

This is the pre-peer reviewed version of the following article: Fernandez, A. V. and S. Wieten. 2015. "Values-Based Practice and Phenomenological Psychopathology: Implications of Existential Changes in Depression." *Journal of Evaluation in Clinical Practice* Vol. 21, no. 3, 508 – 513, which has been published in final form at [DOI: 10.1111/jep.12313](https://doi.org/10.1111/jep.12313). This article may be used for non-commercial purposes in accordance with [Wiley Terms and Conditions for Self-Archiving](#).

**Values-Based Practice and Phenomenological Psychopathology:
Implications of Existential Changes in Depression**

Anthony Fernandez¹, MA
Department of Philosophy
University of South Florida

Sarah Wieten², MA
Department of Philosophy
Centre for Humanities Engaging Science and Society
Durham University

Author affiliations:

¹Philosophy Department, University of South Florida, 4202 E Fowler Avenue, FAO 226, Tampa, FL 33620, USA

²Philosophy Department, Centre for Humanities Engaging Science and Society, Durham University, 50 Old Elvet, Durham, DH1 3HN, UK

Running Title: VBP and Phenomenological Psychopathology

Keywords: Values-Based Practice, Evidence-Based Medicine, Phenomenology, Depression, Values

Abstract
(242 words)

Values-Based Practice (VBP), developed as a partner theory to Evidence-Based Medicine (EBM), takes into explicit consideration patients' and clinicians' values, preferences, concerns and expectations during the clinical encounter in order to make decisions about proper interventions. VBP takes seriously the importance of life narratives, as well as how such narratives fundamentally shape the patient's and clinician's values. It also helps to explain difficulties in the clinical encounter as conflicts of values. While we believe that VBP adds an important dimension to the clinician's reasoning and decision making procedures, we argue that it ignores the degree to which values can shift and change, especially in the case of psychiatric disorders. VBP does this in three respects. First, it does not appropriately engage with the fact that a person's values can change dramatically in light of major life events. Second, it does not acknowledge certain changes in the way people value, or in their modes of valuing, that occur in cases of severe psychiatric disorder. And third, it does not acknowledge the fact that certain disorders can even alter the degree to which one is capable of valuing anything at all. We believe that ignoring such changes limits the degree to which VBP can be effectively applied to clinical treatment and care. We conclude by considering a number of possible remedies to this issue, including the use of proxies and written statements of value generated through interviews and discussions between patient and clinician.

Introduction

Value-Based Practice (VBP), developed as a partner theory to Evidence-Based Medicine (EBM), is an explicit attempt to take into consideration patients' and clinicians' values, preferences, concerns and expectations during the clinical encounter in order to make decisions about the proper intervention. In this paper, we argue that values-based practice does not adequately account for the implications of existential changes in people with certain kinds of severe psychiatric disorders. While VBP adds an important dimension to the current paradigm of evidence-based medicine by suggesting that patients' values should be taken into consideration in decisions about interventions, as currently formulated, it does not account for dramatic changes in the patient's value-system or capacity to value.

This paper is divided into five sections. First, we give a brief background of VBP in relation to EBM. Second, we offer an example, taken from the work of Bill Fulford, of the role VBP can play in clinical decision making. Third, we illustrate VBP's problematic assumptions regarding the static nature of values. Fourth, we discuss the ways in which phenomenology suggests that some severe disorders (depression, in particular), can involve a shift not only in the way the subject values, but in their ability to value anything at all. Fifth, and finally, we suggest some possible amendments to VBP that accommodate clinical situations that include shifts in, or the loss of, value.

VBP and EBM

In the paradigm of evidence-based medicine (EBM), knowledge of best practices ascertained through systematic review of randomized controlled trials plays a fundamental role in clinical reasoning. EBM, an approximately twenty year old movement, "is the conscientious, explicit and judicious use of current best evidence in making decisions about the care of

individual patients” ([1], p. 71). Consensus about what exactly constitutes best evidence has shifted over time, with early versions of EBM flatly rejecting the inclusion of expertise and mechanistic reasoning and more recent versions incorporating them at low positions in the hierarchy of evidence. At the top of this hierarchy of evidence is the randomized controlled trial and the systematic review. Randomized controlled trials “differ from most observational studies in that they involve random allocation and experimental administration of treatments” ([2], p. 43). These studies, because of the ways that they control for possible confounders, are considered to be the preferred method for gaining new knowledge about clinical interventions. A systematic review is a review of all the literature (usually articles about RCTs are preferred) about a particular issue with explicitly stated rules for the inclusion or exclusion of articles from consideration in the review. The findings of these reviews function as guidelines for the best practices in the field.

Clinicians and patient advocacy groups pushed back against this “new paradigm,” arguing that it failed to take into account the realities of the clinical encounter, did not stand up to critical scrutiny, and did not account for the ways in which individual patients might differ [3].

In the wake of these calls to reformulate EBM to be more patient-centered, a partner theory, values-based practice (VBP), rose to prominence. Developed by Bill Fulford in the field of psychiatry before being generalized to all health professions as a “new partner’ for evidence-based practice,” VBP offers a “new skills-based approach to working more effectively with complex and conflicting values” ([4], p. 976). This movement takes care to—perhaps problematically—differentiate itself from bioethics, though ethical values are among those values the movement is concerned with [5]. A health professional working in the mode of VBP is expected take note of and investigate her patient’s values in the course of the clinical

encounter. A health professional working in the mode of VBP is also, however, expected to take into account her own values, as well as the values of anyone else involved in the clinical encounter. Fulford's work includes many examples in which at least three separate sets of values are taken into consideration before coming to a conclusion [6].

Fulford is careful to note, however, that VBP should not be seen as an alternative to evidence based medicine. He writes, "A particular feature of values-based practice is that [...] it is fully complementary to and supports evidence-based approaches" ([7], p. 20). Fulford's method urges practitioners to "think evidence, think values too!" ([6], p. 180). According to this approach, values are "preferences, needs, hopes, [and] expectations." ([7], p. 11) While values in this system are not explicitly defined over against facts, the structure of the partnership with EBM makes clear the traditional dichotomy: EBM seeks to identify and bring to the health professional the best evidence (read: facts) and VBP seeks to identify and bring to the health professional a clear idea of the values of all the relevant actors in a medical decision making arena. Fulford writes,

Thus, we can think of values-based medicine as being to values what evidence-based medicine is to *evidence*. Just as evidence-based medicine offers a process for working more effectively with complex and conflicting evidence in medicine, so values-based medicine offers a process, albeit a different process, for working more effectively with complex and conflicting *values* in medicine. ([7], p. 12)

In addition to the evidence provided by EBM, VBP takes these concerns as important factors in selecting the intervention that leads to the patient's best health outcome.

VBP in the Clinical Setting

In Fulford's illustrative example of the role of VBP in the clinical setting, an artist begins taking lithium to control her bipolar disorder. From a traditional medical point of view, this treatment was very successful—the lithium controlled her mood swings and she had few side

effects. However, she stopped taking the lithium because it blunted her perception of color. This side effect, which had not seemed important enough to take into consideration in previous studies of the intervention, but was well documented in the patient narrative literature, was of paramount concern to this patient because of her set of values related to her role as an artist. Armed with this clarification of values, the artist and her clinician were able to find a more suitable intervention. In this case, the doctor's values (e.g. use of best practices, importance of efficacy) were at first assumed to be paramount to the patient's values (e.g. quality of life, artistic functioning) as the patient's full assortment of values was not made clear in the original encounter [8]. This case makes clear the benefit of taking values, as well as evidence, into consideration in clinical decision making. In this case, however, the patient was able to continue to express the ways in which her treatment was not in line with her values, even while experiencing the condition in question. In other cases, such as depression, it is not as clear that this will be possible.

Difficulties for VBP

This addition to evidence based medicine is not without its difficulties. Especially in his clinical workbook, Fulford does a good job discussing the way in which values are “squeaky wheels”—that is, they are always underlying the clinical encounter, but only tend to be noticed when they are causing conflict. Even in these “squeaky wheel” encounters, Fulford orchestrates examples in such a way that a mutually beneficial solution is always possible with all parties' values intact and unchanged. Fulford even relates that an early reviewer of the book was confused that there were “no villains” in the cases studied; that is, Fulford gave no examples in which conflicting values could not be reconciled [6]. While the cases may need “villains” to be compelling, it does seem unlikely that all values can be brought into accord—surely there are

cases in which the differences in values between clinicians and patients are problematic and irreconcilable.

There is one instance in which Fulford seems to contend with the possibility of shifting values. In his 1994 article written with Andrew Moore and Tony Hope entitled “Mild Mania and Well-Being,” Fulford and his co-authors examine the case of Mr. M, a patient who was diagnosed with “mild mania” (though his treatment with lithium begins after a depressive episode). Over the course of Mr. M’s treatment—including his time on and off lithium, periods in which he was manic or depressed, and periods of relative stability—Mr. M articulated a wide range of values; sometimes, “He found his wife and family boring and claimed that his marriage had never been good...openly expressing his intention to divorce his wife and to marry his girlfriend,” other times “he...described his relationship with his girlfriend as superficial and unimportant” ([9], 167).

In light of the difficulties inherent in taking seriously these shifts in values, the authors argue that we should cease to take the immediate values of the patient into account, writing, “...In the case of hypomania, it is the long-term welfare of the person concerned rather than his or her immediate express wishes, which is the relevant measure of his or her best interest” ([9], p. 167). While Fulford and his co-authors seem aware of difficulties involved in changing and shifting values in the case of severe psychiatric disorders, their attempts at making sense of such values is quickly abandoned in favor of a more objective notion of the patient’s “well-being.” However, further disagreements about what constitutes well-being, as well as which kinds of well-being the clinician should aim to achieve for his patient, lead the authors towards a pernicious paternalism.

While Fulford and his co-authors fail to develop an unproblematic notion of well-being in

their article, it is even more important to note that in Fulford, in his subsequent works, returned to the idea of taking patients' values seriously. However, rather than finding a new way to approach the problem of shifting values, he begins to rely exclusively on cases in which values do not change.

Fulford's failure to adequately address the ways in which values can shift and change over (especially for subjects with severe psychiatric disorders) is a potential obstacle to the implementation of VBP in clinical practice. Fulford has been able to avoid confronting this obstacle by maintaining a methodological pluralism in regard to the question of how to actually obtain knowledge of a patient's values. By portraying the process of obtaining knowledge of values as something distinct from the way in which one should use these values to make decisions in VBP, he has been able to avoid deeper questions about how we gain our values, how they develop, and how they can be altered in cases of severe psychiatric disorders.

We argue that adequately addressing these deeper questions about values and the ways we value is required in order to adequately implement VBP in real, clinical settings. In order to illustrate some of the difficulties that arise for VBP we consider three different kinds of phenomenological investigations of people with psychiatric disorders. These investigations bring to light changes in one's set of values, changes in one's mode of valuing, and changes in one's capacity for valuing.

The Phenomenological Method

Phenomenology, emerging in the early 20th century as a continuation and redevelopment of the Kantian transcendental project, is a method for discovering the basic structures of human existence and worldhood. In other words, phenomenological investigations are meant to uncover

the necessary, invariant, and constitutive characteristics of human existence.¹ While some investigations encompass a wide range of characteristics of human life, including emotion, perception, intersubjectivity, and temporality, a major concern of phenomenological investigations is the constitution of meaning. All of these characteristics of human existence are tied together by the fact that each plays some role in constituting the ways in which our world is meaningful, or how it can be meaningful at all.

The prime example of a phenomenological study of the meaningfulness inherent in human life is Martin Heidegger's *Being and Time*. In this text, Heidegger sets out to discover the characteristics of human existence by which our world is disclosed to us. He argues that care [*Sorge*] is the core characteristic of human existence. By care he refers to our openness upon the world in which our self, the world, and others are disclosed, or revealed to us, as meaningful. In other words, the fact that things *matter* to us, in one way or another, is the fundamental characteristic that must be accounted for in a proper study of human existence. Further, because of our temporal existence (i.e. because we always exist in a temporal unfolding towards the future), who we are is an issue for us. As Heidegger says, human beings are distinctive in that we are the beings for whom our being is an issue [12]. All of our roles, identities, and social relations impose burdens upon us. They matter to us, in one way or another, and as a result we must take them up as a task. Whether my intention is to continue being the person I already am, or to become someone else, I must perform certain actions, behave in certain ways, say the right things, and so on. The identity of a "good father," for example, is not something one simply achieves at some point in life and then retains as if it were a trophy placed upon the mantel. One has to behave in particular ways and express particular feelings in order to gain this identity in

¹ For a concise introduction to phenomenology and the phenomenological method, see Sokolowski [10]. For a historical introduction to the discipline of phenomenology, see Moran [11].

the first place—and once this identity is gained, these kinds of actions must be continued in order to retain the identity of a good father. My world always shows up to me, first and foremost, *as* meaningful, but the particular meaningfulness of *my* world is experienced through the lens of who I take myself to be, the obligations this identity imposes upon me, and the values I must hold and express in order to maintain, or change, this identity.

Phenomenological psychopathology, as an outgrowth of 20th century transcendental phenomenology, continues in the tradition of these classical phenomenologists. However, it does so with slightly different aims. Rather than studying the universal characteristics that must be in place for any meaning whatsoever to show up in the lived world, phenomenological psychopathologists typically study distinctive and anomalous changes in the constitution of everyday existence.

There are at least three distinct domains of phenomenological research, each of which is relevant for the understanding of psychiatric disorders [13]. These domains are interpretive schemas, modes, and existential structures. In order to illustrate the kinds of changes studied within the domain of interpretive schemas, we draw on further examples offered in Fulford's work. In order to illustrate the kinds of changes studied within the domains of modes and existential structures, as well as the implications of these changes for VBP, we draw on recent work on the phenomenology of major depressive disorder.

Interpretive schemas are the contexts or frameworks of meaning through which our world makes sense to us. For the purposes of this paper, we can simply think of them as system of value, or value sets. These value sets are typically tacit, not being explicitly articulated or expressed by the person in question. However, such value sets can often be made explicit by contrasting them with the value sets of other individuals or cultures. For example, if two people

from different religious faiths—one being Christian and one being Hindu—were presented with a cross, the Christian would immediately perceive the cross as sacred, while the Hindu might not. While both may have a interpretive schema or value set in which the *sacred* is a possible object of experience, which objects show up *as* sacred differs between them. We can push this example even further by considering the experience of someone who is not religious, and perhaps never has been religious. While people from two different faiths will perceive different objects, locations, or people as sacred, someone who has lived a life without a religious faith may not perceive anything as sacred—which is not to say they necessary lack a concept or understanding of the sacred. While such a person may immediately perceive certain objects with reverence, the sacred is simply not part of the schema or value framework through which their world makes sense to them.

It should also be noted that studies of these schemas and value sets are not, strictly speaking, the subject matter of phenomenology proper. Rather, the interpretive method by which we unearth the background meanings and prejudices that shape our lived world is typically referred to as hermeneutics. One of the insights derived from both phenomenological and hermeneutical studies of background prejudices is that these lived frameworks of meaning are by no means static. Our systems of meaning and value are passed down to us and sediment through the social-historical events that have shaped our cultural, political, and religious lives. And further, personal-biographical contingencies can fundamentally alter the significance of particular people, places, and events, along with the goals we believe are worth achieving, and the habits and roles we believe are worth cultivating [14].

When Fulford is faced with a case study that might be interpreted as a dramatic change in values, he typically interprets it as a discovery of one's true values, rather than a fundamentally

new way of valuing. It might be the case that an individual's values are hidden or undisclosed and a practitioner skilled in VBP must uncover them, but they do not change. This holds in cases in which patients pass through puberty, confront major illnesses, and undergo radical changes in goals. Even in the case of a teenager with schizophrenia who discloses after an episode that she is no longer as committed to her art as she once was, and wishes to change her career goals in a way that will require a change in treatment program, her values are taken as unchanged by either maturation or psychosis. Instead, her "true" values were simply covered over by her artistic talents and her parents' wishes for her future ([6], p. 50). In contrast, a hermeneutic phenomenologist would interpret this as a major life event that fundamentally altered the teen's value set. While it is true that static values are much simpler to negotiate, it seems unlikely that an individual's values will remain consistent from childhood through old age, in spite of major life events, changes in circumstances, or mental illness.

While phenomenological studies of one's interpretive schema illustrate the ways in which a system of values can undergo shifts and changes throughout the course of one's life, phenomenological psychopathologists also study changes in modes of human existence and in structures of human existence, both of which entail more profound changes in the meaningfulness of one's world, and therefore in one's values. It should be noted here that the phenomenological, or Heideggerian sense of "meaning" is not synonymous with Fulford's discussion of "values." When Heidegger speaks of the meaningfulness of the world, he is typically referring to the fact that the world and the things, people, and events within it matter to us. Values, then, are derivative of this Heideggerian sense of meaning. My values are developed and cultivated in light of the way the world shows up to me as meaningful, and the kinds of meaning I find in it. As a result, profound changes in the way in which my world shows up as

meaningful, such as those changes brought about by mental illness, often motivate corresponding changes in values.

One example of phenomenological studies of changes in the mode of human existence in MDD is found in Matthews Ratcliffe's work on deep guilt and emotional depth. Ratcliffe argues that some cases of depression are characterized by a deep, all-pervasive sense of guilt.² By developing this account within the framework of Heidegger's theory of groundmoods [*Grundstimmungen*] and Ratcliffe's own theory of existential feelings, he is able to account for the deep guilt associated with depression as an all-encompassing change in one's mode of existence. One of the first-person reports Ratcliffe draws upon in order to illustrate this kind of deep guilt goes as follows:

One awful thing about my depression was the tremendous sense of guilt that I was unable to attach to any memory, or action or any part of myself. I was all feeling at the time and no thought—not real thinking, only a slow-motion kind of guilty rumination. Certainly I had no hope that the future would bring me relief, let alone happiness. ([19], p. 270, quoted in [20], p. 612)

As Ratcliffe goes on to explain, the depressed person is not guilty about anything in particular. Instead, one is guilty as such; one's whole world is oriented by a sense of guilt. As a result, emotions, feelings, beliefs, and values that do not conform to or coincide with guiltiness are unable to arise [20].

A depression characterized by such deep guilt, when understood in respect to the limitations and constraints it imposes on the way in which a patient values and which kinds of values a patient might have, has serious implications for VBP. The depressed patient is cut off

² One of the reasons that phenomenological studies of MDD have become popular in the last few years is, in part, because of the profound heterogeneity found in the symptomatology and first-person reports of people diagnosed with this disorder [12-15]. In light of this, it should be kept in mind that the phenomenological accounts we discuss below might not capture the lived experience of everyone who meets the requirements for a diagnosis of MDD. Rather, these accounts bring to light fundamental features of the lived experience of some people who meet the criteria for diagnosis, many of which are expressed in first-person reports, patient narratives, and memoirs, as discussed below.

from many of the values she would have had in the absence of a depressive episode. Consequently, the clinician lacks access to these values as well—at least for the duration of the patient’s episode. This is particularly troubling considering the fact that Fulford’s account of VBP assumes clear and unmitigated access to the patient’s values, if not from the perspective of the clinician, then at least from the perspective of the patient herself. If some psychiatric disorders fundamentally alter the kinds of values one is able to hold, then the ability of the clinician to adequately develop and execute a values-based program of care is put into question.

In contrast with phenomenological studies of modal changes in psychiatric disorders, phenomenologists can also study changes in existential structures as a whole. While deep guilt, hopelessness, or ecstatic joy are modes of human existence, they all belong to the same existential structure, or categorial characteristic of human existence. Heidegger calls this existential structure *Befindlichkeit*, which we translate here as “situatedness.” This existential is meant to highlight the fact that we always find ourselves situated in and attuned to the world in some particular way. The way in which we are situated and attuned is understood as a mode, while being situated and attuned at all is an existential structure [12].

In light of this distinction, we can examine another dimension of depressed existence. In many reports of depression, especially of the most severe and debilitating episodes, there is reference to an eroding of one’s capacity to have moods and feelings, to find anything meaningful, or to be affected at all. For example, Andrew Solomon writes,

The first thing that goes is happiness. You cannot gain pleasure from anything. That's famously the cardinal symptom of major depression. But soon other emotions follow happiness into oblivion: sadness as you know it, the sadness that seemed to have led you here; your sense of humor; your belief in and capacity for love. Your mind is leached until you seem dim-witted even to yourself [...] You lose the ability to trust anyone, to be touched, to grieve. Eventually, you are simply absent from yourself. ([21], p. 19)

Here we see an account in which depression is lived not as a kind of mood, or a distinctive way

of being attuned to the world, but instead as an erosion of the capacity for being situated and attuned [22]. This existential shift, in other words, encompasses the category of moods as a whole. While the depressed person might still have moods, they are not particularly forceful or intense. One's situatedness and attunement seems to degrade to such a degree that major events in one's life seem of no consequence—one is unaffected even by the most tragic of circumstances.

Lesly Dorman, recounting her experience of coming out of a long episode after taking antidepressants, offers a similar account. She says, "I marvel at my ability to move in and out of ordinary feelings like sadness and disappointment and worry. I continue to be stunned by the purity of these feelings, by the beauty of their rightful proportions to actual life events" ([23], p. 241). Reports such as these bring to light the fact that many cases of depression cannot be adequately understood as something akin to sadness, or even despair. Such feelings, according to Dorman and Solomon, would have been a welcome escape from their depression.

The implications for VBP that emerge from such existential shifts are slightly different from those discussed above. Rather than being enveloped in a particular mood that blocks off certain kinds of feelings, dispositions, beliefs, and values, the experiences of depression recounted by Solomon and Dorman express an erosion in one's capacity to feel and value at all. While the erosion may never be total, it does severely degrade the degree to which the state of one's self and world can matter, or be of any consequence.

In contrast to the case in which a patient can only express certain kinds of values (e.g. as the consequence of a mood of deep guilt), this existential change can result in cases where the patient has trouble articulating and expressing any values at all—not because she is experiencing an impediment in her capacity for expression, but because there do not seem to be any real

values to express. In this situation, the clinician finds herself at a loss when trying to develop and execute a values-based program of care. At most, she might project her own values, or even the values of her other patients, onto the patient in question, but this practice would be in stark contrast to the express purpose and goals of VBP.

In light of these phenomenological studies, we can understand some cases of depression as either a way of valuing that is distinctly different from our typical modes of valuing (e.g. in the case of deep, all-pervasive guilt), or an erosion of our capacity to value anything at all (e.g. in the case of an erosion of our capacity to be affected through moods, or find the world meaningful). We might distinguish the two by characterizing the former as a mal-attunement (i.e. a particularly problematic or distressing way of being attuned to the world) and the latter as a dis-attunement, or de-situatedness [22, 24].

Conclusion—Proposed solutions

Supporters of VBP can remedy this failure to address the shifting nature of values or diminished ability to have values at all that occur in disorders such as depression in several ways. The first, and perhaps most problematic, remedy is to take the shift in values or the inability to have values seriously. This might involve making changes to the individual's plan of intervention based on the individual's new values or new lack of values. This solution seems problematic in that, at least in the case of depression, we understand this new set of values or this new lack of values as episodic, or transient. If this is the case, we would want to plan interventions that are in line with the individual's pre-episode values.

Another option is a pre-episode clinical encounter in which the clinician and the patient set out to discuss and record the patient's values and preferences for future treatment. This option seems promising in that it most explicitly captures the values of the individual. In addition this

option provides a resource for the clinician to refer to in the future. However, this solution also presents some difficulties. First, episodes of depression and other disorders often arise with little warning, not allowing for a pre-episode interview in which a statement of values can be produced. In addition, this one-time clinical capture of values seems to suggest, as much of VBP does, that values are static and will not legitimately change over time—a problematic assumption. A solution to this might be more frequent, thorough discussions of values.

A third possible solution to the difficulty of shifting or diminishing values for values based practice is the use of proxies. In other health care settings, the use of proxies, a relationship in which the decisions of a designated family member or friend stand in for the decisions of the patient herself, is standard practice. When applied to values based practice, a proxy would be a designated individual whose job is to be an advocate for interventions that are in line with what they believe to be the patient's values.

VBP is an attempt to take the values and preferences of the involved parties into consideration during the clinical encounter. However, VBP limits its clinical applicability by neglecting the fact that value sets change in response to major life events, that mental illness can result in dramatic shifts in the way patients are able to value, and that in some cases of severe mental illness the capacity to value anything at all can be degraded or absent. In order to remedy these issues, we suggest that VBP take seriously the implications of existential changes in depression and other disorders that are made manifest through phenomenological and hermeneutic studies.

References

1. Sackett, David L., et al. (1996) *Evidence-based medicine: What it is and what it isn't*. *British Medical Journal* (312): 71.
2. Howick, Jeremy. (2011) *The Philosophy of Evidence-Based Medicine*. Wiley-Blackwell.
3. Miles, Andrew, et al. (2008) *Evidence-based healthcare, clinical knowledge and the rise of personalised medicine*. *The Journal of Evaluation in Clinical Practice*.
4. Fulford, K.W. M., (2011) *The value of evidence and evidence of values: bringing together values-based and evidence-based practice in policy and service development in mental health*. *The Journal of Evaluation in Clinical Practice*.
5. Gupta, Mona, (2011) *Values-based practice and bioethics: close friends rather than distant relatives. Commentary on 'Fulford (2011). The value of evidence and evidence of values: bringing together values-based and evidence-based practice in policy and service development in mental health*. *The Journal of Evaluation in Clinical Practice*.

6. Fulford, K.W. M., Peile, Ed, & Carroll, Heidi. (2012). *Essential Values-Based Practice: Clinical Sorties Linking Science with People*. Cambridge University Press.
7. Fulford, K.W.M. (2008) *Values-Based Practice: A New Partner to Evidence-Based Practice and A First for Psychiatry?*. Mens Sana Monographs no. 1.
8. Fulford, K.W. M. (2004) *Ten Principles of Evidence Based Medicine*. World Psychiatric Association.
9. Moore, Andrew, et al. (1994) Mild Mania and Well-Being. *Philosophy, Psychiatry, & Psychology*, 1 (3), 165-177.
10. Sokolowski, Robert. (2000). *Introduction to Phenomenology*. Cambridge University Press.
11. Moran, Dermot. (2000). *Introduction to Phenomenology*. Routledge.
12. Heidegger, Martin. (1927/1962). *Being and Time*. Harper & Row Publishers, Inc.
13. Fernandez, Anthony and Giovanni Stanghellini. (forthcoming). Comprehending the Whole Person: On Expanding Jaspers' Notion of Empathy, in A. L. Mishara, P. Corlett, P. Fletcher, A. Kranjec, and M. A. Schwartz (Ed.s), *Phenomenological Neuropsychiatry: How Patient Experience Bridges Clinic with Clinical Neuroscience*. New York, Springer.
14. Young, Iris Marion. (2005). *On Female Body Experience: "Throwing Like a Girl" and other Essays*. Oxford University Press.
15. Horwitz, A. V., & Wakefield, J. C. (2007). *The Loss of Sadness: How Psychiatry Transformed Normal Sorrow into Depressive Disorder*. Oxford University Press.
16. Parker, G. (2000). Classifying Depression: Should Paradigms Lost be Regained? *American Journal of Psychiatry*, 157 (8), 1195-1203.
17. Parker, G. (2006). Through a Glass Darkly: The Disutility of the DSM Nosology of Depressive Disorders. *Canadian Journal of Psychiatry*, 51 (14), 879-886.
18. Ratcliffe, Matthew, et. al. (2013). A Bad Case of the Flu? The comparative Phenomenology of Depression and Somatic Illness. *Journal of Consciousness Studies* 20, no. 7-8: 198-218.
19. Rowe, Dorothy. (1978). *The Experience of Depression*. John Wiley & Sons.
20. Ratcliffe, Matthew. (2010). Depression, Guilt, and Emotional Depth. *Inquiry* 53, no. 6: 602-626.

21. Solomon, A. (2001). *The Noonday Demon: An Atlas of Depression*. Touchstone.
22. Fernandez, Anthony V. (2014). Depression as Existential Feeling or De-Situatedness? Distinguishing Structure from Mode in Psychopathology. *Phenomenology and the Cognitive Sciences*. DOI 10.1007/s11097-014-9374-y
23. Dorman, L. (2001). Planet So. In N. Casey (Ed.), *Unholy ghost: Writers on depression* (pp. 229-241). Perennial.
24. Fernandez, Anthony V. (forthcoming). Reconsidering the Affective Dimension of Depression and Mania: Towards a Phenomenological Dissolution of the Paradox of Mixed States.