  

**Psy:** Otrivin or something.  

**P:** Yeah I think that’s what it was.  

**Psy:** No, that’s all peanuts. Any hypersensitivity or allergies? Have you ever suffered any serious disease?  

**Psy:** Appendicitis, were you ever operated on for that?  

**P:** Yes.  

**Psy:** Well you can count yourself lucky, but you’re young, most people collect all kinds of problems throughout their lives.

*Unclassified, following reasoning*

This mode was reserved for questions, mostly in the early exploratory phase of the intake, where the psychiatrist is giving the client room to express his or her problems, complaints, and expectations, and where the psychiatrist is clearly allowing the client to determine the subject under discussion. The psychiatrist is seen as having a very limited influence on the subject matter or on the way it is being discussed. See also *Following* in level two: interaction.

### 3.3.2. Level two: interaction

This level describes the *dynamic* nature of the clinical encounter and the manner in which phenomena manifested by the patient (actively or passively) interact with the thoughts and actions of the psychiatrist. Whereas in level one, the features can be seen as amenable to state-like observation, in this level, the focus is more on processes, mostly of communicative and meaningful interaction. The structure of
Diagnosis in practice

this interaction proves to differ from standard textbook structure. Though the participating psychiatrists do possess a concept of the general structure to the interview that accords with the standard for the process of diagnosis found in textbooks comprising of general exploration, specific anamnesis, psychiatric examination, medical examination, drugs & alcohol, pharmacotherapy history, biography, developmental history, social & family relationships, diagnosis and treatment, these are generally not explored in a sequential, linear fashion, but by moving forwards and backwards between components. The forms of reasoning described in the first conceptual framework are therefore generally not present in a neat sequential order. Also, different forms of reasoning may be operating in parallel. Though it was very common to find more exploratory questions at the beginning of the interview, these were interspersed with descriptive questions, encouraging remarks, procedural explanations, or therapeutic maneuvers aimed at fostering a working alliance (collaborative reasoning). Interactions could be noted, whereby a switch from one form of reasoning to the other could be motivated by another reasoning mode. The model derived from the iterative framework in this study for the manner in which these interactions occur is described below.

A: Structure and dynamics

The Developing Explanatory Framework

The Developing Explanatory Framework (DEF) is the main structural element of the intake. This is the gradually developing set of descriptions and explanations for the phenomena that the patient is bringing to bear on the encounter. Through the application of different clinical reasoning modes, the phenomena are explored, characterized, and – to varying degrees- explained. A striking feature of this study is that these characterizations and explanations were performed in varying idioms, where the use of medical terminology was but one of a diverse linguistic set, including (frequently) lay language, folk-psychological terms, or terms derived from psychotherapeutic or sociological theory. Here are a number of examples of explanatory statements made throughout different intakes in varying settings:

Psy1: This seems to be your main problem: can you feel safe, have faith in good intentions, can you trust people to be faithful to you, that they won’t abandon you, trust them to think you’re good enough, nice enough. That, I understand, is a difficult area.

P: It’s because I myself, I think, those kids will think I’m stupid. I’m very scared of that, extremely scared, of being found out and such. That feeling. I always have the idea that people think ‘Oh she’s quite smart, and she’s talented’, and then the truth turns
out to be totally different.

**Psy2:** That base eh, the ground seems to have been blown away it seems.

**Psy3:** You clearly have some problems in this area, that's clear. They've existed for some time. It isn't the way you were born but more what you experienced in different periods in your life. That influences your character, how you are put together. Not like a hard or clear personality disorder. I don't really believe that, for now. So in that sense I think a psychotherapy or cognitive behavioral therapy is best suited to you. I think.

**Psy4:** Good. Well you've noticed we're not there yet. But to finish up for now, this interview, my impressions and ideas, is that okay? You came here because you've stopped taking Prozac. Which you were taking for twenty years. And since stopping you've noticed you are more unsure, anxious, down, depression. You feel less like having fun. Exhausted, tired feeling. I think you’re question actually is, I'll translate it here, what should I do with the Prozac, or something else. Should I start it again, what's that about? So that's the actual question, what about the medication. I can't just answer that, except this. That in the next few appointments, you get an answer to that question. That you make a decision. By us discussing it. Because you also have acquired various thoughts about yourself and others which result in fear and insecurity. So is it possible to handle such thoughts differently. Or is it the case that the sadness and fear are so much in the way, that you cannot change. That worrying and obsessing. There are other aspects, in your life and existence. You're actually a very bright, happy, expressive woman, who experiences a lot. And therefore I can understand why the Prozac was restrictive for you. You lost a piece of yourself. That enjoyment, the intensity. But that also has disadvantages. Sometimes it's too much. So we could also look, is it possible to retain that experience, but not let it come in so strongly, so you can find your way better in that. Handling feelings and emotion. Which I want to develop further, in order to understand you better. Because if I understand you better, then you understand you better. It's difficult to do that yourself. Because you have blind spots, of course. What's important there, is that I hear something from you from the past. How things went when you were growing up. What happened. That's the way I want to go with you. Is it clear like that?

These examples have been chosen for the variation they display in the language used to couch explanations in. In the first example, a psychological explanation centering on trust is given. In the second, a metaphor is applied: losing the ground beneath your feet. The third displays a kind of vagueness that was a feature of a substantial number of explanations, also being quickly connected to a therapeutic suggestion.
The last quote especially offers a good impression of the amalgam of lay, medical, and psychological language integrated into offering a description of the problem, and connected to an idea of the treatment. The psychiatrist begins with medical terms: Prozac, anxiety, depression, exhaustion, tired. He brings it back to a personal question of what to decide on the pros and cons of using Prozac, but then goes on to move to what appears to be CBT psychology: acquired self-cognitions. From there, he takes a further step into existential questions on life and existence. In doing so, the psychiatrist connects these different perspectives. It also demonstrates a depth to the encounter which goes beyond an evidence based answer to the question: should the patient restart an antidepressant? Throughout the intake, the DEF has encompassed descriptions and impressions of the patient’s personality, and this has been integrated into this sequence. In the interview, the psychiatrist commented:

“The idea was that something had been taken away from her by the Prozac. I was interested to see what she would say if I stated it like that. Maybe it would put set her to think “Hey, now you mention it, what is this thing called ‘self’, how should I see this in using pills.” Because that’s what it’s really about, that’s what I need.”

The psychiatrist explained this was motivated by professional values related to the goals of psychotherapy, including self-actualization and autonomy. More on such motivations follows under Level 3. The fact that such a variety of language was used is the reason why the structure is not characterized as diagnosis, which would seem to be the apt description for the process of identification of problematic phenomena, explanation, and bridge to treatment. It would also be the way in which a number of participants would describe this process. However, some participants reserved the term diagnosis for the descriptive reasoning mode directed at a formal diagnosis of a known psychiatric diagnosis (e.g. referring to a DSM-disorder), whilst noting they also ‘wanted to get to know the person’ or ‘wanted to understand the problem’. ‘Diagnosis’ was thereby conceptually associated with formally defined mental disorder and formal classification, and though it was mostly part of the DEF, it was not all of it. Therefore, the phrase ‘explanatory framework’ was chosen instead of diagnosis. The adjective ‘explanatory’ was added as in most cases, explanations for the phenomena were part of the framework. This is illustrated under Explanations below.

The latter quote is also an example of a summary explanation given at the end of an intake. However, the position of the final explanation or summary at the end was not a universal feature, on the contrary. Mostly, characterizations and (partial) explanations were strewn across the intake temporally, where there may be intermittent, brief summaries (see binding, below), and there would not always
actually be an identified sequence where the phenomena as a whole would be summarized, and a treatment proposed. Rather, the DEF could be a combination of different phenomena and explanations, with different degrees of coherence, developing throughout the interview, and not necessarily being integrated under one explanatory construct. Within this set of phenomena, however, a causal structure or a hierarchy between phenomena in the sense of importance or relevance, could be made, with implications for treatment. See below under Explanations. At a point where the DEF seemed sufficiently complete and/or time constraints intervened, a suggestion would be made of how to go forward, mostly without referral to some unifying construct.

Examples:
Psy1: I see time’s up. I want to make a bridge to the next appointment, if you agree, to make one.
P: “You too, if you agree.
Psy1: Oh yes, it’s my job to talk to people and look at the problems and how to tackle them. That whole practical side, we need to talk about that. I can give you hints, but I can’t do anything myself, that’s my limitation you could say, but the first phase of therapy, the journey, I can certainly walk with you.
Psy2: Okay, it looks like we’ve come to the end of the questions. Of course, there’s still a lot to ask and explore. I think we should look practically at what needs to be done. I’ll study the papers later and see whether what I think about it corresponds to what’s in those. But, do you have any ideas yourself?
P: No.
Psy2: I do!
P: Oh!
Psy2: You’re the one who has to do it in the end. I can say well if I were Mrs. B. I’d do this or that, but you’re the one who has to do it and has the last word in this. Okay?
P: Mhm.
Psy2: And indecision on your part might result in me procrastinating. I’d like to see you follow our day-care treatment. It’s quite intense....

In these examples, taken from the last part of intakes, plans for further treatment and appointments are being made, but no mention is made of a diagnosis or explanation. These have been previously constructed throughout the intake and are not summarized or repeated here. This is why this process is characterized as the developing framework. The psychiatrist also mentions going over the ‘papers’, with which he is referring to the referral note including previous diagnosis and treatment. This is another feature of the structure of the DEF: if we define the DEF as the ostensive set of phenomena consisting of the ‘problem at hand’ in the intake,
and its subsequent descriptions and explanations throughout the intake, it is clear that these phenomena have a (linguistic) history preceding the intake. Part of this history is how the patient has conceptualized and given words to the phenomena, and part is the ways in which these have been represented by the previous professionals (and possibly others, e.g. family members). These conceptualizations and representations will, again, carry more or less explicit explanatory concepts, and will be more or less open to revisions, hence fitting the general ideas of the DEF. Therefore, as a convention for this study, we distinguished the ‘internal’ and ‘external’ aspects of the DEF, where ‘internal’ denotes the DEF that is internal to the intake itself. The external DEF consists of the patient’s conceptualization and (private or public) linguistic expression of the phenomena prior to the intake, and the representations thereof in professional materials: the referral note, of the verbal expressions from the referring physician or mental health worker to the psychiatrist. The psychiatrist too may have developed an external DEF based on the information in the referral note, or by information delivered verbally by a referring colleague. This also points to another feature of the internal DEF, namely the fact that it is a co-construction of the participants in the conversation, i.e. the patient and the psychiatrist. Both participants have their individual and partially private thoughts on the phenomena, how to view, express, and explain them, and to varying degrees will express these thoughts. However, such expressions may also be strategic, in the sense that for any conversation to continue, some common linguistic ground must be found, in this case, what is sometimes professionally expressed as a shared rationale or shared understanding. In order to attain this, the psychiatrist will generally express his or her own theoretical concepts and explanations that are understandable and to a degree acceptable to the patient. So there is an ostensive, shared DEF, observable through the linguistic expressions in the intake, and there are two individual DEF’s, belonging to the psychiatrist and the patient, respectively (fig 3.2.).
Fig 3.2. Schematic representation of individual and shared DEF’s. The temporal progress of the intake is denoted through the timeline. When the intake starts (dotted line), patient and psychiatrist communicate (blue arrows), in which level one reasoning modes are observable. Both participants possess or acquire an explanatory framework, a way of understanding and naming the phenomena. The patient enters the intake already in the possession of a view to the phenomena (individual, external DEF), and this may be modified throughout the intake. In this example, the patient’s initial DEF (blue) is altered (yellow) based on initial exchanges. This different explanation is accepted by the psychiatrist (red to yellow) and becomes the revised DEF. Later in the intake, the psychiatrist proposes a partial explanation for a subset of the phenomena (light blue). This explanation is accepted by the patient and integrated into the shared DEF.

All DEFs progress through time and under the influence of the exchanges throughout the intake. Both participants contribute, to greater or lesser degrees at varying moments in the intake, to the Shared DEF, which is modified in the process. Obviously this is a highly simplified schematic of a complex, dynamic process, and should be treated as such. We will attempt to enrich this schema as we progress through the findings.
The degree to which these three aspects are in accordance will vary, and the relative contributions from the private DEF’s to the shared DEF will vary too. This aspect of the model can represent a number of clinical situations, shown in the table below.

<table>
<thead>
<tr>
<th>Agreement ↓</th>
<th>Balance - &gt;</th>
<th>Patient dominant</th>
<th>Balanced</th>
<th>Psychiatrist dominant</th>
</tr>
</thead>
<tbody>
<tr>
<td>+</td>
<td>A</td>
<td>b</td>
<td>c</td>
<td></td>
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<tr>
<td>? or 0</td>
<td>D</td>
<td>e</td>
<td>f</td>
<td></td>
</tr>
<tr>
<td>-</td>
<td>G</td>
<td>h</td>
<td>i</td>
<td></td>
</tr>
</tbody>
</table>

Table 3.1. Agreement and dominance in the DEF.

In this table, the letters a-i denote different DEFs. The columns denote the relative overall contribution to the shared DEF, and the rows denote the degree of agreement in relation to the shared DEF. For example, a denotes an intake in which the patient has offered the dominant contribution to the DEF, in which the psychiatrist may have chiefly adopted a following stance, and there is agreement between both participants on the DEF. In contrast, i denotes an intake in which the psychiatrist has provided the dominant input into the DEF, and there is no agreement: the patient in this case, disagrees with the diagnosis.

Example:
During an interview with a psychiatrist from institutional psychiatry, the discussion was centered on the ways of understanding the patient. In the discussion referral is made to the recorded intake.

I: We’ve talked about various theoretical backgrounds. And what your personal influences have been. What is notable is that throughout the intake, gradually an explanation starts to form. We often see, also in your example, that if we look at the codes they are small and tentative remarks: ‘Could it be possible that...?’ In this intake, the first remark you made that could be construed as going towards an explanation was: “You actually really want to be special.” She was a woman who on the one hand was quite socially reclusive, and on the other seemed to set the bar high for herself. Searching for an explanation, together with the patient. This comes back in your report [to the GP]. At the same time there is room for psychiatric examination. You, and others, have indicated that this is a kind of separate activity within the intake. I’m interested in the relationship between these two sources of information. What happens with them. You said that doing a psychiatric examination is something that kind of stands apart from the rest of the intake, and that you briefly perform your work in a different manner. Do you recognize this, if I put it this way?
**Psy:** Yes. You have, of course, the personal life story and the personal idiosyncrasies of someone and also the psychiatric examination which has more to do with symptoms, the psychiatric qualities of the person. It’s striking that you should bring this up... I had quite a conflict recently with a patient who was telling a story. At her request I’d increased the dose of the SSRI’s and at a certain moment, I asked: “Have you noticed recently becoming very busy and overactive?” Since she originally had come to me with the question: Am I suffering from bipolar disorder? Later she told me she had been neglected as a child and that were a great many other things that she wanted to talk about. So then she said: “Well, I can’t accept this... you’re looking at me as if I’m a patient!!” I should note she’s a psychologist herself. But I wanted to know since if I increase the fluoxetine then it’s possible you provoke a manic episode. If you yourself already suspected that you’re bipolar... so as a psychiatrist I have to keep an eye out for complaints and whether the psychiatric condition stays well. So it’s not just in the intake, but throughout treatment. Always checking how people are functioning, whether they’re getting depressed or manic, whether something’s going wrong with eating, sleeping etc. You’re playing doctor all the time.

Besides that there’s the psychotherapeutic way in. Seeing how it’s going with conflicts old and new, relationships etc. It’s difficult. Sometimes these things get mixed up. This patient was troubled by the fact that she felt she was in a trusted relationship but at the same time I distanced myself slightly from her and viewed her as a psychiatric patient.

In this example we see the conflict in the approach to explanation from what is described as a life story perspective versus the ‘psychiatric’ perspective. Note also that the latter is connected to the professional role of the psychiatrist, and to his status as a doctor. This will return under ‘alignment’ below. The sequence also illustrates the sensitivity on the part of the ‘patient’ to the connotations of patienthood, and a resistance to this. This alerts us again to the fact that intake and diagnosis do not occur in a social vacuum: both psychiatrist and patient may be aware of the social and personal implications of patienthood and diagnosis, and within intakes, the DEF may be affected by their views on these implications. In other words, the construction of the DEF is influenced by value features related to social and other implications of diagnosis. We might view this as an example of Hacking’s looping effects in practice (Hacking 2000). The schema of fig. 3.2 is itself part of, and open to a wider context, a number of influences of which are noted in table 3.1. This context impinges on the DEF to a greater or lesser degree, depending on the participants, who may or may be aware of these influences, and may or may not resist or amplify them. This aspect will be discussed in depth in the level 3 section.
<table>
<thead>
<tr>
<th>Societal</th>
<th>Political</th>
<th>Professio</th>
<th>Family</th>
<th>Institutional</th>
<th>Scientific</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public attitudes to Health and Mental Disorder</td>
<td>Health Care System Organization</td>
<td>Professional Education and Training</td>
<td>Attitudes to Mental Disorder</td>
<td>Organization &amp; Structure of Care</td>
<td>Prominence of science base in practice</td>
</tr>
<tr>
<td>Socioeconomic status</td>
<td>Form and conditions of reimburse-</td>
<td>Professional Regulato-</td>
<td>Support from family</td>
<td>Rationalization of care</td>
<td>EBM</td>
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<td>ns and Guidelines</td>
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</tr>
<tr>
<td>Cultural, religious and existential views on relevant phenomena</td>
<td>Resources for treatment</td>
<td>Professional values</td>
<td>Support available to family</td>
<td>Division of labor</td>
<td>Available theoretical and explanatory resources</td>
</tr>
<tr>
<td>Lay explanations of relevant phenomena</td>
<td>Professional language</td>
<td>Available (nonprofessional) explanatory resources</td>
<td>Available treatment resources</td>
<td>Classification system</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Cultural, religious, and existential beliefs</td>
<td></td>
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</tbody>
</table>

Table 3.2. Examples of contextual influences on the DEF

The degree to which patient and psychiatrist contribute to the Shared DEF is a function of another feature within the DEF, the *initiative*. Initiative denotes which of the participants is contributing most to the content of the DEF. Frequently, in the early stages of the intake, the patient would have the initiative and the psychiatrist would be following the patient’s lead, possibly paraphrasing elements, summarizing them and checking whether the summary accords with the patient’s views (performed, at level 1, by following, see also level 2 *binding*). Subsequently, the psychiatrist would gradually contribute more to the DEF, either by structural moves such as changing the reasoning mode, or by directing the DEF to different subjects, or by reformulating (parts of) the DEF.

In the following brief excerpt from an academic encounter, the psychiatrist takes the initiative in ‘naming’ the complaint:

*Psy:* *What you’re describing and has been mentioned before is that you really suffer from depressive complaints and one of the characteristics thereof is that people*
withdraw socially or find it very scary to interact with others. Is that what you mean?
P: Yes.
Psy: I want to talk about that stage fright. Even though you’re not up on stage now but if you have that then what does it look like?
P: It’s actually more fear of exams.
Psy: Yes, but I call that stage fright too.
P: (hesitates and thinks)... The patient acquiesced through silence and from that point, ‘stage fright’ was taken up in the DEF.

Dynamic elements: prompting, partitioning, binding, and perspective
The DEF provides a general structure to the intake. Within this structure, a number of concepts arose which function to define the dynamic interactions proceeding within this framework and in the process shaping it.

Prompting
From the start of the intake, the psychiatrist applies different reasoning modes to explore the phenomena that the patient is expressing. One determinant of which reasoning mode was applied, was the nature of the expressed phenomenon as understood by the psychiatrist. For example, let us take two well-known symptoms, depressed mood and auditory hallucinations. Where patients expressed terms connected to depressed mood, such as sadness, lack of pleasure in activities, feeling blue, etc., psychiatrists would tend to react with narrative or following modes of reasoning first, thereby emphasizing meaning and understanding, possibly followed by descriptive mode aimed at identifying criteria for the DSM-diagnosis of depression. In contrast, mentioning auditory hallucinations would tend to prompt descriptive mode reasoning in the psychiatrist, leading to questions aiming at quantification and temporal location (how often, how long, what time of day?). The different mode was related to a different understanding of the phenomenon (in an ontological and causal sense), where ‘hallucinations’ as a concept were seen as more related to a set of ontological ideas: biology, material, essential, and this ontology was aligned with a certain epistemological viewpoint (naturalism), implying a descriptive-empirical perspective as the correct way to identify such phenomena. In contrast, sadness and depression were associated with more diverse, broader ontological concepts, including psychological and social elements besides biological ones, which themselves were aligned with a different epistemology (hermeneutical) and different reasoning modes. This is a striking finding and suggests a location of philosophical action at a deep practical level, in how phenomena themselves are...
understood and named as they are presented. The related feature of ‘alignment’ is further elaborated below under Explanations. In practice it was observable that a series of questions in one mode or related to one subject could be switched to another mode or subject based on the occurrence of a phenomenon or set of phenomena understood by the psychiatrist in a different ontological manner. This was termed the ‘ontological potential’ of the phenomenon, and the process itself was termed ‘prompting’. It is important to note here that the term ‘phenomenon’ is chosen precisely because of its neutrality: it may equally refer to a recognized symptom, a mental disorder, an emotional experience, a social fact, a biographical element, or any set of such features.

In this example of an intake in private practice, the psychiatrist has been asking questions in meaningful mode pertaining to the patient’s feelings of insecurity at high school and in subsequent educational settings.

**Psy:** So you quit three schools?

**P:** Yes, and basically for the same reason, that I couldn’t take it, and I would start to procrastinate or avoid things and then I’d fail it. Somewhere I know that I did that on purpose, because the grades I had were always good, but not enough.

**Psy:** And you had a bad time, you didn’t feel at ease in class, right?

**P:** Yes, that was a bit mixed, since I also had good times and I got to know a lot of people, made some good friends even, but...

**Psy:** So why did you quit?

**P:** I don’t really know.

**Psy:** Was it that you couldn’t handle the stress or something?

**P:** I don’t know; I really wish I knew.

**Psy:** Are you worried it doesn’t look good or something?

**P:** Well for example the choices I’d make or that I make say something about me, and then I’d like to know that other people think about that, and that sounds a bit weird saying that, but that’s.

**Psy:** You could ask them, right?

**P:** Yes, but you can’t constantly go around asking people and go round the whole school asking people well what do you think of this. And it makes me anxious, and it sounds really stupid saying it out loud but in practice this is what makes me anxious.

**Psy:** You want to be certain all the time, or to be reassured, like, you’re okay, we like you.

**P:** Even if it were bad, but I want to know something, it’s just that I can’t control.

**Psy:** Yes, but you can’t control my thoughts either.

**P:** Yes but it’s a hundred times better now, because the fact that I actually started that school four years ago, says something about how far I’d changed then. I can actually remember from kindergarten when this was going on. At primary school I
couldn’t choose between subjects, for example we used to have to make small reports on a subject and I can remember standing for hours in the library, looking over all the books and being unable to choose a subject, just because that if I were to choose one, I’d be scared of what my friends would think about it. And that only got worse. The last years of high school and the years after were a real low point.

Psy: So you had a bad time? Were you bullied?
P: No I actually did some bullying myself.
Psy: You bullied?
P: Yes, I tagged along.
Psy: You tagged along?
P: So no opinion of my own, like.
Psy: And does it occur now that you have difficulty deciding? I’m delving into that deciding now”
P: Not much…
Psy: Decisive?
P: No, not at all. A lot better though, but still, very deliberative. I can really get caught up weighing the positives and the negatives, what should I do, with some things there’s really nothing to decide, so it doesn’t really matter and that’s there is just as much for as against and then, even then, though actually it’s better now since I recognize those situations and I think ‘OK, so it really doesn’t matter’, so then I just pick a choice and often, at the moment you’ve made a choice you see, oh, that was a good choice, or it doesn’t really matter. And then the pressure’s off.
Psy: The pressure’s off, yes, sometimes we call that chewing it over, that you’re constantly preoccupied by something, and you postpone the decision on it. That belongs to obsessive behavior a bit, that’s what we call that”
P: Yeah, that could be it.
Psy: But I mean, has it taken on serious consequences, that you check whether doors are closed, the gas is off, that kind of thing, or with dirt, that you think: Oh dear, a doorknob?

In this sequence initiated in a narrative on the patient’s educational history, the patient describes insecurity, a desire to make choices that would meet the approval of his friends and others, and attached to that mentions a new phenomenon, namely indecision. The psychiatrist then pursues this phenomenon, which he also marks verbally (“I’m delving into that deciding now.”) and there is a mode switch in the questioning from narrative to descriptive: the psychiatrist is focusing on recognized descriptive symptoms of obsessive-compulsive disorder (he mentions obsessive behavior) such as obsessive thinking and compulsive checking.
Partitioning
An inherent feature of the modes of level one is the fact that sequences of questions that can be characterized in the same manner are grouped together. The existence of such reasoning modes as identifiable in practice was a pre-existing hypothesis prior to the study, which was confirmed in the material. Though mostly moves from one mode to the other were made without remark, sometimes a change in perspective would be commented on, for example on commencing a series of medical and descriptive mode questions, one psychiatrist remarked to the patient that she would be putting on her ‘doctor’s hat’, a Dutch expression denoting the assumption of a certain role.

Binding
If the understanding and explanations of the phenomena at hand diverge too much between psychiatrist and patient, co-operation towards treatment becomes impossible. Binding is the process whereby the psychiatrist, mostly consciously, makes an effort to ensure that a ‘Shared DEF’ remains intact. This is generally done by repeating, paraphrasing, and summarizing the content that the patient is offering, and by checking with the patient whether he or she agrees with these elements. It is done in a piecemeal fashion, building partial characterizations of elements towards a whole.

An example from private practice. The patient has previously described having received a diagnosis of chronic fatigue syndrome.

P: My nose, I used to hate it. I hate looking in the mirror. I think... worthless.

Psy: Your body, it bothers you, doesn’t it? I mean, it hurts, your body is tired. Are you angry with your body?

P: Yes, quite often. Yesterday I knitted a scarf and you have to stitch up the edges and I made such a mess of it! I was always good at handiworks and such and did it all the time. But now, just opening a parcel... a plastic bag... I'm just fumbling, and I think: ‘Blast!’ I can get really angry at myself.

Psy: There’s a lot of anger in you?

P: Yes.

Note how the experience is being reduced to one emotion, but that this reduction is also being checked with the patient. The concept of ‘stored anger’ in this example will serve an explanatory function later in the DEF and be a focus for treatment. The fact that the patient concurs with this re-conceptualization and reduction implies that this aspect of the DEF is shared, and the binding is, for now, successful.

As the DEF develops, explanations for the phenomena often arise, either from the patient or from the psychiatrist, and these are also presented to be agreed or
disagreed upon. As mentioned above, though agreement is the ideal, it may not always be reached. (Also, agreement may be provisional, or insincere, either or both participants hiding their disagreement.) In a few situations, the psychiatrist could be seen to rephrase important characterizations within the DEF in response to negative reactions from the patient.

Example: Academic practice. In the intake, a pregnant patient has been referred within three months of her term date. She had previously been diagnosed with bipolar disorder and was taking a mood stabilizer, though in the intake she contested the diagnosis. The psychiatrist is making preparations towards the period around the delivery.

**Psy:** So when's your term date?

**P:** 30th of July.

**Psy:** So it's moving along then. Because of the holidays, I won't be here until early August. So I want to make that clear, there will be someone filling in of course, but I'll check to see what's best. Since where you live you have no contacts, is that right?

**P:** No, no. But I know – just a second now – I get the feeling... what kind of scenario are you thinking of?

**Psy:** Well, for example, a post-partum depression, that's possible. That doesn't necessarily occur right after delivery and it's usually not immediate but about 6 weeks of being very depressed. Or possibly a post-partum psychosis. But that's a risk at any birth. And you know, you do carry a vulnerability in you.

**P:** Yes, yes. But I don't know whether after the delivery, that vulnerability I have, I assume, it comes back, and then... I don't know if.... it to such a degree... so it can come back twice as badly or something?

**Psy:** "That's a possibility. But it's always difficult, you don't know in advance. That's why I need to look at the medication you're taking.

An interlude follows in which they discuss dosage and the psychiatrist suggests increasing the dose post-partum of the mood stabilizer the patient is using. The patient then changes tack:

**P:** But, so I, yes, psychoses, if you say all that then that really scares me. We aren't psychotic in our family.... so I don't expect...

**Psy:** No, but I didn't suggest... so there is nothing in the family? Mother was fine after labour?

**P:** No, no problems.

**Psy:** No, so we shouldn't be exaggerating any problems.

**P:** No, but it's scary." (sound very anxious.)

**Psy:** No, precisely. But I take that back now. I do think... it's my responsibility to
inform you and what I hear and see is that you’re hypersensitive. But okay, that doesn’t have to be a risk factor and to go off the rails immediately.

This example is illustrative of a DEF in which both participants had been actively participating, but in which the shared DEF became contested. In the sequence above, the psychiatrist associates the risk of postpartum depression and postpartum psychosis with an ‘inherent vulnerability’ in the patient. ‘Vulnerability’ as an essentialist conceptualization (which might be either seen as a reification of a statistical risk, or as an expression of an inherent genetic -and hence materially conceptualized- risk) was seen in a number of participants. This conceptualization, as we see above, carries causal and hence explanatory weight: the vulnerability might lead, in certain circumstances, to depression or psychosis. As the patient reacts with severe anxiety, the psychiatrist retracts her previous statement, and changes the conceptualization from ‘vulnerability’ to ‘hypersensitive’. This may seem like a very slight modification, but note that the causal weight has been shifted slightly outward, from an inherent vulnerability to hypersensitivity. The psychiatrist also moves from a position of alarming and prevention against possible mishap, towards reassurance. The reconceptualization within the DEF was part of this process.

One feature of binding was the use of metaphor or vague language within explanations and characterizations. From the point of view of preserving the Shared DEF, these strategies offer the advantage of a wider scope for interpretation and understanding. Privately, the psychiatrist might be associating the phenomena presented with a personality disorder, but given the expectation that pronouncing this suggestion would provoke both rejection and the risk of damage to the therapeutic relationship, the psychiatrist would express features of such a diagnosis in a different manner.

Example, academic setting. The excerpt is taken from the end of the intake, in which the psychiatrist notes that he is going to offer his views.

**Psy:** Okay, I’m going to wrap this up. We’ve discussed your complaints. And that a number of things from your childhood still play an important role, being unwanted and the tension and that kind of thing. Secondly that there is vulnerability in the family. That’s bad luck of course. There’s not much you can do about that, that vulnerability, as a manner of speaking. Right now we’re looking for what, given all this, you possibly could do. Maybe with medication, sessions, or more generally. You have medication for depression and mood changes. That combination has given you, in your view, little benefit and the disadvantages seem to be increasing. So that in any case is something we should assess, whether we should think of a different combination or whether there’s something better. I want to save that for next time.
But I am going to look into it, the medication. Diagnostically, again, I've already said, there are some character things involved, some hereditary things, character things, mood things, so it can belong to different things. I want to give you two pamphlets, and ask you to give them a look. One's about borderline problems. I don't want to say that....there's a lot of overlap between manic depression, borderline and other things, but you should take a look. Just cross through stuff you don't recognize, what's nonsense and such, fine. We can use that maybe next time to uhh, it can help us, and well, if it doesn't, forget it.

Note in this excerpt the use of terms such as ‘vulnerability’, ‘character things’, ‘mood things’ and ‘hereditary things’, all quite far removed from either clinical diagnoses or classificatory concepts. The psychiatrist then uses pamphlets on certain diagnoses to introduce an element of self-diagnosis for the patient. The phrase “I don't want to suggest that..." closely following the use of 'borderline problems' suggests a strategic move to soften the suggestion of a diagnosis (borderline personality disorder) which carries a risk of public and personal stigma. Also, the psychiatrist himself has either not reached a diagnosis fitting a singular DSM- classification, or sees the individual diagnosis as being unable to conform to DSM-classification, a much noted commentary on the relationship between clinical diagnosis and classification. The discrepancy between the explanation given here (the shared DEF) and the psychiatrist's personal DEF is evident in his intake report, from which the sections on clinical diagnosis and classification read:

Descriptive conclusion:
The patient is a 44-year old man with long existing mood problems and periodical cannabis abuse/dependence which he has stopped now three weeks ago with help from Addiction Care. Patient has a desire for treatment or support for his complaints and a pharmacotherapeutic evaluation.

DSM-IV diagnosis:
I Dysthymia (300.4), Depression NOS (311), diff. diagnosis Bipolar Disorder (296.89)
II Personality Disorder with cluster B features
III Hypertension
IV Dissatisfaction with previous treatment
V: GAF 70

Note that in this report, the psychiatrist has made an axis II diagnosis and also notes drug abuse/addiction. Such discrepancies between the ostensive DEF and the report occurred regularly, and participants’ main explanations for this were either that the DSM simply is an insufficient tool to validly represent clinical
diagnosis, or that the report itself serves a communicative function towards the GP
and/or the insurer and therefore is necessarily reductive.

Perspective
This denotes a set of aligned views on the part of the psychiatrist which remain
consistent over time throughout the intake. This is present where a psychiatrist
self-professes either a general professional allegiance to a certain
theoretical/therapeutic perspective (e.g. “I see myself primarily as a biological
psychiatrist”), and this perspective is recognizable within the intake, or where the
phenomena within the DEF are ostensibly connected to an encompassing
theoretical framework, e.g. when a cognitive-behavioral perspective is brought to
bear upon the phenomena. If we were to represent prompting as a bottom-up
phenomenon from the phenomena upwards towards psychiatrists’
conceptualizations, then perspective is a top-down process of harbored
theoretical/therapeutic convictions and affinities in relation to these phenomena.
Perspective is traceable where language is used that is verifiably (e.g. through
member check) related to theoretical affiliations, and may also be expressed at the
level of initiative, as psychiatrists take the initiative to either explore certain
subjects and not others, or to apply certain aligned modes of reasoning and not
others (see Alignment).

Example, private practice. The intake concerns a patient who has been referred to
a psychiatrist who self-identified as ‘psychiatrist and psychoanalytical
psychotherapist’. The patient was looking for a psychotherapist, having recently
been in clinical treatment.

Psy: It’s best to start with your question. What you’re looking for. And other things,
because you said you have a long history in psychiatry.
P: Yes, I’ve written it down and it’s probably handy to read that. Or I might repeat
myself. But yes, three years ago it went wrong. I haven’t worked for three years, I’m
on benefit, I’m 36 and yes, it all has to do with my mental state, so to speak.
Psy: As you’re telling me this, you’re getting emotional.
P: Yes, very. I just notice how vulnerable I am. I’ve thought up of all sorts of ways to
fight it. And for some reason I can’t seem to return to society. And that’s very hard. I
can have two faces. Someone who’s really sharp and easily handles things, but now,
recently, I feel so insecure and I’m scared to do anything. And I feel worthless. I feel
really bad. I just don’t know how to handle this. I recently moved back in with my
parents, for the second time in the past three years. I just don’t know any more.
Psy: You’ve lost your way?
P: I don’t know, I don’t feel my identity, I don’t know who I am. I feel worthless and
feel like I, I’m very angry with myself that I’m screwing up my life like this, I’m
ashamed that I have no partner and no kids, no job. That kind of thing.

**Psy:** You’re ashamed.

As is apparent, the psychiatrist, in this early phase of the intake, is reflecting the emotions on the part of the patient. This fits with a psychotherapeutic approach (with predominantly narrative-meaningful mode questions) to the intake, which was confirmed in the interview. In the further intake, there was also an emphasis (expressed in the codings) on (social) relationships. The combination of meaningful and relationship codes fit with the psychiatrist’s theoretical and psychotherapeutic (Lacanian) orientation. During the intake it was also noted that the psychiatrist repeatedly emphasized the value of taking time to explore one’s feelings in psychotherapy. This emphasis was discussed in the interview:

**I:** A number of times certain phrases return such as ‘allowing room for’ or ‘taking the time to’, pertaining to therapy, when you’re explaining therapy, for example. And when you’re explaining about symptoms you stress that there’s ‘more than that’. This person spoke of depression, the symptoms and the treatment. And you responded with, okay, but I think there’s more to it, and you then talk about this kind of thing. The meaningful aspects. We code that as more narrative-meaningful as opposed to more medical terminology. Would you say that this is a conscious thing for you in the contacts with people you see here?

**Psy:** All the time. Not only with patient but especially with colleagues. GP’s have that especially. That scientificization syndrome, you see it especially in GPs who have to work quickly. Ten minutes for the patients and then refer. And the idea that they refer to someone with no waiting list, that’s where it starts. But that’s also someone who makes them better quickly. And that often means, you see it in the referrals, that they want a cognitive-behavioral treatment because they work symptom-oriented or symptomatic and want to get rid of symptoms as soon as possible. And that’s something that, well, it irks me. I know how symptoms shift. I see people here who have come back for the umpteenth time because the symptoms have gone temporarily but resurface somewhere else. So there is something there feeding the symptoms, and which isn’t being treated.

In this passage the psychiatrist is distancing himself from a, in his view, descriptive and symptom-oriented approach which is aligned with values of economic efficiency and a superficial pragmatism. The latter part referring to deeper causes of symptoms, and symptom shift, are recognized features of psychoanalytical thought. His emphasis in the intake on time, space, meanings and relationships are part of this overarching theoretical perspective. What makes this an example of **perspective** is the fact that there is a coherent set of theoretical notions and values guiding the psychiatrist’s thinking and actions throughout the session, of which the
A psychiatrist is conscious, and which he expresses intentionally. It should be noted here, that this is an entry point for such notions and values to become integrated into the DEF.

**B: Explanations**

Whereas the previous section emphasizes *structural* aspects of the DEF, this section focuses on the *content* of the developing explanation, and aspects that influence its development. As the DEF proceeds, the phenomena brought forward by the patient are characterized and brought within a general framework in which the elements stand in certain relations to one another, including causal and meaningful connections. In most cases a shared DEF develops which attains a degree of stability. This characterization is related to treatment. In this section, elements relating to the content development of explanations are identified.

*Causal dualism*

Participating psychiatrists generally held dualist perspectives on causation: the more a phenomenon is seen as being materially caused, the less it is seen as being psychosocially caused, and vice versa. This has obvious implications for the ontological understanding of the phenomenon. Besides pre-existing notions on the phenomena coming to the fore via prompting (see above), a dynamic influence was also observed, where *understanding* plays a key role. Phenomena associated with material causation tended to elicit descriptive reasoning, and psychological/social phenomena tended to elicit narrative reasoning, as set out under ‘prompting’ above. This is the immediate ontological potential of the phenomenon as it arises. However, not all phenomena are immediately categorized as either material or psychological/social. Such phenomena have a *wider* ontological scope, and are more open to different causal characterizations. For example, the phenomenon of thought insertion, associated with severe forms of psychosis, will tend to be associated with material causation and elicit descriptive reasoning. In contrast, feelings of regret will tend to be associated with a psychological/social causal story and elicit meaningful reasoning. Expressing sadness, however, could be part of an understandable reaction to loss, a clinical depression, a dysthymic personality, and many other possible causal/meaningful explanations. The phenomenon itself is, therefore, open to a wider variety of explanations and characterizations, in the current state of relevant knowledge. Phenomena are ontologically and etiologically represented on a dimensional continuum between the poles of ‘biological’ and ‘psychosocial’, but, as we saw previously, clinicians tend to think dualistically about causes. Therefore, how these phenomena with a broader ontological scope (as a general concept) are understood in the individual case, depends on the specific
causal theory applied to the phenomenon in the singular case. In practice, a form of default reasoning with regard to ascertaining causes became apparent: a phenomenon would be explored using level one modes, including meaningful reasoning. If, after careful exploration of the social and psychological domains, the psychiatrist could not develop a to her satisfactory (meaningful) understanding of the development of the phenomenon in question, then the phenomenon would be perceived as psychosocially ‘unexplained’. Causal dualism then leads the psychiatrist to be more inclined to view the phenomenon as biologically caused, on the assumption of a kind of zero-sum view of the relationship between causal and meaningful reasoning: the more a phenomenon is (understood to be) meaningfully caused, the less it is (understood to be) materially/biologically caused. Such psychosocial understanding involves both rational and intuitive, empathic understanding which participants can’t always put into words.

In this excerpt from an interview, the discussion was focused on the concept of disorder-as-disease, in the material, brain-based sense. A number of disorder categories was thrown up for categorization as disease or not:

**I:** So, someone with schizophrenia, is that person sick? Is that a disease?

**Psy:** Yes.

**I:** And ADHD?

**Psy:** Yes.

**I:** Depression?

**Psy:** Hmm...(hesitates). Them too.

**I:** All depressions?

**Psy:** No.

**I:** Where are the differences?

**Psy:** Well, in the influence of the environmental context. Like this patient who is clearly depressed due to contextual factors and not like suddenly –boom!- everything was fine and suddenly she becomes depressed. So clearly material.

The excerpt also demonstrates prompting based on severity and symptoms rather than whole diagnostic concepts, as it continues:

**I:** But let’s say, due to circumstances for example, let’s say she suffered a number of serious losses and she developed a serious depression with all vital symptoms. What would you say then? Sick or not sick?

**Psy:** Yes, sick.

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2 In the Dutch language sense of suffering from a disease.

3 ‘Vital symptoms’, a historical concept stretching back to the 19th century, refers to bodily alterations as core features of depressive states. They might include headaches, heaviness of the chest or abdomen, unpleasant sensations of weight, tension, or heaviness. Kurt Schneider viewed such vital feelings to be the core of depression, equivalent to first-rank symptoms in schizophrenia.
I: Then she’s sick?
Psy: Yes.
I: Why?
Psy: Because, well, my concept thereof is that there is something wrong at neurotransmitter level and that may be caused by the environment, but finally there is so much going on in the brain that I call it a disease.

Here we see an association between severity, certain symptoms, and a material ontology. Interestingly, though vital symptoms are expressed in various areas of the body, the brain is seen as the locus of material causality. The connection between severity and materiality is examined below.

Example 2 (academic setting). The discussion is focused on the participant’s views on mental disorder:
I: One point of discussion on this kind of thing is, for example, to what degree are mental disorders given by nature as opposed to determined by us humans, or by society? When is something a disorder? What are your thoughts on this?
Psy: Real psychiatry is to a large degree biologically determined and if you’re talking about slightly deficient coping combined with life problems on that continuum, it becomes gradually less determined biologically and more psychologically-socially.

Example 3 (private practice): The discussion is focused on the process of diagnosis:
I: Okay. Let’s talk about the manner of diagnosis. That’s right up your alley. It seems you make a kind of a distinction. That’s the question, your way of doing diagnosis. Wat is happening psychologically and what you’re going to do as a psychiatrist. Leaving the point behind of not addressing the psychotherapeutic process, the question is, does this imply that in relation to your diagnostic activities you might do it differently. Do you assess someone fully if he/she hasn’t been to a psychologist yet, for example? Or is this way of doing diagnosis, for you, always the best way to do it?
Psy: It depends a bit on the kind of problem. Is it a more biologically-related clinical picture or does it have some dynamic aspects. It’ll depend on that. In this example, I think, it’s a kind of anxiety disorder, and that the latter certainly plays a role. I think it is a case of hereditary disposition, a kind of endogenous aspect in her tendency towards anxiety but on top of that a lot of secondary dynamic has been added. So that is very relevant for the psychological diagnosis. Not so much for the DSM and not so relevant for the medication. That’s why I the question is, what is the diagnosis, I think in terms of classification and the choice of medication. I limited myself in that case.

Note that causally, biological causes are separated from psychological-dynamic causes, but also, that these are allotted to different diagnostic schemes,
psychological and 'DSM-classification'. Also, the psychological is not so relevant for medication. The dualism involved at causal level is associated with a dualism at diagnostic level, and at therapeutic level. This extension, which we termed ‘alignment’ will be explored further below.

![Diagram]

**Fig. 3.3. Schematic overview of the dynamics of ontological potential, scope, and causal dualism.**

P1-3 represent 3 phenomena as produced in practice. Their positions on the continuum represent the pre-existent notion (i.e. prior to the intake) on the part of the psychiatrist as to their causation and ontological status. As the DEF develops, the initial view of their causal/ontological status may change based on the reasoning in the intake. P1 is initially seen as a material phenomenon, P3 as mental/social, and P2 may be both, or either. First, *prompting* occurs: P1 elicits
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descriptive reasoning, P3 elicits meaningful reasoning. The degree to which a phenomenon generally elicits one type of level 1 reasoning is its *ontological potential*. P2, however, has a mixed potential, and prior to exploration, in the mind of the psychiatrist it has a broad causal-ontological status. This also implies its potential to prompt a reasoning switch is lower.

P1 and P3 retain their ontological status throughout the development of the DEF. For P2, meaningful reasoning is first applied. The outcome of this analysis may deliver a meaningful explanation in the DEF, or not. The outcome may also remain uncertain. These options produce P2', P2'' and P2‴, respectively. As we see, these take up different positions along the Material-Mental/Social continuum. The degree to which the pre-existing notion applied to the phenomenon is generally amenable to such ontological re-interpretation, is the width of its ontological scope. In this example, the ontological status of P1 and P3 has remained unchanged. This may point to a strong ontological potential with narrow ontological scope.

It is important to repeat here that when speaking of ‘phenomena’, we may be speaking of individual symptoms such as ‘fatigue’, but also of higher-level concepts such as ‘depression’. Also, the language used may be that of the patient, the psychiatrist, or even a third party (in the case of a concept derived from the DEF). This is to emphasize the malleability of this schema. Recall also that a shared DEF is constituted by a number of characterizations and explanations, each with their own ontological character. This may lead to an ontologically heterogeneous DEF even where partial explanations of lower-level phenomena are ontologically homogeneous. This requires an openness to explanatory pluralism, which will be discussed below.

Metaphysical Alignment

Alignment is the process whereby the *ontological conceptualization* of a phenomenon within the DEF (as material or mental) is associated, in the mind of the psychiatrist and/or the patient, with specific scientific perspectives (natural vs. human science), theoretical explanations and level 1 modes of reasoning (descriptive vs. meaningful), but also certain forms of taxonomy (DSM), treatment (psychotherapy vs. pharmacotherapy) and professions (physicians vs. psychotherapists).

Both verbal and nonverbal cues elicit conceptual and theoretical notions in the clinician and inform and influence subsequent choices made with regard to avenues of questioning in the process of constructing causal hypotheses. (Theory
here denotes all phenomenological, conceptual and etiological theories connected to both mental disorder, normal and abnormal psychological development, and social and relational influences on mental functioning.) Though there was clear evidence of models-based reasoning (see under Perspective), rarely was there one singular theoretical model operative and determinative of all the psychiatrists’ questions. Rather, the phenomena were conceptually connected to (partial) etiological theories and avenues of treatment. Such couplings exhibited ontological associations: if a certain phenomenon or group of phenomena was perceived as being explained biologically, and hence more ‘biological’ (generally understood as material) in nature, a material (pharmacotherapy) solution would tend to be offered for it. Conversely, psychological/social phenomena would be coupled with psychotherapeutic or social solutions. This process requires a degree of causal dualism as explained above.

Therefore, in Figure 2, P1 would be associated with concepts such as: severity, dysfunction, pharmacotherapy, DSM diagnosis, psychiatry, brain, atomism, essentialism and physician. P3 would be associated with: less severe, psychological/social theory, psychology/sociology, mind, psychotherapy, holism, and psychologist or social worker.

The following example illustrates a number of these aspects:

In this interview, the subject is the combination of diagnoses that the participating psychiatrist had noted in his report, namely depression, dysthymia, and a ‘cluster C’ personality disorder. The interviewer had noted that these diagnoses are conceptually and taxonomically closely related, and is interested in how the psychiatrist might distinguish these diagnoses:

I: ... In your final conclusion, you state that it is comorbid. Dysthymia, depression and a personality disorder with cluster C features. Those are three complex concepts, diagnostically speaking because they can lie close together with respect to complaints and symptoms. We mainly wondered how you made a distinction between these three things. Depression and dysthymia you can distinguish temporally pretty well. Cluster C is pretty difficult. Maybe if you can affix a causal, psychodynamic story to the cluster C. An idea we had was, that if were to go back 20 years in time when everyone was still under the influence of psychoanalysis then this lady might have had far less chance of getting a diagnosis of depression. Then those periods might have been construed as passivity, introjection of aggression, or suchlike.

Psy: That too. But those are mechanisms. So that’s the psychopathological hypothesis you attach. So that’s right.

I: You think she would just as well have gotten the diagnosis of depression?

Psy: Yes, neurotic depression. That’s also what’s on the page. Dysthymia is, in my view,
the current pendant of neurotic depression. That's what it was called, in DSM-II, neurotic depression. The combination of a mood disorder and a personality disorder is, in my view, a modern variant of the neurotic depression. That's the distinction that is made. A depressive disorder then is mostly a biological cause or etiology and a neurotic depression or dysthymia, that is much more determined by someone's character structure and by psychological factors. And that's where the distinction lies.

I: What consequences does this distinction have for treatment?
Psy: Psychotherapeutically. Whether you decide that insight-oriented psychotherapy is indicated.

I: And that chance is greater in a neurotic depression?
Psy: Yes.

I: And why not in a biological depression?
Psy: Then the question is whether those mechanisms play a role. Because I think that neurotic mechanisms determine someone's vulnerability. If the mood disorder is determined by a neurotic vulnerability, you should treat that.

I: So you attach different causal stories to those concepts?
Psy: Yes.... If I notice that many neurotic or personality factors play a role in the patient's experience and it's reactive, then I think it’s more related to dysthymia and neurotic depression. If you have a depressive disorder, then it’s kind of an autonomous lowering of mood.

In this example, the psychiatrist thought both biological and neurotic causal mechanisms were at work in the production of the clinical picture. The causal dualism is clearly apparent. Alignment of treatment to mechanism also is expressed: a psychological treatment should fit a psychological cause. Note also the use of the concept of 'neurotic depression', derived from psychodynamic theory, of which this participant had said he used it as a theoretical basis for his practice. Use of the term 'dysthymia', a DSM concept, is a commensuration between the taxonomy and his theoretical background. As noted above, the degree of understanding of the meaningful causation of the phenomena is crucial in making the distinction. This is explored further in the interview:

I: So that is what's often referred to as 'it came out of the blue'. This woman couldn’t offer an explanation, it was ... boom! I collapsed. And maybe with the same symptoms, but the distinction seems to be in the explanation you can give. Not the phenomena themselves, they can be the same, the way it looks, the way its experienced. You say: that's not the distinction, it's the explanation. If you think it’s based on psychological/social grounds, the emphasis is on the psychological, then you tend to see the phenomenon as such.
Psy: Yes.
I: And others have said it’s not all absolute. You can have hybrid forms. Are there symptoms that prompt you to think: “I see that as physical.” Since biological is physical. Or are you saying that you can’t put it like that? Depression as physical?

Psy: No. It’s the feeling that it elicits in me. A depression that prompts me to feel ‘I don’t understand this’, almost analogous to the precox feeling4, there is a lowering of mood but I have no foothold at all to understand where it has originated, from psychological or social perspective. If I can walk along a little and it resonates, so to speak, with my emotional life, then I think it’s more neurotic.

This sequence clearly illustrates the interplay between meaningful understanding and causal dualism. Note that this understanding is not only rational, but emotional and experiential.

The following excerpt from an interview with an academic psychiatrist illustrates the conceptual association of terms from clinical, taxonomic, and theoretical domains:

I: Are there other things that influence you in your work?

Psy: My training in Z. What we were taught there, the existential... The Rogerian approach, we also did Rogerian therapy. That was in the late Eighties. I did a lot of psychoanalysis but also the level of meaning... how do I put it? A patient with a depression is, a depression is also descriptive DSM, but okay, that was not the most important, by a long shot. Het was much more who the person was behind that depression. Much more what is the existential meaning of this disease for this person. People like X and Y were our heads of residency training. They had more the German psychiatric background. That was my framework. That’s how we were trained in Z. We did get some DSM, you had to know it, but it was also your enemy, a bit. That was the atmosphere.

I: If we’re talking of German psychiatry, meaning, existential, descriptive, then you can say that’s back to Jaspers and his distinction between meaningful and causal connections. With the causal connections, DSM is based a little on that physical model, at least, that was the idea. You could say, I’m interested in your experience, that a general hospital might have more of a basis in the natural scientific approach than in the existential perspective, in its general attitude. That’s pretty obvious.

Psy: Yes, absolutely.

I: My question is, that if you think about this, that this is a guiding approach for you,

4 A term originating in the first half of the twentieth century, referring to an experience felt by the clinician whilst examining a person with schizophrenia, seen then to be specific and possibly pathognomonic for the diagnosis. The concept was popularized in the Netherlands by Rümke and was associated with phenomenological thought in psychiatry.
can you say what that means for how you work in the hospital, or here at the polyclinic?

**Psy:** Yes, it’s difficult. I think that when I’m in the hospital I wear the hat of the theory of the model from Z. I have had to depart from that a bit. Because the other, the natural science – biological model, is so central. If you look at residency training now, after 2000, it seems to be only DSM. It’s become so descriptive. In the polyclinic I still try to perform the older model. That’s my reference framework. Just listing depressive complaints etc., I think that’s very reductionist. In your polyclinical work you can do more to give a more analytical description. I do notice the frustration I feel when I work with residents. Just being descriptive and then they’re done, but the background often... I run into this sometimes. Difficult. I do try to impart some of this to them but there doesn’t seem to be a lot of interest. It isn’t nurtured by the training climate. Our head is a really DSM person, so...

This participant, prompted by a general question on work influences, makes a distinction between meaningful (existential, Rogerian, analytic) approaches versus the ‘natural science biological’ model. DSM is clearly associated with the latter (in spite of its purported ‘theory-neutrality’). Also, a way of working is attached: descriptive, listing symptoms and (implied) less attention to ‘the person behind the symptoms’. This is the sense of alignment that was seen frequently in participants: associations between meaning, psychological explanations and therapeutic approaches, meaning and person-centered diagnostic approaches in practice, versus descriptive, causal, natural science explanations associated with DSM-diagnosis and reductionism. These alignments are also associated with general approaches, ‘climates’ bound to institutes such as hospitals and residency training, and are connected to the view of those in charge. These latter points will be addressed in the chapters on science and legitimacy.

Another example, with an institutionally working psychiatrist, in which the coding of the intake is being discussed. The interviewer remarks that the first descriptive codes arise at the midpoint of the intake:

**I:** Here’s another part of client experience: “There’s a lot of anger in you.” Another bit of experience and psychology. Here there is a deeper explanation: “A bit like mother was...” which draws a line between past and present, her social situation, how old they are. Most of this is directed at her personal experiences and here is the first psychiatric examination code. Around the middle of the intake. There you see the most serious signs, maybe self-harm.

**Psy:** It’s interesting and I think I usually do it like that. I first see what kind of a person is in front of me and after that I look to see what the complaints are exactly.

**I:** So this order is representative of your way of working?
Psy: Yes, but if I think about it... Imagine if I were to examine the complaints very technically, I'd assume that it would be much more difficult to get contact. I want to get contact with this person, if you work the other way around then I'm in a kind of technical mode and it becomes a lot harder to get the experiential side into view. I: Yes, and if you see it like that... you first need contact with the person, a kind of a feeling for his or her experience... I know you think that experience is important but would it be actually possible for you to perform this technical approach without the experiential contact? Imagine if you skipped it and...
Psy: I think that would be very difficult for me. Just like prescribing medication. In the experience, the dynamics, to get the patient to take a more active stance to life. The same is that if I make a purely biological assessment, then I have an irresistible urge to see what the medication will do with the person. I think I'm unable to do it.
I: OK. You said: “Even if I make a purely biological assessment.” The word biological there is very interesting to me. What does the word biological mean there?
Psy: Sometimes I use it for a biological treatment method, medication, whilst, biology you can understand differently.
I: What I'm interested in... most psychiatrists use the word but what does it mean in this context?
Psy: Yes, that's a good one! In this context I mean, I think, if a treatment directly influences brain function.
I: Right. May I say that it's associated with 'material'?
Psy: Yes. Broadly speaking. In biology you also have behavior, some kind of experience, but that's not how I mean, my sense is that in psychiatry, if you're talking about biology, you're talking about material, brain, body, molecules.
I: Exactly. We've heard that in the research. But you said that you make a kind of distinction that makes the psychiatric examination 'complaints-oriented' and a broad categorization you apply between the experience of the person and a complaints-oriented bit that falls under psychiatric examination. Maybe the 'special anamnesis', at least more complaints-oriented. And that's in the same complex as complaints-oriented, medication, biological, material.
Psy: Yes.

Again, we see here that the participant draws connections between concepts and makes a broad distinction in two domains. The excerpt reiterates the association between associated concepts and an approach to the interview: person, or experience-centered, versus complaints-oriented. Slightly further in the same interview, the participant notes an association between certain symptoms, severity, and biology. The question is on weighing the different perspectives for treatment:

Psy: It depends on the practical options there are to offer one or another treatment.
And the intellectual and perspective possibilities of the patient. It also depends on the clinical picture. If I get a very vital depression, with bad concentration for example, then I can imagine that I decide a biological treatment is more apt.

I: So it depends on what you can offer, a person's basic capabilities and the severity of the picture. And the more serious the clinical picture, the more incapacitated someone is by the disorder, then you say you have more reason to work with medication, for example, the material, biological approach.

Psy: Yes.

Here we see that 'severity' is associated with biology, hence with material causation, which is associated with material treatment. Note the possibility of prompting by 'vital symptoms' such as bad concentration.

*Pluralism*

Combining the dynamic elements of the DEF (prompting, partitioning, perspective, binding) with those of the explanation (causal dualism and alignment) leads to a process whereby through the application of different forms of (level 1) reasoning, participants developed explanations of complaints and phenomena *without necessarily leading* to an integration at the level of a singular diagnosis or a case formulation. In a substantial number of interviews, no diagnosis was pronounced by the psychiatrist, rather the pattern of causal/meaningful exploration was summarized up to the point it had come to, with a promise to continue the exploration. Rather than point to a causal essence, psychiatrists either spoke in terms of multiple partial explanations for separate phenomena which had been bound and taken up in the shared DEF. A causal structure thereof was sometimes given, but was also frequently absent. To illustrate: someone may be suffering from depression and from chronic feelings of anxiety and insufficiency, and also, from a developmental perspective, her personality may be described as avoidant. Such factors may be presented in a causally hierarchical fashion (where one explanation is causally prior to others) or in parallel fashion. A common example of the latter is the description of a diagnosis as comprising of an axis-I disorder, e.g. depression, and an axis-II disorder (the study was carried out before the advent of DSM-5) with no stated causal relationship between the two, and a therapy suggestion of antidepressant medication for the former and psychotherapy for the latter. Such parallel diagnosis-therapy couplings could also be made at lower levels of symptoms (“I added an antipsychotic since he seemed a bit paranoid”) or through different theory-based understandings (“This person’s main problem was that she keeps falling into the same trap and keeps using the same survival strategies, that's her personality side and she needs to develop some insight into that, so that’s why
I referred her to our group therapy.”)

This pluralist approach is one reason practitioners designate the DSM-classification to a relatively peripheral role in practice: the DSM taxonomy is only one of the taxonomies and heuristics they apply to practice, others for example being either derived from certain theoretical models, or from clinical exemplars stored in memory. The most frequently mentioned role for the DSM was in fact post-hoc: as a necessary categorization required for reimbursement purposes and for communication with other professionals. Within practice, the role was mostly limited to a heuristic chiefly for pharmacotherapy, though even there, alternative taxonomies e.g. relating to personal clinical experience or to neurophysiology, were also applied.

A number of examples of partial explanations, given by different participants in intakes:

**Psy 1**: I don’t know what you think yourself but it’s quite possible that you’re in a kind of a depression now. Though there is a lot of anxiety in your person and as a person you also think very negatively. Altogether more black than it should be.

**Psy 2**: I distinguish 2 things. That have emerged since 2001. What you might call a burn-out: very serious fatigue and problems with concentration. The feeling of ‘I’m not living my own life.’ It’s about someone else. That’s one. And the second is that sleep apnea. The third is that you have always been someone with certain characteristics that I want to get in focus better. That’s important in order to give you optimal advice.

**Psy 3**: You have a burn-out, eh? Things don’t interest you, it’s not like you have a huge depression. It’s in that area, so to speak, but it isn’t... I think it’s very much due to the fact that you’ve got wrapped up in family problems, and that’s where the most important solution lies.

**Psy 4**: Well, I’m wondering whether there might be a depression. That’s always pretty hard to say. But if you have a lot of anxiety then it can occur that you become exhausted. That your brains become so exhausted that you can’t enjoy things and you have little energy. I think that is the case. Having less appetite fits that.

**Psy 5**: So you have quite a lot of overdue repairs, that we need to address. But you still tend to laugh over it a little. We’ll be encountering that a lot here too.

From one participant, a number of remarks strewn across the latter part of the intake:

**Psy 6**: You have a wish to be really special, eh?
**Psy6:** It’s all in your head, right? There is, apparently, a destructive side in your head and the desire to develop a lot of knowledge and skills.

**Psy6:** I think there are a number of things that are a bit askew. I think at a certain point you’ll trip yourself up since you have a lot of energy to make something of it but also a lot of energy to break things.

Here, an example of a number of brief binding summaries strewn throughout the intake leading to a treatment proposal without the psychiatrist offering a final summary, from an institutional intake. The following psychiatrist remarks are therefore fragments with interspersed exchanges omitted:

**Psy7:** It’s interesting to note that you do become active when you’re with friends, in a kind of a structure with people but that when it has to come from you yourself, you fall silent.

**Psy7:** If you help others you get a thank you, some kind of validation. But if you do it for yourself you don’t get that.

**Psy7:** I read the diagnosis ADHD was made, do you recognize yourself in that?

**Psy:** You say you’re very lively in company, you talk a lot. You could say, so what? Is that a problem or a disease?

**Psy7:** It’s interesting what you say. If you’re in a structure, the passivity isn’t there.

**Psy7:** If we do it here in the outpatient clinic 3 days a week then the question is what will you do the other 4 days? If you just wait around until you’re back here… you’ll learn nothing.

**Psy7:** I’d say the 3-day Outpatient Treatment would be advisable.

In the interspersed comments the patient himself had agreed that the most important problem was passivity. The diagnosis of ADHD was neither confirmed nor denied, just shunted to the side as not the prime focus of treatment.

Negative case: Actuarial Reasoning

For most participants, the DEF model served well to describe the process. However, there were participants who displayed a predominance of actuarial type reasoning, in which detailed attention is given to descriptions of symptoms, building towards the identification of a diagnosis according to DSM disorders, frequently assisted by validated questionnaires, and associated with statistical knowledge derived from research. The term ‘actuarial’ was derived from Meehl’s studies on clinical reasoning e.g. Dawes, Faust and Meehl (1989). These examples were so specific as to warrant a separate mode of reasoning, and were found within the Academic group. They may be said to deviate from the DEF model, as there is little or no attempt to actually explain the phenomena, rather, they are described,
identified, brought into relation with the scientific taxonomy, and then the related scientific literature is brought to bear on the questions posed in the intake. The approach clearly follows evidence-based practice principles. This approach emphasizes general, nomothetic knowledge, and therefore, it does not necessarily require an explanation at the individual level in order to be able to produce an answer to the question of whether a certain treatment is advisable for condition A. These examples were mostly limited to advice on pharmacotherapy, for which there is abundant scientific evidence.

Here an excerpt from this kind of reasoning. The intake is an academic second opinion, accompanied by a number of specific questions from the referring physician:

**Psy:** My impression is that you’re suffering from psychosis. You also suffer from depressive complaints that actually never last longer than one week. In the past too, never longer than one week?

**P:** Yes, before I started the antidepressant, I was pretty depressed for half a year. Quite a difference to now.

**Psy:** You can also have psychotic symptoms when you’re not depressed?

**P:** Yes.

**Psy:** Can that also last two weeks? In two weeks now and then psychotic complaints, not all day but a few times per week. That you weren’t depressed for two weeks but that you were bothered by those thoughts and such now and then?

**P:** Yes, that’s very possible.

In his questioning, it’s clear the psychiatrist is aiming to differentiate a number of DSM diagnoses (in this case, aiming to see whether the patient fulfills criteria for schizoaffective disorder).

A little further in the intake, the psychiatrist comes to his advice. The excerpt has been edited for the content relevant to actuarial reasoning:

**Psy:** So, and now the question, what to do? ... One medicine that could be considered, and all the things I’ll be saying now haven’t been studied well enough for us to say that this is definitely what should be done, because otherwise your own psychiatrist would certainly have done it already. These are all things where there are small clues that it might help..... You might consider using lamotrigine. That is, originally, an anti-epileptic, and there are indications that it might be beneficial for people with delusions together with negative symptoms.

This participant clearly refers to research literature, and comments on the strength of the evidence base in presenting it to the patient. The mode of reasoning, adapted
towards the DSM taxonomy, was present throughout a majority of the diagnostic phase of the intake.

**Level three: methodological reflection**

This form of reasoning is observed when clinicians take up a reflective position towards their own line of reasoning and choose to apply certain modes of inquiry based on such reflection. The example of collaborative reasoning determining a narrative line of inquiry sketched above, is an instance of an interaction between two forms of reasoning. The content of this framework refers to a ‘meta’-position on the side of the practitioner in which there is reflection on the choice of method not simply determined by the object of inquiry and the fitting response to that object, but from the perspective of an ulterior aim or motive. This form of reasoning, which we have termed ‘reflection’ to emphasize its slightly ‘decentered’ character (Dutch professionals are fond of using the term ‘helicopter view’ to denote this kind of observed practice-within-practice). A feature of such reflection was that its content was partially determined by wider goals, models, or values.

**Intuition**

This feature is the sole structural element at this level, in contrast to the following features, which all relate to content. Intuitive reasoning has been defined as a response ‘generated without effort and below the threshold of perceptible consciousness’ (Hogarth 2005). At first glance this feature seems at odds with the idea of reflection, which seems to imply conscious reflection. However, with time, reflection on certain modes of action or diagnosis in certain situations can become embedded in illness scripts, for example, which subsequently are performed intuitively, and for this reason in this study we allow for a concept of ‘intuitive reflection’. Psychiatrists recognize that intuitive reasoning forms part of their practice, to varying degrees, and with different degrees of legitimacy.

In this example, whilst on the subject of the use of different (narrative and descriptive) reasoning modes, the interviewer noted a form of overarching integration, a summary in the DEF:

*I: It was interesting that at a certain point in the conversation you do that [attempt an integration] in my opinion. At a certain point you’ve asked a number of medical questions and the client has let some of those things go, so to speak [the client had declined to seek out medical help for a number of afflictions, repeatedly]. And you then summarized that by saying: there’s a lot of overdue maintenance there. The*
interesting thing was that that phrase applied both to her physical and her mental life, because she’d neglected herself mentally, but also physically. And the way you wrote it and suggested it in the treatment plan was the concept of overdue maintenance, connected to how she treated herself, namely that she neglected her own maintenance.

The psychiatrist agreed that this was a case of a degree of integration, but added that it was in no way planned, or part of a strategy:

**Psy:** I never use a strategy. I just mess around.
**I:** Okay. You work mostly intuitively, I guess.
**Psy:** You could put it more flippantly as: I mess around. But yes, I work primarily intuitively, I really believe that.

**Pragmatism**

Pragmatism here is taken in its common understanding as an action guided by its supposed contribution towards a desired outcome. At a superficial level, pragmatism is a necessary component of the intake process: the aim of the encounter is for an improvement in the situation of the patient. The process of the intake, including diagnosis, is a means to this end. Pragmatism in this sense was ubiquitous in participants, in identifying the ‘help request’ of the patient, in connecting bound elements of the shared DEF to treatment, and in various supportive measures designed to sustain the therapeutic relationship. Hence the term ‘therapeutic pragmatism’. Reflections on which course of exploration and action were a common feature of this level of reasoning. The overriding concern thereby was therapeutic improvement, but secondary objectives may be seen as a necessary condition for attaining this primary goal, e.g. establishing trust with the patient so the latter remains in treatment, or offering practical advice.

Example: pragmatism in aid of the therapeutic relationship. An example from private practice:

**I:** “We noted that you, more than the average participant, were open about personal aspects about yourself. Talking about school, behavioral problems. A couple of those things. Other therapists might say, especially analyticals: ‘Not done!’ It’s noteworthy that you do these things. Is this representative of your practice? Is there a way of thinking behind this?”

**Psy:** “With this boy I did it because he did something I hardly ever come across. He missed three appointments. What I do then is simply try to create a connection.”
**I:** “So it was a conscious attempt to...”
**Psy:** “Absolutely!”
**I:** “That does fit the codings we found. We already noted that you spoke a number of
times about safety. So we kind of suspected it.”

Psy: “Yes, it’s very wondrous. He did it again after. So I mailed him and wrote that that cost me 50 euros which I couldn’t bill, and that he could only come back if he paid. And he did! He’s a bit of a biter, but after that... it happened again. So four times all in all. He lost a total of 200 euros on me! I never saw that before! So this is quite an exception.”

I: “Right.”

Psy: “What I did was to ensure a cooperative alliance to make him come. Before you know it I’d lose him!”

Here self-disclosure on the part of the therapist was a conscious move in aid of maintaining the therapeutic relationship.

An additional, conceptual form of pragmatism was identified, related to the dynamics of the DEF. In a number of examples, participating psychiatrists, especially in the face of a phenomenon with a wide ontological scope, would consider whether conceptualizing a phenomenon in one way or another would be helpful to the patient.

In this fragment from an interview, the diagnostic process during an intake is being discussed:

I: At a certain point, you perform a psychiatric examination and ask detailed questions on the complaints. Then comes this bit:

“Hmm, I’m wondering whether there is a depression. It’s always hard to say but if you have a lot of anxiety then your brains can become exhausted. That your brains become so exhausted that you can’t enjoy things and you have little energy. And that does seem to be the case. Having less appetite fits this too...”

Psy: Yeah, I said this... that’s the dilemma there... that I put to her I mean.

I: Exactly. You’re expressing your doubts: “It’s hard to say.” Does that go for only depression or for all disorders?

Psy: Well with this patient it was hard to say in any case. But I very often find it very difficult. From the point of view of the theory and therapy I adhere to depression has to do with coping... how someone copes with his complaints, if they run into difficulties and tend to retreat... Tend not to confront things that are important but instead assuage their feelings by ruminating... then you’re already some way into a depression. Many many facts...things that are defined as depression you can see as behavior. Very closely knit together with the personal. So, the longer I’m a psychiatrist the harder I find it to say that something is a depression. At the beginning I looked it up in the DSM book. Easy as pie, this is a depression and that’s a psychosis and you give these medications and you’re done! The distinction... I find it hard to say whether it has something to do with what you’ve experienced and how you cope with
it and what actually is a depression? I find it really difficult.

I: Yes, the way you put it is that one of the things the difficulty comes from is this application of different perspectives, the complaints-focused descriptive approach, describing what someone’s complaints are. But you can also see things from a different perspective. In the sense of coping mechanisms or a different psychological explanation. Those are two perspectives. So hard to say one perspective is better than the other. They just stand next to one another.

Psy: The evidence, we should weigh too. We estimate that the less severe forms of depression, then evidence says, it’s unclear how helpful antidepressants are, and because of my doubts I chose in this case to let them do their interventions first, the psychosocial intervention, before we continue with medication. Well, it’s a hard judgment.

I: If I understand you correctly it could even be... you’re weighing the whole context, on the one hand you look at the severity of the mental state... above a certain severity or dysfunctioning you see an indication to prescribe medication since that is part of the guidelines, but if we limit ourselves to the level under this severity... you look at the person’s context and what the person wants. What I hear I want to put to you: How you explain to the person that it may have something to do with that (the context). Like you give it a title: ‘You have a depression’, that it also has something to do with your person...

Psy: Yes, this is also a person who tends towards dependence... having the feeling, that what happens to her is fate... balance... People are fate and deed. This lady tends to feel herself subject to fate and is less oriented to deed. If I say: “You have a depression”, that could have a negative impact on her personality which already tends to wait for good things to come from without.

I: So the idea then is that a depression... it entails that it is not something own, it happens to you...am I putting it right?

Psy: I think that’s the way it often works in the dynamic. Put simply: “Waiting for the pill.” It becomes a thing outside of you. It does not invite people to get to grips with themselves.

This excerpt is an illustration of third-level (reflective) reasoning affecting a second level interaction between different forms of first-level reasoning (descriptive versus narrative reasoning: the psychiatrist first expresses doubt and anxiety about the conceptualization of depression, and describes his theory-driven perspective on depression. He consciously weighs the possible negative effect of conceptualizing depression in a reified way (as in “You have a depression”), a ‘third level’ reflection. In the intake he relates his impression of her personality (second level interaction) to the manner in which he would like to present his diagnosis of depression, with a view to moving the patient towards “getting to grips with
herself”. A partial diagnostic impression (the lady tends to feel herself subject to fate) leads to a partial therapeutic goal (avoiding passivity) and influences the explanatory conceptualization of “depression” at the first level expressed in the DEF.

A second example of conceptual pragmatism, from a private setting. A patient presenting with complaints fitting with depression remarks early on in the session that he is ‘fed up’ of these complaints and is so disheartened by his situation he’d like the doctor to ‘stuff him full of pills’ to get some change in his situation. The psychiatrist addresses this wish specifically in the interview, expressing her desire to carry out her full examination before coming to a treatment plan, including a biographical and developmental history. Nevertheless, before this is completed and prior to the discussion of the treatment plan, she decided to suggest to the patient to switch antidepressants, a decision the patient accepted with great enthusiasm. This was in part prompted by the results of a self-test questionnaire on depression that the patient had filled in between appointments, but was also in part, as the psychiatrist noted in our interview, influenced by the patient’s wishes and ‘pragmatic considerations’: she said this decision had been based primarily on the expectations of the patient and the referring psychologist, and perhaps, though she said this was not a conscious part of her thinking at the time, because it might have been too narcissistically injurious for the patient to have the suggestions in place that his personality may have caused him to be unable to work. In the interview, this was addressed.

**Psy:** “What I try to do is, to see what will help the individual patient. Would it help him if I call it a depression? Sometimes you call it depression but in one patient you might sooner explain that with a kind of disease model and in another you won’t. It’s a very complicated process to describe. It’s more of a judgment: what will help this patient at this moment?”

Interestingly, this psychiatrist noted that her choice may have been subconsciously made on the basis of an overarching pragmatic perspective. The form of reflection described here does not necessarily imply a conscious process. Another feature of this form of reflection is that it is not limited to a certain phase of the encounter. On a perhaps overly technical view of diagnosis-as-identification, one would expect inquiry to proceed in a manner chiefly directed at describing and categorizing the relevant phenomena (e.g. signs and symptoms) as objectively as possible. Methodological reflection could be allowed within this context, but only as a means of facilitating such a process. However, we found that general therapeutic aims, such as those described above, had a deeper influence on the process of diagnosis,
sometimes profoundly influencing the explanatory avenues taken, and not being limited to a post-hoc application once a diagnosis has been made.

A further example of pragmatic conceptualization, from academic practice (the phenomenon was present across all contexts). This diagnostic interview occurred in an academic setting in the form of a second opinion. The patient had been referred, at his own request, by his psychiatrist, because of his desire to discontinue the antipsychotic medication he had been taking for some years up to that point. Throughout the interview, the patient had argued for discontinuation of the drug on the grounds that the only reason he had experienced psychotic symptoms in the first place was due to an exceptionally strong strain of cannabis he had smoked at the time. At a certain point in the intake, the interviewing psychiatrist challenged this explanation through a succession of interchanges:

**Psy:** You make the connection between smoking strong weed and the paranoia, and now the next step I want to put to you, mark you, the next step I want to put to you, and one you certainly don’t have to accept, but can you imagine that you produce a substance in your own brain that can cause such phenomena without smoking weed? For example, if you’re in a very stressful situation. Can you imagine that this is the case?

**P:** Well, what can I say, that it could be a possibility or that I don’t suffer from that.

**Psy:** What you should do, by my reckoning, is react like you did just there, by thinking about it for a minute. Because I thought I saw a penny drop there.

**P:** Well, I understand what you mean, but I really don’t have any problems with anxiety or paranoia anymore, so how should I respond? Or should I say, yes, there is a substance that does do that sometimes with me and that’s what I take medicine for. Should I have said that?

**Psy:** But you would be jumping to conclusions if you did.

**P:** I don’t know how to respond.

**Psy:** Exactly, the point is that I’m saying it is imaginable, it is imaginable, it is possible that a substance that I inhale from the outside, that I’m sensitive to, it is possible that there are substances in the heads of people, which can cause certain phenomena too.

The discussion continued along this path and the psychiatrist gradually convinced the patient to continue taking the medication. This was subsequently addressed in the interview.

**I:** Can you recall whether you had certain goals in this interview?

**Psy:** Yes.

**I:** Can you tell me what they were?

**Psy:** It’s almost always about the fact that they disagree with the diagnosis and want to stop their medication. In my use of language, I choose an interview which is called
motivational conversation technique. And that’s what I feel comfortable with, Rogerian. It works sometimes, that’s the trick to help someone gain insight\textsuperscript{5} or to bring them to treatment.

... 

\textbf{I. You make the connection to an endogenous vs. exogenous model. The main point is about the substances. The endogenous model. Do you attempt to bring people towards this model?}

\textbf{Psy:} Yes. That’s a very astute observation. That’s completely due to the background. How can you ensure that someone who has taken an entrenched position in resisting all those labels that have been stuck on him? Doesn’t think he’s sick and therefore doesn’t want to be treated. But how do you get someone to move towards some sense of “I”. I see myself in this regard as someone who is of course different from others but does use a certain way of talking (motivational technique). Attempting to create a certain working relationship in a relatively short time span. It’s doctor-like. You influence with an exogenous substance, that’s what you ask about. Does that produce phenomena that you recognize in yourself? No, that substance causes such and such phenomena but it has as a background: you use this substance and you can observe in yourself that these phenomena then occur. If people can understand that in the interview, then I see this as significant progress. It’s a kind of social-psychological model of: I’m me and you’re you. We’re sitting opposite each other in a different role. But the communication and the working alliance is an important model which you adopt. Cannabis, drugs, they have taught us most about psychopathology. I find that a very powerful statement! And now you want to present this to a patient.

In this example the psychiatrist repeatedly points to general therapeutic aims with regard to these encounters, and the excerpts show his conscious use of motivational reasoning methods to obtain this aim. Part of these aims is to motivate the patient to continue using antipsychotic medication. Of note is the fact that again, this process of shifting the explanation from exogenous to endogenous was performed \textit{before} the psychiatrist had ostensibly come to a diagnosis or discussed his diagnosis with the patient. The psychiatrist takes a leading role in developing the DEF (one which, in this particular case, was resisted), shifting the explanation from exogenous to endogenous. Alignment effects are observable: where an external material cause (cannabis) would best be treated by removing the exogenous agent, an internal material cause necessitates a material curative agent: antipsychotic medication. The general pragmatic aims, therefore, affect the nature of the explanation of the phenomena that develops as a co-construction between patient and psychiatrist throughout the diagnostic interview \textit{before} a

\textsuperscript{5} Insight should be understood here in the professional psychiatric sense of the term as denoting awareness on the part of an individual that what he/she is experiencing is actually a mental disorder.
shared DEF has been pronounced. This also demonstrates that alignment relationships are conceptual and therefore work in different directions: it is not just the case that where a phenomenon is seen by the psychiatrist as material, that a material cure is associated, if a material cure is preferred, the DEF can be brought towards a material/internal explanation and hence, ontology, legitimizing through alignment, such an approach. This phenomenon we termed strategic conceptualization.

A final example illustrates an important general feature of the pragmatism here: the 'help' or 'care' request ('hulpvraag': the care request as defined by the client himself) is seen as of prime importance in guiding the pragmatic treatment goal:

**I:** What I understand is that you... there is a tension. On the one hand you're saying you might have clients... the way the care request is presented.  
**Psy:** Of course, of course!  
**I:** Say, I don't know if this approaches reality, you have clients who, in their presentation mostly stay at that descriptive level: I have this complaint and I want rid of it, and how you do that I don't care. Then you would say, from what you said before on working eclectically, then you could manage fine with CGT, medication, exposure etc.  
**Psy:** Yes.  
**I:** So that means, the client's presentation, his wishes, how he thinks about these matters, has a certain power over what happens next.  
**Psy:** Yes, but you still have to... the patient has the right to hear things that he doesn't see but are relevant for his choice. But you do have to remain close to the patient's care request.

From the examples given it should be clear that pragmatism features strongly in the reasoning of the participants, and that it not only pertains to aligning treatment to the help request and preferred outcomes on the part of the patient, but also to the quality of the therapeutic relationship, and deeper still, may affect the conceptualizations within the DEF, aligning those with a preferred outcome or mode of treatment. Such pragmatic conceptualization works in concert with features of the second level such as binding, causal dualism, and alignment.

**Theoretical knowledge and affiliations**

This relates to the repository of theoretical and clinical knowledge on the part of the psychiatrist, that he or she draws from in characterizing and interpreting the phenomena of the intake. The development of such knowledge will be examined further in Chapters 5 and 6. The knowledge might be applied either as a more
general framework (see: Perspective), or (more frequently) as a partial explanation or perspective on a phenomenon or set of phenomena. Knowledge could be derived from a variety of sources including, but not limited to curricular knowledge from training, clinical training experience, professional clinical experience, textbooks, professional and institutional guidelines, lay literature, or CME. Participants described varying levels of ‘authorship’ in applying such knowledge, from examples where phenomena could prompt or trigger certain theoretical associations (passive) to the conscious projection of a theoretical perspective by the psychiatrist on the phenomena (active).

Example (institutional setting):

**Psy:** So you’re actually trained eclectically, at least in different directions. I still have, in my work... my framework is, in principle, a psychodynamic framework, especially when I’m thinking diagnostically. But, in my work I also do, in my therapies, cognitive-behavioral bits. I also work systems-theoretically if I think it’s necessary. In fact, sometimes I work eclectically because pure analytical processes can only be applied to a limited number of patients. So, to that degree I’m someone who works and looks pragmatically. I’m only well versed in cognitive behavioral principles, at least the basic principles, and reasonably well in systems theoretical principles. But also Rogerian, especially conversation technique things, as well as theoretical... humanist... but these have an insufficient underlying theoretical framework.

An example of the interaction between the prompting from phenomena and selection of a theoretical perspective:

**I:** One of the remarks you made during the last interview...it was about a fragment on asking into the patient’s background. That it was logical to ask about that, in view of what she had told you and how she presented herself. It was quite apparent that something was going on related to attachment and that suggested connections to psychodynamic theory. You also said: “If someone comes to me with exam anxiety, I don’t go this deep, I’ll stay more on the surface.” On reading that again, that last remark... could it be that certain complaints, certain presentations, that they suggest a certain perspective, maybe even a certain theory? It was in terms of background, attachment, dynamics. I wanted to check that with you. Can you envisage the thought that certain psychological theories are connected a little, in your mind, conceptually? If it goes this way with the story then I tend to go to this theory, and if it’s a different presentation, to that theory?

**Psy:** For sure. See if someone tells me that he wasn’t well understood by his previous therapist and left due to a conflict... And someone then also has a story... I mean, that wasn’t the case with this patient... but of early childhood neglect and difficulty with...
contact, attachment, the tendency to break off good contact, yeah then you start to search for borderline personality structures, that side.

It is important to note here that the concept of a borderline personality structure rather than a borderline personality disorder, derives from Otto Kernberg’s psychodynamic theory of personality. Consciously held attitudes (philosophical) beliefs pertaining to science, diagnosis and classification, mental disorder, and philosophy of mind, are also represented here. Though a minority, a number of participants were, for example, familiar with philosophical issues in psychiatry such as the problems surrounding the concept of mental disorder or Jaspers’ division between causal explanation and meaningful understanding. Such understandings furnished general guiding notions for practice.

In this example of a psychiatrist employed at an outpatient clinic, the interview has been directed at diagnosis and the role materialism might play in offering a balance against an overriding pragmatic practice. The question was whether material findings could provide a demarcation for illness.

**Psy:** I think the two (material and immaterial) are inseparably connected.

**I:** There is something essentially immaterial?

**Psy:** Yes, it has to do with meaning too. What does it mean for someone to be confronted by these things? It has all sorts of consequences and emotions in daily life. It makes it more complicated. If you describe the speed of molecules, then you still don’t understand what temperature is. You miss a bit.

**I:** Okay, that’s clear.

**Psy:** But, it’s both. Both are important. I wouldn’t say the physical isn’t interesting because...

**I:** You wouldn’t want to reduce to one or the other side?

**Psy:** I think you gain a better understanding if you can work it out at a physical level but I wouldn’t then say: “I understand it now.” You understand one aspect. That gives you more insight and more possibilities to do something with this knowledge. Maybe you could think of a substance that would enhance the growth of neurons... or something! But that doesn’t mean that you understand it – the world around you.

Another feature of theoretical knowledge is a position regarding the role of classification in practice. Most participants declared that the DSM classification fulfilled a peripheral role in their practice, having a chiefly communicative function towards referring G.P.’s, or serving a simple legitimizing role with regard to reimbursement. This was different for those participants consciously practicing actuarial reasoning, for which DSM classification is essential as a connection between clinical diagnosis and research literature.
Example (academic setting):

**I:** You made a remark about diagnosis: “Diagnosis for me has little explanatory power.” The question was on the DSM classification we use. What role does it play in your practice?

**Psy:** Formally it’s obligatory, but its role... Sometimes it’s a burden. The formal part: everyone has to have a DSM because of the financing. But for me the treatment doesn’t hang on that. The DRG⁶ can be get rid of in my view. It’s a non-issue. There is no relationship between the diagnosis and the treatment, even more so if there’s a combination. We have antipsychotics but no antischizophrenics. Maybe... I don’t know exactly what I should do with all those groupings...disorganized, paranoid. There are typologies of complaints of course. For me it’s more important that I see: well, descriptively I think he fits a psychotic state that is long-lasting. That fits the description of what the DSM in the classification system calls schizophrenia, but I do have to search further: what are the mechanisms that sustain this, what are the mechanisms that make this person dysfunction. Why is it all not working?

**I:** Whilst care is organized around the DSM, I gather. Can you say something about what happens in practice... You might expect it to cause tensions in some way..

**Psy:** Yes, does it conflict? I don’t know. If it does then I would have to offer a better alternative. I don’t have one.

**I:** Well, you might notice that it’s in conflict in practice.

**Psy:** Yes, of course. I said it’s a burden. And it is. I think that the DSM, that’s how it goes with anything you classify, it has a certain effect. That limitation comes into effect especially when... people with schizophrenia or bipolar disorder in my practice... I see them once a month at a house call. That goes great and stable. Theoretically you get the same amount for that as for the people that are admitted here. But you really should get more for the people who are admitted. I thin in a different dimension. The insurers however use it to steer the care. There it does cause friction.

**I:** To put it briefly: the DSM itself isn’t the problem, but is has limitations as a classification system and effects, depending on what it’s used for.

**Psy:** Yes. I think that dimension, it isn’t in it. You lose it. In reality you do need it. That is a big problem.

**I:** Is the DSM classification something that, more or less, only arises in your thinking at the end of a session, when you start making notes?

**Psy:** Yes.

Like many participants, this psychiatrist noted an external requirement to note the DSM for communicative and reimbursement purposes, but in practice, he was

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⁶ DRG: Diagnosis-Related Group, specific form of health care reimbursement of fee attached to diagnosis.
more interested in ‘mechanisms’ operating at individual level. The ‘naming’ through DSM was repeatedly contrasted with the understanding of the individual, which was seen as primary.

*Individual values (professional and patient)*
Participants generally held views on good professional practice that went beyond the set codified norms of the profession or institution. Professional norms and guidelines afford them space to apply personal values to their practice. Again, these are related to a general concept of the therapeutic ideal, but there are also influences of more general world views, such as that of the ‘good life’.

In the following example, a psychiatrist describes a general professional value which plays an important role in his choice of reasoning in practice. In an interview in which a patient who had used an antidepressant for a number of years for anxiety problems, the psychiatrist engaged in a discussion about her real self. At the advice of her G.P., she had recently discontinued this medication, but she doubted whether this was a wise decision, since after stopping symptoms described under the categories of anxiety and depression had recurred. Therefore, the question put to the psychiatrist was whether she should resume taking the medication:

*Psy:* Perhaps this is a funny question, but may I ask how long you have been taking the Prozac?
*P:* Twenty years.

*Psy:* Twenty years. And now you’ve stopped taking it. And now you feel like you just described (the patient had just spoken of feeling depressed, very tired, insecure, said everything was a chore, and her appetite had diminished. She had lost 8 kilograms in 5 months.) When were you yourself? When you were taking Prozac, or without?
*P:* Without the Prozac.

*Psy:* But it isn’t a happy self.

*P:* No.

*Psy:* Some people say, for example, I had a patient once who was anxious and depressed. He got a pill and got better and said: but it’s still coming out of a box. Another patient, who’d also got better with medicine, said: I see it like this: because of what’s in that box I’m more myself.

*P:* Well I’ve always had the feeling that if I took the Prozac, it lifted me over something. That the insecurity couldn’t become as strong.

*Psy:* Exactly. Anxiety and insecurity can get in the way of how you want to be. And in that case you could say: the Prozac makes me more myself.

*P:* You’re turning it around.
When questioned on this interaction, the psychiatrist explained that his guiding attitude to (psycho)therapy is that it implies learning to think, learning to be conscious, learning to develop a different way of thinking. In this exchange he challenges the patient to think about the tension between a concept of authenticity (the I without pharmaceutical enhancement) and self-expression through higher functioning. He was careful to add that as a therapist he tried not to take a position on which of the two was better, but that he saw it as his responsibility to encourage the patient to think about this tension herself. Such a contemplative approach to psychotherapy is not dictated by any evidence base and is value-driven: the psychiatrist clearly stated this aspect of therapy as a crucial part of his practice and one representing an alignment of personal and professional values. Other examples of general values influencing the diagnostic process included, amongst others, efficiency (whereby the therapist consciously focused only on areas directly relevant to ‘solving the problem’ of the intake), religious (where the therapist’s practice was transparently grounded in Christian values), responsibility (as a central value and theme within therapy) and autonomy (where the therapist stated emphasizing patient autonomy was a central aim of his practice and he therefore used a ‘following’ style of interviewing). In strategic conceptualization, values pertaining to good outcomes and the ways to attain them are implied or inherent.

The role of patient values in third-level reasoning was ubiquitous and unsurprising given the professional prescription to take these into account. However, the form this took and the degree to which this was allowed, differed. All participants supported the necessity of understanding the problem and the person’s own meaningful interpretation or explanation thereof, moreover, a significant number of participants emphasized requiring an understanding of the patient as a person in order to be able to relate their findings to this meaningful context.

_**Institutional values**_

These include all values derived from institutions, concrete or abstract. The rules and norms specific to a certain mental health provider are included here, but also those related to the norms of the psychiatric profession and the medical profession. Guidelines passed down from nationally or locally recognized institutions, explicitly or implicitly contain values and hence are relevant here. Values derived from medical and residency training may be partially influenced by the values of the training institutions (see Chapters 4 and 5).

For example: in the group of psychiatrists working in institutions, the intake process required the patient to speak separately with a psychologist and a
psychiatrist. A degree of division of labor was involved, where the institutional assignment for the psychiatrist was to perform a psychiatric examination. For some psychiatrists, this implied a division in the mode of questioning, whereby the emphasis within their own interview would be on descriptive reasoning, an alignment effect. As mentioned in the methods section, a purposive sampling decision was made to select a number of psychiatrists (4) working at the polyclinic of the same institution, to examine the possible variation of practice within one institution. In the following interview excerpts, the implications of the institutional setting are discussed:

I: In this setting the intake consists of two separate appointments for the patient, one with a psychologist, and one with a psychiatrist. Can you tell me what this implies for your tasks and responsibilities in your session?

Psy1: It means I’ll focus on the medication, because most of the patients at our polyclinic have a therapist and we just do the pills. So, what is the mental status, would be the question.

Psy2: Someone can have a certain predisposition to depression, or psychosis. That can be encapsulated in the heredity an once that has been explored then you can see what other factors play a causal role, like what a person’s life looks like. Has he shielded himself, protected himself from a relapse. Yeah those are points that I’ll go deeper into.

I: If you put it like that it doesn’t sound like in your thinking you align yourself to one certain etiological view. You could say, for example, I’ll explore someone’s cognitive schema’s. Or I’ll focus on a pattern of defense mechanisms or his personality makeup. That’s not what you’re saying.

Psy2: You can ask about these things.

I: But what do you do?

Psy: In a real psychotherapeutic setting I’d delve deeper into these things of course. How does someone handle his defenses, but the person involved would have to be able to cope with this. Cope with introspection, and with confrontations with the defenses. I: So in the setting you work in now, at this polyclinic, you’re saying this is not the kind of setting to ask about these things?

Psy2: I look at them briefly, I search for them briefly, and then I leave it.

I: And why is it that you leave it?

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7 Translatory note: ‘mental status’ is the translation for the Dutch phrase ‘psychiatrisch toestandsbeeld’, which roughly corresponds to an axis-I diagnosis, and is sometimes also referred to as a ‘psychiatric diagnosis’, and whereby a distinction must be made both with a DSM-classification (which in the period of this study still consisted of multiple axes), and the psychiatric formulation of the case (which should generally include references to the patient’s personal makeup and the situational context).
**Psy2:** Because I'm only involved in medication. That's how the arrangements are, that I can't do real talks.

Given such a statement on the division of labor we would expect the interviews in the institutional setting to be primarily descriptive, aimed at symptoms of disorder, with relatively fewer social and psychological codings. Interestingly however, there were substantial differences in the ways psychiatrists navigated such institutional arrangements. Within this single polyclinic, both highly ‘descriptive’ interviews were found, as well as highly contextual/meaningful ones. This did not solely depend on the nature of the phenomena themselves. In the following example this could be explained in part by the fact that the psychiatrist employed a developmental and primarily psychodynamic model in his practice and organized his exploration around this model. Compare his response to the same initial question:

**I:** This intake was at the polyclinic, and related to occupational rehabilitation. Could you tell me what this implies for your responsibilities and tasks in the intake?

**Psy3:** I relinquish that framework. I try to understand what's troubling the patient.

The psychiatrist went on to describe both a general etiological theory for mental disorder and a personal set of professional values derived from it, and motivating his approach to practice from these. This applied to other participants too: personal theoretical views and values could outweigh institutional values and constraints.

In the following example of a psychiatrist working in an institutional context, the first question was related to the framing of the session and its implications for practice. The session was termed a ‘medication consultation’, and the interviewer asked the psychiatrist what that meant for her approach:

**I:** The case in point is a medication consultation. What does that mean for the way you approach it?

**Psy4:** I have a limited amount of time, and everything I've read in the biography I won't repeat, so I skip part of what I would do in a full intake, I won't go over that again. I think I'm more businesslike than I would be in a normal intake. People generally know why they're visiting me, so I usually don't explain that unless I get the impression that they don't understand why they're here. With this patient I got the impression he knew why he was there.

The psychiatrist described that for her practice, she was more businesslike, more goal-directed and more specific:

**Psy4:** How can I make this clear... I think I keep more structure in it than I would in an intake. That, if people start to talk around it a lot, that I sort it out.
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On further discussion, this participant also noted a personal preference:

**Psy4:** I think that it also has to do with my person, because I like to structure things. I’m to the point, so it’s not just that, it’s not just this client, it’s also my style.

**I:** It’s a style that suits you, but it can also contain a view on diagnosis.

**Psy4:** I think it’s a combination.

**I:** What view is that then?

**Psy4:** That we have little time. But even if we had more time, I would still think it’s important to get, in a short time, an impression of what’s wrong and what needs to be done. And yes, it gives me something to go on.

**I:** The word ‘complaints’ came up. Do you consciously ask questions directed at complaints?

**Psy4:** Yes.

**I:** Why?

**Psy4:** Because it’s simply the case that we work at a time in which the classification system is important, you have to make a diagnosis in a short time, and the diagnosis leads to a treatment plan. A great amount of our treatment is aimed at that so it really is aimed at achieving a diagnosis as efficiently and quickly as possible and as far as possible, from an early stage here, a fitting treatment offer.

This participant demonstrates a ‘middle position’ vis-à-vis the institutional constraints. She clearly mentions institutional pressures ‘It’s simply the case that...’ leading to a certain approach (note that this is another example of alignment, here between ‘medication’, ‘complaints’, ‘DSM’ and ‘efficiency’). But she also notes that this way of working does suit her person and her approach.

In the following example, the psychiatrist has taken active steps to distance herself from certain institutional contexts that she was uncomfortable with. The discussion had been focusing on the demarcation of mental disorder, and the term ‘dysfunction’ had been raised:

**I:** How would you describe that dysfunctioning in a legal context? Let me put it like this, the behavioral frame, it’s more normative. It’s related to broad norms. That’s something else than scientific lawlike relations. Norms that we have put in to law for example, aren’t based on some physical law or other. It’s about what we expect in a certain situation and context.

**Psy:** Well I have a lot of difficulty with that normative aspect then.

**I:** What difficulty is that?

**Psy:** That I think, yeah, that’s just my point of view.

**I:** Relativity. What difficulty does that bring you?

**Psy:** It troubles me when I have to fill in very limiting scales, that put people into boxes. Whether someone is legally competent, for example. I think, well, who am I to
determine that. It’s so normative.  
**I:** Yes. And that means for you that you have difficulty with it, because you feel you are forcing your norm onto someone else. Which might have something to do with power.  
**Psy:** Or whether or not to admit someone involuntarily, or seclude someone.  
**I:** In that kind of situation where things come to a head, it becomes very difficult, because you have to make a very sharp and very impactful decision on dysfunction and disorder or not. How do you handle that?  
**Psy:** Well, in practice I solve that problem by not doing that kind of work.

The psychiatrist involved noted that these strong moral dilemmas were part of the reason for her to move from an institutional setting to private practice, another way of navigating institutional pressures. Besides local institutional influences with regard to the ‘division of labor’, institutional values pertaining to reasoning could take the form of an academic or professional culture. For example, descriptive reasoning was aligned with the medical role. Conscious switches to descriptive reasoning were described by participants as ‘looking through medical glasses’ or ‘putting on my doctor’s hat’. Descriptive reasoning in this sense extended to not only a mode of inquiry but a mode of understanding, and a preferred object of understanding; it was associated with concepts such as ‘real psychiatric disorders’, ‘brain disorders’, ‘biological disorders’, the DSM, and pharmacotherapy (cf. the pluralist approach to diagnosis described in the second conceptual framework). Examples of academic and professional influences on etiological thinking will be given in Chapter 4.

**Import**

This describes the degree to which personally held convictions on the part of the psychiatrist, theoretical, philosophical, and ethical, are resilient to external influences and themselves influential in the shared DEF. The former relates to the degree to which such personal convictions resist possible modifying effects from level 2 processes such as prompting, or a process in the DEF where the initiative lies with the patient, or from level 3 external influences, such as the aforementioned institutional values, professional discourse, etc. One example above shows resilience on the part of a participant related to an institutional constraint. In practice, there were repeated examples of psychiatrists resisting prompts or partial DEF explanations. The adjunct to this resilience is influence: the degree to which the psychiatrist’s convictions are afforded room in practice, influence the development of the DEF and the subsequent treatment plan. Personally held theoretical and/or philosophical beliefs might be enveloped in an
identified psychotherapeutic approach, for example. As described previously, psychiatrists varied in the degree to which they applied general models to their practice. Psychiatrists identifying themselves with one theoretical stance (e.g. 'biological psychiatrist' or 'psychoanalyst') were a small minority. But import here not only refers to theoretical perspectives but also to individual values, lower-level partial explanations, philosophical perspectives, etc., as set out in the categories above. To put it more colloquially: import expresses the degree to which the psychiatrist is expressing his or her own convictions in practice.

Example of resistance to 'patient prompting': an institutional encounter. The patient has been referred for a 'medication consultation':

**Psy**: What is the reason that this examination was planned?

**P**: I suffer a lot from mood swings to a degree that it's bothering me a lot. I want to see if something can be done about them. It troubles me a lot.

**Psy**: Mood changes are normal, I presume.

This is an immediate 'normalizing' reaction, that resists accepting 'mood swings' and altered the DEF using his own.

**Psy**: You're saying your problem is mood swings. They're justifiable according to you. You're angry because your mother suddenly gets angry and breaks off contact. You think it's quite logical you get angry at that, but it's about the degree of anger. You say it's going too far, since you become irritable and combative.

**P**: Yes.

**Psy**: Clear. Well, I do understand your train of thought as such, but I do think you're being overly critical of yourself, the way I understand it. Because the reason you're getting angry, you don't doubt that. You think it's justifiable. But that you then get irritable, and angry quickly, well, what's so bad about that? What is the issue there?

In this exchange, again the psychiatrist is reasoning that the emotional reaction is understandable and as such (see Level Two), less pathological. This continues later in the session:

**Psy**: From what I'm hearing, honestly speaking, with the examples you've mentioned, I don't get the impression that this is a serious problem. The question is whether it's your problem or your mother's problem. Maybe your mother is less reasonable than you, I don't know, it's possible. I don't get the sense of a major problem in that. But if something could be done about that, what would that supposed to be?

Again the participant normalizes the complaints, shifting some of the explanation towards the mother and thereby altering the DEF. The point here is not whether
this position is valid, but to illustrate the manner in which the psychiatrist resisted the patient’s prompt (‘mood swings’) and altered the DEF using his own perspective (import).

3.4 Discussion

The aim of this chapter was to explore the philosophical beliefs of psychiatrists as they manifest in practice. In order to identify and characterize these beliefs, throughout the development of the framework analysis, it was necessary to describe structural and substantial elements of the diagnostic process, and the distinction between three ‘levels’ follows this structural approach. Within these levels, it was possible to identify philosophical ideas ‘in action’, moreover, dynamic processes were identifiable evoking such ideas, e.g. prompting and strategic conceptualization. Finally, philosophical positions held by participants such as theoretical pluralism and causal dualism, which delimit the possibilities of philosophy-in-action, were described.

The structural characterization of diagnosis itself was striking. It is represented as a multilayered and dynamic process, in which identification (of signs, symptoms, patterns) goes hand in hand with narrative and causal construction, based on a firmly pluralist application of theory, and shot through with a normative teleology. The lack of etiological certainty with respect to mental disorders here allows for varying degrees of ontological (and implied epistemological) potential and scope associated with the phenomena of practice, and connections to different explanatory theories, which are applied to the problem, often in a pragmatic fashion. Below we will discuss these findings in relation to the empirical studies of clinical practice reviewed in the first part of this chapter.

In characterizing ‘the philosophy of practice’, it also became clear that a distinction must be made between participants’ ontological and epistemological understandings of specific phenomena, e.g. whether or not ‘psychosis’ or ‘depression’ are seen as in essence material/biological or otherwise, and their broader philosophies pertaining to the act of diagnosis itself, e.g. causal dualism and (normative) pragmatism. Though further examination of the philosophical understandings of specific phenomena in practice is certainly warranted, here we are more interested in the deeper lying philosophical positions delineating such understandings.

*Philosophy in practice*

The most significant such philosophical positions described in the framework
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analyses were theoretical pluralism, causal dualism, and values-oriented pragmatism. Theoretical pluralism seems to entail a significant departure from traditional medical diagnosis, the latter aiming for parsimonious diagnosis with high explanatory power, preferring a singular causal explanation to plural ones. Lacking a singular, dominant etiology, psychiatrists prefer to—critically—apply those theoretical perspectives that they see as apt and productive (and that they are familiar with). In this study, this preference seemed to supersede the actuarial EBM-approach, though it is not necessarily inimical to it.

Causal dualism, perhaps representative of a deeper mind-body dualism, was a precondition for the kind of zero-sum causal reasoning apparent in assigning an ontological status to the diagnosis as it progressed through the DEF. In medicine generally, the ontology of diseases is composed of causal elements that have widespread recognition, as evidenced by their status in medical textbooks and curricula, and therefore, diseases possess relatively settled ontologies. For psychiatry however, etiologies of disorders and psychiatric phenomena are contested, and generally consist of the classic triad of biological, psychological and social elements. Where for general medicine, diagnosis-as-description is crucial to identifying the correct underlying pathology related to the surface manifestations, in psychiatry the differentiation is in relation to taxonomic constructs, not etiologic ones, as far as identification goes. Our findings show psychiatrists navigating such etiological uncertainty by combining different forms of reasoning, demonstrating pluralism, pragmatism and values-based reflection. In doing so, they prioritize the reality of the clinical situation, and their professional expertise in representing this reality in diagnosis. There is a sense of autonomy and sovereignty to this clinical reality. Due to its complex and hybrid nature, describing it as a mix of the idiopathic and nomothetic, or a combination of natural and human science, does not do justice to the dynamics involved. Therefore, a fourth philosophical position should be added, one we will term *clinical realism*. This term is used to emphasize the manner in which participants view the clinical process as of a distinct nature. In the following we will examine these positions in relation to the literature on clinical practice.

*Clinical Reasoning*

This study was not devised in order to distinguish between different hypotheses on the cognitive processes of clinical reasoning, so we cannot derive any support for one or the other position. A different matter is whether the findings here accord with previous research. One notable difference is in the area of problem solving, expertise, and diagnostic accuracy. In psychiatry, the latter is defined in relation to
DSM-criteria for diagnostic classification. If such a form of accuracy were deemed to be crucial in psychiatric practice by participants, we would expect to have seen a preponderance of actuarial reasoning in relation to DSM-diagnoses. Accuracy of diagnosis in relation to the DSM-standard is taken as an indicator of expertise in CR studies relating to mental health (cf. Witteman et al. 2012). However, this was clearly not the majority process observed here and stands in contrast to the clinical realist position. An explanation of this fact may be derived from participants’ views on the DSM, namely, that it does not represent the sole categorical or taxonomic scheme available to which clinical knowledge relates. DSM categories are seen as valuable as connected to inductive knowledge on the effectiveness of treatments, but are seen as having limited connections to etiological theory and limited prognostic value. From the clinical realist position, the DSM is assessed first on its value for clinical decisions. Use of the DSM most frequently was seen as being derived from external, institutional requirements, namely reimbursement and communication. Rather than relating information to a singular knowledge framework such as the DSM, psychiatrists organized and related the phenomena to plural frameworks, constructing a (re)conceptualization and explanation tailored to the individual (through the structural dynamics of the DEF) in the process. Given the centrality of the DSM and of the EBM approach in the professional literature, this is noteworthy. One possible explanation for this may be the preference for causal knowledge found by Schmidt & Rikers (2007), based on its lower cognitive load (compared to the probabilistic approach of EBM). This accords with the preference for theory-based diagnosis found in Ahn and Kim (2008). But EBM and DSM are not excluded: the DEF consists of varying combinations of meaningful, descriptive and actuarial modes. Where applicable nomothetic knowledge is used, chiefly in the form of relating a DSM category to an expected reaction to treatment, in EBM fashion. Such strategies were mainly used in relation to pharmacotherapy, which fits the predominance of pharmacotherapeutic trials in evidence-based research. DEFs are amalgams combining knowledge from various domains, co-constructed with the patient, and worded (through the binding process) in terms the patient not only understands but supports. The importance participants place on ‘having understood the patient’ points to the centrality of this shared understanding (one aspect of clinical realism). If the DEF is validated by the patient, it has a degree of predictive power in the common sense that our meaningful understanding of others allows us, at individual level, to predict their behavior. If the applied theory succeeds in being accepted by the patient, predicting behavior, and facilitating treatment, it is validated pragmatically at the individual level, thereby also validating the diagnosis couched in its terms. The importance of such shared explanations (also referred to as ‘rationale’ or ‘narrative’ in the literature) has been apparent from the
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studies of Frank (1961) onwards. The fact that the DSM heuristic was seen as relatively unproductive by most practitioners is a remarkable finding given the fact that one of the central aims of the DSM project was to improve reliability as a bridge to bolstering the scientific foundation of practice. Participants repeatedly stressed however that, outside of pharmacotherapy, the scientific results from the DSM project so far had little bearing on and limited value for clinical problems. This may, however, be a consequence of the relatively high average age of the participating psychiatrists: we expect younger psychiatrists to have experienced a higher prioritizing of EBM in both medical and psychiatric training. For EBM, DSM-diagnosis is a crucial step in connecting statistical findings to clinical practice. Influences of training will be examined further in Chapters 5, 6 and 7. Further research aimed at the influence of age, experience and curriculum differences is warranted.

Diagnosis and classification

A second important deviation from the models of CR research is the application of strategic conceptualization. In service of an expected therapeutic benefit, the characterization and explanation within the DEF was thereby constructed in such a way as to legitimate a certain course of treatment. Diagnosis was infused with values derived from the encounter itself, but might also be influenced by professional, personal, and institutional values, because of the ethical teleological orientation of the process. But values may also act from a distance, derived for example from views extolled by influential figures throughout residency training (this will be addressed further in Chapters 5 and 6). Factors such as initiative and import, described above, determine whose values will dominate in the state of the DEF at the end of the intake phase.

Were this finding to be replicated, this might carry serious implications for the relationship between scientific classification and clinical diagnosis. Diagnosis-as-construction implies that local factors outside the scientifically derived taxonomy may influence the clinical diagnosis (and secondarily, the classification derived therefrom). Rather than functioning as a determinative touchstone, a DSM-classification might become an object of manipulation. From an empirical perspective, the taxon’s validity and universality would be undermined. The empirical cycle requires stability of the object under scrutiny (in this instance, the taxon) over scientific and clinical settings, and if this practice were found to be widespread, this would constitute a flaw in this cycle, leading to a loss of feedback from clinical experience to the scientific domain. In other words: the taxonomy might be in danger of ‘spinning freely’ from the clinical realm. This is underlined by the often heard opinion of participants that the primary function of the DSM
classification was is reimbursement, and by the discrepancies between the ostensive DEF in the encounter and the written reports, where the latter were primarily seen to serve a communicative function. In other words: clinical diagnosis enjoyed epistemic precedence relative to the role of classification as a conduit for scientific evidence.

In only a minority of cases was an actual DSM diagnosis mentioned in the intake, rather lay language or general terms such as depression, psychosis or mood swings were used. Privately, however, as evidenced by the written reports, the psychiatrists held conceptions which differed from the literal language of the encounter, both theoretical and taxonomic. If we take the example of a patient who is told he 'has a depression', the psychiatrist could feasibly have associated the phenomena with the DSM-classification of Depressive disorder, thereby assessing the severity and presence or absence of psychotic symptoms, without communicating all this literally. If she subsequently chooses to martial the DEF towards a biological explanation on the grounds that a social explanation would entail a narcissistic injury and possible termination of treatment, this might be defended ethically on utilitarian grounds: effective treatment of the depression might be considered the greater good. The legitimacy of such practice would require analysis on a case-by-case basis as the ethics of specific cases would tend to differ.

The fact that personal and professional values intrude constitutively within diagnosis to some might suggest subjectivity in an area in which psychiatry has aspired to be objective. The issue of values in psychiatric diagnosis has been discussed extensively elsewhere (Sadler, Wiggins & Schwarz (eds.) 1994, Fulford 1989, Sadler 2005), leading to an acknowledgement that the presence of (embedded) values in a taxonomy or in the conceptualization of mental disorder need not invalidate its scientific status. However, where psychiatrists construct the DEF from a value-bound pragmatic perspective, this raises a number of ethical issues, not the least of which is the safeguarding against abuse, given the recognized power differential between patients and professionals. It might be argued that the reflective practitioner will be aware of her own pragmatic strategic conceptualization and take up a reflective and ethical position towards its consequences. But to what degree is it morally acceptable for a psychiatrist to one-sidedly determine a certain (therapeutic) end, and to consciously modify an understanding of a patient’s phenomena to achieve this end? A simple example hereof is that of a psychiatrist promoting a brain-based explanation for a mental disorder based on the professional opinion (derived from diagnosis combined with EBM) that pharmacotherapy is necessary, and that framing the DEF in this manner
will increase the chances that the patient will accept this advice. Is this ethically acceptable? Should it make a difference whether the clinician truly believes this causal explanation, or is causally agnostic but employing strategic conceptualization? Should possible ‘side effects’ of such conceptualization, such as stigmatization, be considered in such practice, and if so, how? Another problem could be the question of what is disciplining the psychiatrist’s ethical deliberations, since pragmatism necessarily invokes a normative teleological concept of the good. Is simply pointing to expected therapeutic benefit good enough? If a treatment then fails, is it morally defensible to again perform an ontological shift and say, for example: “Well, we tried psychotherapy and it didn’t work. Maybe it’s biological. Let’s try pills.”

The epistemically and ethically complex nature of clinical reasoning in psychiatric practice suggests it may be productive to recognize both the practice and the knowledge involved as sui generis rather than attempting to reduce it to an either idiographic or nomothetic activity. The distinct reality of the clinical encounter is recognized and prioritized by the participants in clinical realism and the prioritizing of professional expertise and reflection on all other knowledge sources. The scientific legitimacy of this approach will be explored further in Chapters 5, 6 and 7.

_Cognitive Research_

A number of findings from the cognitive research corresponded to our study. The strong distinctions between biological on the one hand and psychological/social causes on the other found by Ahn, Proctor and Flanagan (2009), were present here and played an important role in ontological characterizations of the phenomena. Also, the preference for client-specific explanations rather than general ones found by de Kwaadsteniet et al. (2010) was also evident in the predominance of the idiographic approach. The construction of theory-like structures from individual symptoms of DSM disorders was represented here in the workings of the DEF, though this was amplified by the finding that beyond DSM-symptoms, different concepts from different theoretical frameworks were applied to such explanations. This implies it could be of value to extend the focus of cognitive research in relation to diagnosis beyond DSM-symptoms and to allow for other phenomena in the construction of explanatory structures.

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8 This brief scenario is less ironic than it seems: a number of psychiatrists working in institutional settings experienced exactly this scenario where if long-term psychotherapy was deemed to be insufficiently effective, patients were referred with the hope of providing medication to provide relief. Psychiatrists perceived this as having the cards already stacked before the session began.
Intuition
A number of participants acknowledged the importance of intuition for their clinical and diagnostic work. The study was not designed to identify which kinds of intuition were at play, though certain examples suggest at least matching and associative intuition. If intuition is assumed to encompass tacit reasoning (Polanyi 1966, Collins 2010, Gascoigne and Thornton 2013), then the importance of empathic understanding as a feature of psychological understanding should be mentioned (Potter 2013, Halpern 2003, Oulis 2014). As described above, phenomena with wide ontological scope would be explored through meaningful reasoning and comprehension of a meaningful explanation was a crucial factor in acceptance of such an explanation. Empathic understanding was a component of such comprehension and relevant to the outcome. Again, it is the role of intuition in the process that differs from previous research: traditionally, intuition is one conduit for recognition, either of clinical syndromes, patterns, or illness scripts (Glöckner & Witteman 2010a and b). To this picture we might add that pragmatic choices as described under strategic conceptualization might occur tacitly, implying an intuitive application of ethical/pragmatic norms, for example as a result of repeated performance in similar clinical situations. It is reasonable to assume tacit knowledge and implicit learning may contain values and ethical norms as there is no a priori reason for tacit or practical knowledge to be limited to non-moral knowledge. In this manner, third-level pragmatic or ethical ‘reflection’, including strategic conceptualization, could actually be performed intuitively. Therefore, our findings expand the range of possible applications of intuition in practice.

Anthropological/sociological studies
With respect to the anthropological and sociological literature on social, cultural, and political influences upon psychiatry and in practice, on the one hand, there is clear evidence of the role thereof in practice. Psychiatrists are influenced by professional, institutional, and social norms in their practice, and again, the study points to the fact that such influence may be considerable, including affecting the manner in which phenomena are understood (through alignment and translation of level 3 values to lower levels) (cf. Sadler 2005, Goudsmit 2012). However, we were also able to demonstrate considerable variation between psychiatrists in the degree and manner in which this is expressed in practice (variations in import). The effects of institutional and social values and demands on practice are mediated, and some would say mitigated, by individual personal and professional values. Also, such values and interests, it is hypothesized here, are primarily present in the third framework level. The dynamics of the first and second
frameworks play a further refractory role. Level 3 institutional values may be translated through division of labor, constraints on treatment choice, preferred academic conceptualizations, to name but a few, and these affect levels 1 and 2 in different ways, either by simply limiting the scope of the care request (e.g. to pharmacotherapy) or by having a determinative effect on available theoretical conceptual and explanatory frameworks.

With respect to the ‘models vs. maps vs. narrative’ framework described by Kokanovic et al. (2013) we would agree that these are relevant concepts, however we view this combination as disjunctive: maps and models refer to the scope of certain forms of reasoning, whether these are performed or selected in an a priori manner or are quantitively dominant in an encounter, whereas narrativity is a qualitative feature denoting a certain type of reasoning. Having said this, it is interesting to note that though psychiatrists profess to forms of pragmatism or eclecticism in general, they do, as we previously noted, sort certain phenomena within a general causal domain, with therapeutic consequences. Should we say, with Ghaemi (2003), that this is evidence of dogmatism, only, in this case, diagnosis-based? Again, our previous statements point to structural processes favoring pluralism. However, the causal and ontological dualism on display does merit further study in our opinion. One line of thought runs as follows: if certain mental disorders, or constellations of symptoms or phenomena, are more likely to be conceptualized as materially caused, material in nature, and necessitating material forms of treatment, could this result in neglect of psychological and social domains? In other words: if the psychiatric doctor tends to ‘put on her doctor’s hat’ and perform a kind of diagnostic segregation of ontology, episteme, role and treatment, could marginalization of forms of inquiry not prioritized by the medical profession, be the consequence? We might refer to Mishler’s (1984) work on the diminution of attending to the ‘voice of the lifeworld’ associated with progress through medical study as support for this worry. Conceptualizations of disorder in practice, and their implications, will be the subject of Chapters 8 and 9.

Mental Disorder
A final question brought to the fore here is whether a unitary definition of mental disorder is a) feasible and b) necessary for practice. If practitioners employ various heuristics coupled with different theories pluralistically and without necessarily integrating these into a singular diagnosis, related to different therapies, and we also agree that this involves conceptualizing the phenomena present in the interview differently, then the relevancy of a possible unified definition of mental disorder is low, and inimical to such a pluralist outlook. Even if a single definition were to be accepted (e.g. the DSM definition), its capacity to encompass diverse
theoretical frameworks without becoming so ecumenical as to be meaningless would be in question. Should a concept of disorder have a unifying function, binding practitioners by at least defining a common object? The same tension between the general and the particular that occurs between classification and diagnosis also occurs between general ‘mental disorder definitions’ and the dynamic conceptualization of mental disorder at the individual level in practice. The development of the latter proves to be a result of a complex of piecemeal causal and ontological attributions to phenomena (e.g. prompting) but is also influenced by normative judgments at fundamental levels. Just as DSM-classifications seem to have little practical relevance for the participants, an overarching definition of mental disorder appears to have little utility in practice. However, it may just be the abstract nature of such definitions that make them less ostensive from the perspective applied here, that of diagnosis and classification. The role of mental disorder in practice will be examined further in Chapters 8 and 9.

The explanatory pluralism and preference for theory-based heuristics in evidence in these results raises substantial questions about the DSM-project, which in its current, descriptive form, has been in place for three decades. If psychiatrists who are in general supportive of the scientific progress in psychiatry, supportive of evidence-based medicine and supportive of the use of actuarial methods in psychiatry, nevertheless assign a peripheral role to DSM in practice, this seems to imply that one of the main aims of the DSM, its clinical utility, is not being met. In the face of huge bodies of research not only in the biological, but also in psychological and social domains, the psychiatrists view the utility of the DSM as limited, and use it in an ‘isolated’ manner, connected to descriptive diagnosis, pharmacotherapy, and where applicable, treatment guidelines. This is not to criticize such practice, since it seems perfectly legitimate, and in fact mandatory, not to extend research evidence beyond its valid application to the individual case. However, there does seem to be a discrepancy between the amount of serious research done with DSM as its basis, and uptake of such results in practice. Are practitioners at fault here, insufficiently aware of relevant research? Problems in the uptake of EBM have been noted elsewhere (Wallace, Nwosu & Clarke 2012). Alternatively, these findings may point to problems with the DSM approach, or be a signpost pointing to conceptual problems specific to psychiatry. These questions are the subject of Chapter 4.
3.5 Main points of Chapter 3:

- The diagnostic practice of psychiatrists can be modeled using the Developing Explanatory Framework (DEF).
- Diagnostic practice can be characterized as combining identification and construction and is geared towards pragmatic goals, centered on the betterment of the patient.
- Influences impacting on the DEF can be characterized as ‘bottom-up’ (from the phenomena) and ‘top-down’ (e.g. external, theoretical, institutional).
- The effect of such influences is modulated by professionals’ philosophical and ethical beliefs and positions.
- New descriptive terms have been suggested here allowing for identification of the interplay between phenomenal and contextual influences and practitioners’ philosophical beliefs, e.g. alignment, ontological scope, and explanatory pragmatism.
- The most significant such philosophical positions described in the framework analysis are theoretical pluralism, causal dualism, values-oriented pragmatism and clinical realism.
- The role of the DSM in diagnostic practice is peripheral.
- In clinical practice phenomena are not necessarily reduced to a singular causal explanation.