

## **ORIGINAL ARTICLES**

### **The Third Revolution: Philosophy into Practice in Twenty-first Century Psychiatry**

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*Three revolutions in psychiatry characterised the closing decade of the twentieth century: 1) in the neurosciences, 2) in patient-centred models of service delivery, and 3) in the emergence of a rapidly expanding new cross-disciplinary field of philosophy and psychiatry.*

*Starting with a case history, the paper illustrates the impact of this third revolution - the new philosophy of psychiatry - on day-to-day clinical practice through training programmes and policy developments in what has become known as values-based practice. Derived from philosophical value theory and phenomenology, values-based practice is a partner to evidence-based practice in supporting clinical decision-making in the highly complex environment of mental health care.*

*The paper concludes by setting values-based practice in context with other potentially practical important areas of the new philosophy of psychiatry arguing that all three revolutions need to be brought together if psychiatry is to meet the challenges of the twenty-first century.*

**Key words:** values, values-based practice, psychosis, spirituality, diagnosis, classification

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## **INTRODUCTION**

The closing decades of the twentieth century witnessed no less than three revolutions in psychiatry. The first revolution, as is well recognised, was in the neurosciences: unprecedented advances, such as functional neuroimaging and behavioural genetics, opened up for the first time the possibility of substantive understanding of brain functioning as the basis of disease theories of mental disorder (Andreasen, 2001). The second revolution, also well recognised, was in our models of service delivery: in many countries around the world

mental health services moved from a predominantly doctor-led model to models in which services are community based, multi-disciplinary in organisation, and, perhaps most important of all, increasingly guided by direct input from those who use services, i.e. patients and informal carers (Department of Health, 2001 and 2004). The third revolution in late twentieth century psychiatry was the emergence of a new and vigorous field of interdisciplinary work with philosophy (Fulford et al, 2003). This third revolution is perhaps less widely recognised and

indeed it came to many as something of a surprise. It should not have done, perhaps. Philosophy, after all, had been crucial to the development of modern psychiatry. Thus, Karl Jaspers' phenomenological work in the early years of the twentieth century (Jaspers, 1997), during what has become widely known as psychiatry's first biological phase, was crucial to the development of modern psychopathology. At an earlier period, Philippe Pinel, in liberating the insane from their chains in the Bicêtre and Salpêtrière hospitals, was deeply influenced by the liberation philosophy of Jean-Jacques Rousseau (Pichot, 2000); and his theories of mental disorder directly reflected the associationist model of mind developed by the British empiricist philosopher, John Locke (Porter, 1987). Even in the twentieth century, the American philosopher of science, Carl Hempel, made a key contribution to the development of the Glossary to ICD-8 (World Health Organization, 1974) and thus to subsequent editions of both ICD and DSM symptom-based classifications (Fulford and Sartorius, *in press*). Yet as the Australian psychiatrist and historian, Russell Meares, has shown (Meares, 2003), through much of the twentieth century, psychiatry was deeply influenced by a positivist model of science in which philosophy was characterised, even by philosophers themselves (Williams, 1985), as being unproductive practically.

If the new philosophy of psychiatry was unprecedented, however, it has been remarkably vigorous in its development. As the Table shows, in less than two decades we have seen an explosion of new academic and research initiatives around the world. Equally important, however, as the last bullet in the Table indicates, is the extent to which the new discipline is already making a direct and positive contribution to day-to-day clinical care (Fulford et al., 2004). It is this "philosophy into practice" aspect of the new field that we will be concentrating on in this article, as illustrated, in particular, by developments in what has become known as values-based practice.

**Table 1**

**Developments in the New Philosophy of Psychiatry**

- 43 New academic and research groups around the world
- Special Sections in the WPA and AEP
- Establishment of the International Network for Philosophy and Psychiatry (INPP, launched Cape Town, 2002)
- Annual international conferences in different parts of the world
- New professorial Chairs (Italy, Netherlands, South Africa, UK)
- Training and research programmes (including a recently launched Oxford DPhil)
- The international journal *Philosophy, Psychiatry, & Psychology* (PPP) now in its fourteenth year (from Johns Hopkins University Press)
- Several book series (including *International Perspectives in Philosophy and Psychiatry*, IPPP, from Oxford University Press)
- Establishment of an Institute for Philosophy, Diversity and Mental Health (IPDMH) at the University of Central Lancashire in the UK (with over £1m funding)
- Philosophy into practice (e.g. values-based practice, see text)

Values-based practice, as we will describe, builds on work in both phenomenology (on personal meanings) and analytic philosophy (on the logic of values) to provide a set of practical tools to support clinical decision-making where complex and conflicting values are in play. As such, values-based practice is a direct counterpart for values of the set of practical tools provided by evidence-based practice to support clinical decision-making where complex and conflicting evidence is involved (Fulford, 2004). Again, rather than attempting to cover developments in values-based practice as a whole, we will be illustrating its applications with particular reference to the development of more comprehensive models of psychiatric diagnosis. As described below, there are many important contributions to comprehensive diagnosis, philosophical and non-philosophical. The particular contributions of values-based practice, however, are, as we will see, 1) to raise awareness of the crucial role of values even in

current evidence-based diagnostic classifications, 2) to provide a unique resource of theory for understanding the relationship between diagnostic values and the better recognized diagnostic facts, and 3) to underpin the policy developments and training methods on which values-based practice, as a clinical skills-based approach to working with diagnostic values, critically depends. We will start with a clinical case history, the story of Simon.

## THE STORY OF SIMON

*Simon (40) was a senior, black, American professional, from a middle-class, Baptist family. Although not particularly religious in outlook, he had had occasional, relatively unremarkable, psychic experiences at various times in his life. These had led him to seek the guidance of a professional "seer", with whom he occasionally consulted on major life events and decisions.*

*His story was that his hitherto successful career was now threatened by legal action from his colleagues. Although he claimed to be innocent, mounting a defence would be expensive and hazardous. He had responded to this crisis by praying at a small altar that he set up in his front room. After an emotional evening's outpouring, he discovered that the candle wax had left a "seal" or "sun" on several consecutive pages of his bible, covering certain letters and words. He described his experiences thus: "I got up and I saw the seal that was in my father's bible and I called X and I said, you know, 'something remarkable is going on over here.' I think the beauty of it was the specificity by which the sun burned through. It was ... in my mind, a clever play on words." Although the marked words and letters had no explicit meaning, Simon interpreted this event as a direct communication from God, which signified that he had a special purpose or mission.*

*After this first episode, Simon received a complex series of "revelations" largely conveyed through the images left in melted candle wax. He carried photos of these, which left most observers unimpressed, but were, for him, clearly representations of biblical symbols, particularly from the book of Revelations (the*

*bull, the 24 elders, the arc of the covenant, etc.). He interpreted them as signifying that "I am the living son of David ... and I'm also a relative of Ishmael, and ... of Joseph". He was also the "captain of the guard of Israel".*

*He found this role carried awesome responsibilities: "Sometimes I'm saying - O my God, why did you choose me, and there's no answer to that". His special status had the effect of "Increasing my own inward sense, wisdom, understanding, and endurance" which would "allow me to do whatever is required in terms of bringing whatever message it is that God wants me to bring".*

*His beliefs were highly systematised, in that he interpreted much of his ongoing experience in terms of them. His colleagues were agents of Satan, trying to thwart him, and his career successes were evidence of God's special favour. Relatively trivial obstacles which he encountered in daily life - such as having a cold at the time of the interview - were satanically motivated trials of purpose. In the course of these experiences Simon had both heard God's voice and seen "prophetic" visions. He expressed these beliefs with full conviction "The truths that are up in that room are the truths that have been spoken of for 4000 years". When confronted with scepticism, he commented: "I don't get upset, because I know within myself, what I know"...*

## 1) RAISING AWARENESS OF DIAGNOSTIC VALUES

By conventional psychiatric diagnostic criteria, Simon, presenting with this story, would be diagnosed as suffering from schizophrenia (or, depending on associated symptomatology, some other form of severe psychotic disorder). Thus, his experiences of the wax seals were, by the criteria in such formal mental state examinations as the Present State Examination (PSE), delusional perceptions (Wing et al, 1974); and the presence of delusional perceptions, in the context of a story like Simon's, is sufficient according to the gold standard of the World Health Organization's ICD-10 (WHO, 1992), for a diagnosis of schizophrenia or a related

psychotic disorder. However, Simon, as it turned out, far from having a psychotic disorder, was guided by the messages from his wax seals in winning his court case, his career as a lawyer prospered, and he used the large fortune he made to set up a research foundation for the study of religious experience.

Some psychiatrists presented with this outcome to Simon's story will want to say that he had a "benign" form of schizophrenia. However, the American Psychiatric Association's Diagnostic and Statistical Manual (the DSM), gives us the quite different "diagnosis" that, far from being ill, let alone seriously ill with a psychotic disorder, Simon's experiences really were religious or spiritual rather than pathological (however benign) in nature. This is because the DSM, unlike the ICD, includes, in addition to the traditional symptomatic criteria for a psychotic disorder, a criterion of "social/occupational dysfunction". Thus, Criterion B, as this criterion is called in the case of schizophrenia, requires, in addition to a symptom such as a delusional perception, that the social/occupational functioning of the person in question has fallen 'markedly below the level' previously achieved (APA, 1994, p.285). Clearly, in Simon's case, his occupational functioning was improved rather than impaired. Hence, contrary to the ICD diagnosis, and consistently with at least Simon's understanding of his experiences, these were indeed spiritual rather than pathological in nature.

That the DSM classification has greater face validity in cases like Simon's, might be thought to reflect its more explicitly evidence-based, hence "scientific", approach compared with the ICD. The introduction to DSM-IV, indeed, spells out explicitly and in detail the evidence-based processes on which this edition of the DSM was based (APA, 1994 p.1-2). Yet if we step back from the claims of DSM and look carefully at the language in which Criterion B itself is actually expressed, it is clear that, although of course drawing on the facts of a particular case, this and other similar criteria require, in addition to judgements of fact, a number of *value judgements*, viz., about whether the person

concerned is functioning in a social/occupational context, not merely *differently* from before (that would indeed be a matter solely of the facts), but *worse* than before (a matter also of values).

It is perhaps a surprise to find value judgments right at the heart of psychiatry's most self-consciously evidence-based scientific classification of mental disorders. Stepping back, however, in the way that we have just done, from the claims of such classifications, and looking rather at the language in which their criteria are actually defined, it becomes clear that value judgements are everywhere not only in DSM (Sadler, 2004), but also in ICD (Fulford, 1989, chapters 8 and 9; Fulford, 1994): other examples include the criteria for particular categories (e.g. for the paraphilias and personality disorders), and a number of key symptoms (e.g. "bizarre" delusions) (Fulford et al., 2005). Work in modern phenomenology, furthermore, has shown the extent to which the actual experiences of people with psychotic disorders are deeply values-laden (Kraus, 2003; Stanghellini and Ballerini, 2007; Stanghellini, 2008).

## 2) THEORETICAL INTERPRETATIONS

The process we have just gone through - of stepping back from the claims made in a given text, and looking carefully at the language in which those claims were expressed - is at the heart of what in the analytic philosophical tradition is called "linguistic analysis" or "ordinary language philosophy". This somewhat abstract approach, as exemplified particularly by the work of the Oxford philosopher, J L Austin (Austin, 1956/7), has a wide range of potential applications for psychiatry. Many of these applications, as in the present case, involve raising awareness of elements in the meanings of the concepts by which we structure and make sense of the world around us, elements of which we are generally unaware (Fulford, 1990). This is indeed one of the key respects in which analytic philosophy, as exemplified by Austin's linguistic analysis, is methodologically close to phenomenology (Fulford et al., 2003).

But if there are key evaluative, as well as factual, elements in the meanings of our diagnostic concepts, how should these be understood?

What is their significance? From the perspective of those sceptical of scientific psychiatry, the presence of value judgements in psychiatry's most scientific classifications, will be interpreted as clear evidence that these classifications, and with them the concept of mental disorder, are invalid. Szasz's critique of the concept of mental illness, for example, focused directly on the relatively value-laden nature of this concept compared with corresponding concepts of bodily illness (Szasz, 1960). Conversely, those who are most deeply committed to a scientific medical model of psychiatry, will wish to diminish the significance of these value judgements, arguing that they are at most peripheral (Boorse, 1975; Wakefield 1995) and will anyway disappear with future advances in the neurosciences (Kendell, 1975).

An entirely different interpretation is suggested by a specific branch of linguistic analytic philosophy called philosophical value theory. This school of philosophy flourished in Oxford in the middle years of the twentieth century - in addition to Austin, exemplars include R.M. Hare (1952), G.J. Warnock (1971) and J.O. Urmson (1950) - although the tradition goes back at least to the 18<sup>th</sup> century British empiricist philosopher David Hume (Hume, 1972) and continues to this day, for example in the work of the American philosopher, David Putnam (Putnam, 2002). Although not concerned directly with concepts of disorder, the work of this school of philosophy (sometimes called the "Oxford school"), together with phenomenology, provides powerful analytic tools both for explaining the features of our concepts of disorder, bodily as well as mental, and also, as we will see in the next section, for developing practical tools to support diagnostic assessment. We will not have space here to examine in detail how the theoretical arguments from philosophical value theory and phenomenology help to explain the complex "values plus facts" structures of psychiatric diagnostic concepts (see Fulford, 1989; Fulford et al., 2005). A key point,

however, that we can take particularly from Hare's work (Hare, 1952, 1963), is that the relative prominence of value judgments in psychiatric diagnosis, compared with most areas of bodily medicine, reflects, neither invalid diagnostic concepts (as those skeptical of psychiatry have suggested), nor a primitive stage of scientific development (as those supportive of psychiatry have suggested), but, instead, the greater *complexity of individual human values* in the areas of experience and behaviour with which psychiatry, uniquely as a medical discipline, is concerned. As noted above, Hare did not write about concepts of disorder in this context (although his 1963 article on "descriptivism" makes clear that he regarded "dysfunction" as a value concept). But his general point, as a point that applies to all value terms, is that we become aware of the evaluative elements in their meanings only when the values concerned are diverse and, hence, cause problems.

This general point, that diverse values equals visible values, can be applied directly to psychiatric diagnostic concepts. Thus, in bodily medicine, particularly with the acute life threatening conditions with which doctors are particularly concerned, most symptoms - bodily pain, paralysis, nausea, blindness etc. - are bad (i.e. negatively evaluated) by anybody's standards. If someone has a "heart attack", for example, their pain and risk of death represent a functional state that is bad by anyone's standards (in itself, though of course dying of a heart attack may have good consequences, for example if you already have advanced cancer). Hence there is no requirement for an equivalent of Criterion B in cardiological diagnosis, not because the diagnostic categories in question are value-free, nor because cardiology is (somehow) a more advanced science, but because the values by which we judge between good and bad heart functioning are the same (more or less) for everyone, hence they are a constant rather than a variable in the diagnostic process, and hence they are unproblematic in practice. But in psychiatry, by contrast with areas of bodily medicine such as cardiology, the symptoms with

which we are concerned are characteristically in areas of human experience and behaviour - such as emotions, beliefs, motivations, desires and sexuality - in which human values, as between different individuals, different cultures and different historical periods, vary widely. With psychiatric conditions, therefore, the relevant diagnostic values, reflecting the complex and variable values of people in the areas with which psychiatry is concerned, will be highly variable, and, hence, in contrast with the corresponding diagnostic values in areas such as cardiology, problematic in practice.

It is a recognition of the central importance of the complexity of individual human values in psychiatry that leads directly to the need for a values-based as well as evidence-based approach to more comprehensive psychiatric diagnostic assessment.

### **3) PRACTICAL TOOLS FROM VALUES-BASED PRACTICE FOR COMPREHENSIVE PSYCHIATRIC DIAGNOSIS**

Comprehensive diagnosis aims to combine the best of objective scientific categorical diagnosis with the unique features, including the strengths and resources as well as difficulties, of individual patients (Mezzich, 2002). As noted earlier, resources for building on and improving current diagnostic paradigms in psychiatry with comprehensive approaches, are of course not limited to the possible contributions of philosophy. To the contrary, Mezzich and others, working within the rich international field covered by the World Psychiatric Association, have already established well-developed diagnostic methods for idiographic diagnosis as part of a “whole person” assessment that is complementary to the traditional categorical approach of the ICD and DSM (Mezzich, 2002; Mezzich et al, 2003). Idiographic diagnosis, alongside ICD categories, has already been successfully incorporated into a system of classification widely adopted in Spanish speaking countries of South America (Mezzich et al., 2003). In addition, areas of philosophy other than philosophical value theory and

phenomenology, which are important generally in the new philosophy of psychiatry, also have key contributions to make to comprehensive diagnosis: examples include philosophy of mind (Thornton, 2007), hermeneutics (Widdershoven and Widdershoven-Heerding, 2003), and existentialism (Morris, 2003).

Values-based practice, as a derivative mainly of philosophical value theory and phenomenology, adds to these resources for comprehensive diagnosis, a set of practical tools for working effectively in areas like psychiatric diagnosis, where clinical decision-making depends not only on complex evidence (addressed by evidence-based practice), but also complex values. Values-based practice, then, is the theory and practice of effective healthcare decision-making where different (and hence potentially conflicting) values are in play (Fulford, 2004).

The direct application of values-based practice to psychiatric diagnosis remains contentious (see Fulford et al., 2005, and related commentaries in the same issue of *World Psychiatry*). This is perhaps not surprising. However clear the philosophical arguments may be, the idea that psychiatric diagnosis, as a part of medical science, might involve value judgements requires a considerable shift of paradigms: Robert Spitzer, for example, as the former Chair of the DSM-III Task Force, and a particular advocate for an evidence-based approach to psychiatric classification and diagnosis, made this point particularly strongly among the above commentators (Spitzer, 2005). Most work on values in health and social care, moreover, focuses on the “right values” that are the concern of ethics rather than science. It is important, however, to be aware of the extent of the resources already available from values-based practice to support this aspect of comprehensive diagnosis once we can get past the necessary shift of paradigms. In the remainder of this section, we outline these resources briefly as they have been developed mainly through the UK’s Department of Health working in partnership on an international basis with the World Psychiatric Association.

Values-based practice was first introduced into the work of the UK's Department of Health through the joint programme between patients and professionals that led to the adoption of a Framework of Values for the UK's National Institute for Mental Health in England (NIMHE and Department of Health, 2004). NIMHE is the section of the UK's Department of Health responsible for delivering on key government targets for mental health as defined by a key policy, the National Service Framework for Mental Health (Department of Health, 1999, 2002). The NIMHE Framework of Values thus provides a strong policy platform for ensuring that values-based as well as evidence-based approaches underpin service development in all areas of mental health and social care. Correspondingly, therefore, values-based practice has now been adopted as one of the two key themes (the other being evidence-based practice) underpinning a national initiative in generic skills training, the Ten Essential Shared Capabilities (ESCs) (Department of Health, 2004a). This in turn underpins new ways of working for psychiatrists and others that are more user-centred and multidisciplinary in approach (Department of Health, 2005a), which in turn is crucial to a variety of more specific policies concerned, for example, with such areas as recovery practice (Department of Health, 2004b), delivering race equality (Department of Health, 2005b), and the role of patients and informal carers as 'experts by experience' (Department of Health, 2001). Values-based practice has also been incorporated into wider service commissioning and review policies, for example in the Health Standards for Wales (Welsh Assembly Government, 2005).

Training materials in values-based practice are also now widely available. A training workbook, "Whose Values?", has been developed and piloted with frontline staff, in a partnership between the Sainsbury Centre for Mental Health (one of the UK's largest mental health NGOs) and Warwick University's new Medical School (Woodbridge and Fulford, 2004). The workbook was launched by the Minister of State in the Department of Health with responsibility for

mental health, Rosie Winterton, at a conference in London in 2004. Materials from the workbook have been included in a variety of other training materials, including web-based materials for e-learning that will support the roll out of the ten ESCs (above). A Masters programme in recovery that includes values-based practice was established at the University of Wolverhampton, directed by Piers Allott, the original Chair of the Department of Health Workgroup that developed the NIMHE Framework of Values. Training materials have recently been produced in a Department of Health programme to support implementation of a new Mental Health Act in the UK. As the legislative framework for involuntary psychiatric treatment, the new Mental Health Act presents a particularly sharp focus for values-based practice (CSIP and NIMHE, 2008). The training materials are distinctive in being not only values-based but also based on evidence as derived particularly from patient-led research (Fulford, King and Dewey, *in press*). There are also training developments in a number of European countries and at the University of Pretoria in South Africa (Van Staden and Fulford, 2007).

Building on the above resources, we have recently completed a major programme of consultation and service development that directly applies a values-based as well as evidence-based approach to psychiatric diagnostic assessment (NIMHE and CSIP, 2008; [www.3keys.org.uk/downloads/3keys.pdf](http://www.3keys.org.uk/downloads/3keys.pdf)). This work follows a series of international research seminars, initiated by John Sadler at UT Southwestern Medical Center in Dallas (Sadler, 2002), and then continued in London supported by the Department of Health and the World Psychiatric Association, exploring the role of values in psychiatric diagnosis. These seminars brought together service users and carers with clinicians, researchers and policy makers. It was the last of these seminars, which was hosted jointly with the Mental Health and Substance Abuse Section of the World Health Organization that led to the launch of this programme. Although strongly underpinned theoretically, the programme has directly practical outcomes,

much of the publication itself being made up with examples of innovative practice from the field. As with other work in values-based practice, these examples illustrate in a very practical way how the resources of generalised evidence-based science can be combined with an approach to assessment that is also fully values-based, and hence responsive to the needs, wishes, strengths and other values of the individual concerned.

## CONCLUSIONS

In this article we have illustrated the significance of the new philosophy of psychiatry, as one of three revolutions in psychiatry at the end of the twentieth century, for day-to-day clinical practice. We have focused on work in values-based practice, derived mainly from philosophical value theory and phenomenology, as a contribution to the development of more comprehensive models of psychiatric diagnosis. As we have indicated, there are other important resources for comprehensive diagnosis and values-based practice should be understood as a partner rather than a competitor in this regard. The specific contributions of values-based practice, nonetheless, as we have seen, include, 1) raising awareness of the role of values even in categorical psychiatric diagnostic systems (such as the DSM), 2) providing a clear theoretical explanation for the relative prominence of values in psychiatric diagnostic classifications (derived from the relative complexity of human values in the areas with which psychiatry is concerned), and, 3) through the policy frameworks and training methods already established for values-based practice. Values-based practice thus provides a basis for working as rigorously with diagnostic values in psychiatry as we already work with diagnostic facts.

We began this article with the story of Simon. Simon's story, which is based on that of a real person (Jackson, 1997), showed the importance of bringing together diagnostic values, as reflected in this instance in the DSM's Criterion

B, with diagnostic facts, as defined by the reliable mental state examinations (such as the PSE) and symptom-based classifications (ICD as well as DSM) developed through the use of rigorous empirical methods in the second half of the twentieth century. We would like to end by emphasising that nothing in this article should be taken as arguing against the importance of twentieth century advances in empirical diagnostic methods. There has been a tendency by some, even among those most directly concerned with psychiatric diagnostic classification, to lose confidence in those advances: the editors of the American Psychiatric Association's 'Research Agenda for DSM-V', for example, argue that we may need to sacrifice reliability for validity if we are to make progress (Kupfer et al., 2004). We believe to the contrary that it is vital to build on rather than rejecting twentieth century advances. But we also believe that it will be essential to combine rigorous empirical methods with equally rigorous philosophical methods if we are to draw successfully on the new neurosciences. It is only in this way that all three of the revolutions in psychiatry by which the end of the twentieth century was characterised - in science, in patient-centred service delivery, and in philosophy - will work together to create a psychiatry for the twenty-first century that is indeed fully science based but also, and equally, fully responsive to the unique values, needs and hopes of individual patients and families.

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