1 Introduction

Robert B. Dudas

Values permeate all aspects of psychiatry from aetiology, through classification, to treatment. This is unsurprising, as psychiatry is concerned with areas of human experience and behaviour in which human values are particularly diverse. Evidence-based medicine (EBM) can be immensely helpful at guiding us about the efficacy and safety of diagnostic and treatment interventions, but it is silent about the personal importance attached to these by patient and doctor, that is, about patients' and doctors' relevant values. This is problematic because these values are of crucial importance when it comes to various aspects of person-centred care, such as patient choice, treatment adherence, recovery, and clinician attitudes. This is where values-based practice (VBP) comes into play.

Whilst VBP is often portrayed through contrasting it with EBM, this can be somewhat misleading because VBP is also evidence-based; it is just that its evidence has a different provenance and format. Evidence-based medicine was developed to replace the use of intuition, anecdotal evidence, and subjective clinical experience with examination of objective evidence from clinical research, using formal rules to appraise it. The gold standard of EBM is the randomized controlled trial (RCT). Results from sufficiently similar RCTs can be meta-analysed to produce an overall statistic, which is considered to be the highest level of evidence in EBM. High-quality meta-analyses, such as those in the Cochrane Library, also provide ratings of the quality of the evidence. By now, EBM has developed into an essential clinical tool, but, for the clinician to be able to make the most of it, another step is required. This next step is to apply the group-level evidence in individual cases in a person-centred way. This is where VBP comes in as it offers a parallel framework of clinical theory and skills through which to do, among other things, exactly that.

The development of VBP started largely at the same time as that of EBM, around the turn of the last century. The pioneering work of Bill Fulford, a British philosopher-psychiatrist, was instrumental in working out the main principles of VBP, including ten pointers to a 'good process', which refers to the inclusion and balancing of the values of those involved during clinical decision-making (Fulford, 2007; Woodbridge and Fulford, 2004). These include four practice skills: awareness, reasoning, knowledge, and communication about values. Two important concepts in VBP are user-centredness and multidisciplinarity. They were originally described in the context of models of service delivery, but we have developed these further in this book in other contexts, such as clinical theory and research. Partnership between the patient and the clinician is also a key principle in VBP. The nature of this partnership in psychiatry and the relevance and impact of other stakeholders on clinical decision-making are examined in detail throughout this book.

Psychiatry is both an academic field and an area of medical practice. Ideally, research should seek answers to the main questions of clinical practice and advances in research

should translate into practice. Unfortunately, in recent years there has been an increasing disconnect between academic and clinical psychiatry (de Haan, 2020). Furthermore, despite significant investment in research, progress in our understanding of the pathomechanism and the mechanism of recovery from major forms of mental illness or in the development of new treatments has been slow. At the same time, strong criticisms have been levelled against current psychiatric practice (e.g. owing to the epidemic proportions of benzodiazepine and antidepressant use or the ever-increasing number of detentions to hospital for assessment and treatment in certain countries) and even though many people with mental illness clearly benefit from psychiatry, despite the substantial investment into psychiatric care, rates of mental illness have not reduced as a result (Jorm et al., 2017), a situation known as the treatment–prevalence paradox (Stein et al., 2022). In writing this volume, we wanted to understand what might be at the root of all this and what could help us overcome the current stagnation in psychiatry. We believed that an approach that takes into consideration the hybrid nature of psychiatry in that it combines forms and practices from both the natural and the social sciences holds the key to this. We also believed that there were important opportunities for making progress if we could only capture the role of values all over psychiatry from aetiology, through diagnosis, to treatment. And VBP would provide an invaluable theoretical apparatus for this.

To achieve our goals, we set out to examine the relevant values of the stakeholders, that is, patients, psychiatrists, and others involved in or with psychiatry. Furthermore, we also sought to showcase the positive values and contribution that psychiatry brings. We felt that, in order to achieve any real breakthrough, it was important to do this focussing not just on the here and now but also diachronically and from the different perspectives of not just medicine but also history, social work, art, and philosophy, and to include the voice of those with lived experience of mental illness. Our team of authors represent the multidisciplinarity required for this.

The structure of our book also reflects our intentions. In Part I, we look at the historical origins of psychiatry. To open, in Chapter 1, German E. Berrios and Ivana S. Marková provide an analysis of the birth of psychiatry as a medical specialty, the forces that brought it forth, and the consequences of that for its epistemology and approach to mental illness. In Chapter 2, Robert B. Dudas explores the history of person-centredness and agency in psychology by contrasting some of its main schools of thought, such as psychoanalysis and behaviourism, as well as cognitive and humanistic psychology. Mathew Thomson presents, in Chapter 3, a historical analysis of the social, cultural, and political value context in which British psychiatry has evolved since the late nineteenth century and lays the foundations for future studies of this kind.

In Part II, we turn our attention to value-laden and controversial issues in the present practice of psychiatry as well as some of the current developments that will be influential on the future of psychiatry. In Chapter 4 on ailments of the mind, Robert B. Dudas investigates the role of values in defining mental illness and psychiatry. He also explores the questions of 'Who decides what is pathological?' and 'What determines or influences mental well-being?' from a values perspective. Chapter 5, also by Robert B. Dudas, investigates the values of psychiatry as seen from within the profession at a personal as well as a collective level and also how psychiatry is viewed from outside, in the public discourse. In Chapter 6, Femi Oyebode explores how psychiatry and psychiatrists are portrayed in literature and the usefulness of such portrayals. Chapter 7, written by Robert B. Dudas, Elizabeth Fistein, and Toby Williamson, approaches multidisciplinarity from the perspectives of medicine

and neuroscience, the social sciences, and nursing and social work, respectively. The next two chapters describe progressive developments in psychiatry from a theoretical and a practical point of view, respectively. On the theoretical side, Chapter 8 begins with Robert B. Dudas looking at promising new developments in psychiatric treatment, especially existential psychotherapy and motivational interviewing, and what they have to offer in terms of refining our understanding of mental illness and the role of values in it. In the second half of Chapter 8, David Crepaz-Keay provides insight into recovery and co-production and the potential they carry for improving psychiatric care. Then, on the practical side, in Chapter 9, Benjamin R. Underwood and John Martin present an example of using VBP principles in reorganizing clinical services for the elderly by integrating mental and physical healthcare. To round off Part II, Chapter 10 takes a closer look at the current climate in which psychiatry operates, especially in the UK. Robert B. Dudas first examines the value context of specializing and working in psychiatry. This is followed by Elizabeth Fistein's analysis of the recent extreme focus on managing risk, especially preventing suicide, in psychiatry. Finally, in a section on values questioned and debated, Robert B. Dudas contrasts the approaches of anti-psychiatry and critical psychiatry.

Part III of the book focusses on three common psychiatric conditions and the benefits of taking a values-based approach to them. In Chapter 11, Robert B. Dudas describes a philosophically informed approach to understanding depression and its treatment and presents a methodological description of clinical value-mapping, which can facilitate a good process and reduce moral injury. In Chapter 12, Tom Dening and Malarvizhi Babu Sandilyan explore how during the progression of dementia the person's choices and preferences and the clinicians' philosophy of care may change over time, and how VBP can contribute to addressing the challenges this presents. Chapter 13, by Robert B. Dudas, explores value conflicts in borderline personality disorder and further elaborates on the use of clinical value-mapping.

Finally, as VBP has much to offer for research, too, Robert B. Dudas explores this in Chapter 14, a separate chapter at the end of the book. Owing to its richly value-laden nature, psychiatry is particularly well-placed to play a leading role in developing VBP. More than in other specialties, psychiatrists need to know their patients as people in order to arrive at the correct diagnosis or formulation and to be able to develop effective therapeutic relationships. Cultural and social factors can contribute powerfully to the development of psychiatric conditions and to the recovery from them. Consequently, psychiatry needs to call upon a range of cognate fields, such as psychology, sociology, anthropology, and law, and – to navigate this immensely complex, multidisciplinary endeavour – philosophy. This book is about the unique contribution of psychiatry to bringing about this collaboration and managing this complexity.

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Part I The Origins of the Profession and Its Different Perspectives

Chapter 1

The Origins of Psychiatry as a Profession

German E. Berrios and Ivana S. Marková

Introduction

According to a current definition: 'Psychiatry is the branch of medicine focused on the diagnosis, treatment and prevention of mental, emotional and behavioural disorders. A psychiatrist is a medical doctor (an M.D.) who specializes in mental health, including substance use disorders. Psychiatrists are qualified to assess both the mental and [the] physical aspects of psychological problems.'[1] Hence, psychiatrists (1) require a medical degree and specialized postgraduate training; (2) must be members of a legitimizing institution that accredits their clinical competence via examinations and access to specialized journals, textbooks, congresses, and so on; and (3) need to have their practice regulated and protected by legislation.[2] This chapter maps the history of this professionalization process.

The Beginnings

Although medical practitioners have always shown interest in madness,[3] 'psychiatry' (as defined in the 'Introduction' to this chapter) did not exist before the nineteenth century. Throughout the 1800s, these medical interests and views became organized into a recognizable discipline and profession. The word *psychiatrie* was coined in 1808,[4] but for most of the century the profession was called 'alienism' (France) or 'psychological medicine' (Great Britain, Germany).

Since its inception, psychiatry has been bedevilled by (1) boundary disputes (with neurology, psychosomatic medicine, palliative care, etc.) and the need to (2) justify its usefulness and existence vis-à-vis 'anti-psychiatry' and (3) defend its medical status vis-à-vis clinical psychology, mental nursing, sociology, and psychoanalysis. These challenges continue; hence, the future of 'psychiatry' remains uncertain.

Of late, psychiatry has thrown in its entire lot with the neurosciences. This relationship has biased training and new generations of psychiatrists are being formed with a great deal of knowledge about the brain but with little information on philosophy, history, and the social sciences. If madness proves to be more than a brain disorder, then new disciplines with adequate conceptual and hermeneutic repertoires will step in to offer richer and more useful explanatory accounts. Owing to its conceptual poverty, psychiatry will be unable to compete or break away from its current correlational mentality.

Madness before 1800

Transforming Madness into a Medical Object

An old form of human suffering, madness has throughout history attracted the attention of priests, medics, politicians, philosophers, poets, lawyers, and others. Until the eighteenth

century these views are found embedded in cultural contexts where the predominant religion provided the permissions and exclusions required to construct their own definition of madness. The religious view of madness, therefore, was not one among many but rather a sort of core belief in relation to which all other views needed to be defined. During the nineteenth century, Comte's model of progress influenced the earliest historiographies of madness and views on madness were lined up in stages: theological (fictitious), metaphysical (abstract), and positive (scientific).[5]

Although rhetorically interesting, this view is not helpful in understanding how the narratives of madness were constructed. For example, based on this linear historiography, the religious accounts of madness must be considered a thing of the past and retrograde. Yet, things are more complicated. Indeed, from the start the concept of madness has combined natural, supernatural, and moral elements which can still be found in the current 'medical' narrative.[6] For example, it is likely that the main cause of what is called the stigma of mental illness is not just 'ignorance of the facts' but the active presence in the current definition of mental disorder of hidden moral and religious meanings.[7]

Up to the seventeenth century, irrespective of whether proposed by medics,[8] philosophers,[9] religious writers,[10] or sufferers themselves,[11] views on madness showed Galenic influence.[12] However, a process of secularization started during the 1600s that in the event led to the so-called scientific revolution and later the Enlightenment. This affected the way in which madness was conceived, leading in due course to its medicalization.[13] It started to be considered as a 'natural kind', that is, as an object collocated in both space (a region of the human body) and time (with a beginning and an end). The development of the functional sciences (physiology, psychology) in the nineteenth century caused a reformulation of madness as a pathological distortion of a 'function', and by the end of that century it had given rise to the psychoanalytical narrative of madness.

Madness as a 'Natural Kind'

During the seventeenth century Thomas Sydenham[14] introduced the view that diseases and plants were similar ontological entities (i.e. 'natural kinds'). This gave rise to a form of 'more *botanico*' nosology, namely, the view that diseases could be classified as plants, as can be seen in the work of Linné, Sagar, McBride, Vogel, Boissier de Sauvages, Cullen, and others.[15] Using 'complaints' as their unit of analysis, they lumped together disease states which currently would be differentiated as disease, syndrome, and symptom.

The same applied to madness and mental symptoms, and clusters of symptoms were listed together. On occasions, listing criteria were used such as the mental faculties, for example, under *mentales*. Linné included Order I: *ideales* (delirium, paraphrosine, amentia, mania, daemonia, vesania, and melancholia); Order II: *imaginarii* (syringmos, phantasma, vertigo, panophobia, hypochondriasis, and sonnambulismus); and Order III: *pathetici* (citta, bulimia, polydipsia, satyriasis, erotomania, nostalgia, tarantismus, rabies, hydrophobia, cacositia, antipathia, and anxietas).[16] In the same vein, under *vesaniæ*, Boissier de Sauvages included Order I: *hallucinations* (vertigo, suffusio, dyplopia, syrigmus, hypochondriasis, and somnanbulismus); Order II: *morositates* (pica, bulimia, polydipsia, antipathia, nostalgia, panophobia, satyriasis, nymphomania, tarantismus, and hydrophobia); Order III: *deliria* (paraphrosine, amentia, melancholia, mania, dæmonomania); and Order IV: *folies anomales* (amnesia and agripnia).[17]

Eighteenth-century nosologists agreed with Linné that only a feature or two (of either a plant or a disease) should be privileged as classificatory criteria.[18] For example, William Cullen chose 'aetiology' as a criterion to group the 'neuroses' (*comata*, *adynamiæ*, *spasmi*, and *vesaniæ*) defined as general disorders of sense and motion in the nervous system. This means that dissimilar conditions such as diabetes, asthma, whooping cough, hallucinations, abdominal colic, diarrhoea, mania, melancholia, and so on were all included in the 'neuroses' class. Not everyone agreed with Linné's method. For example, Adanson[19] proposed that classifications should be based on the analysis of all features characterizing either plant or disease. Implementing this method became possible only after the advent of computers and gave rise to 'numerical taxonomy'.[20]

Madness as a Spatio-temporal Object

In addition to the various narratives available to explain it, the concept of 'madness' up to the eighteenth century was different from the current one in terms of its 'ontology' and 'epistemology', that is, of what its deep nature was believed to be and how it was to be known, respectively. As part of the Newtonian mechanization of the world, the definition of physical objects required that they had space–time coordinates.[21] Up to the 1700s, it was not clear whether the metaphysical status of madness required that it had to be a thing collocated in space and time; indeed, it seemed as if it was an a-temporal form placed outside time. Against this background, clinical remissions needed explanation and the notion of 'lucid interval'[22] was introduced to explain the temporary quiescence of madness.

To be placed in space and time, the concept of madness needed reframing and one such proposal was to reduce it to being an abnormal brain site.[23] This conception must be distinguished from earlier views according to which madness was an ethereal substance floating in the cavities of the brain 'ventricles'.[24] The view that madness occupied a region of bodily space was further developed by David Hartley,[25] who conceived of the mind as a signalling system resulting from changes in the pattern of micro-vibrations of the nerves. Complex thoughts and emotions were just vibrational composites put together by means of Locke's laws of the association of ideas. To Hartley, 'madness' could be used to name eight 'imperfections of the rational faculty': (1) erroneousness of judgement in children and idiots; (2) dotage in the elderly; (3) drunkenness; (4) delirium in acute distempers; (5) recurrence of the same ideas in the course of study; (6) violent passions; (7) melancholy; and (8) madness as such. None of these imperfections corresponds to current clinical categories. This mechanistic view of the mind led Hartley to conclude that there was no absolute demarcation between soundness and unsoundness of mind.[26]

Madness after 1800

Madness as a Disease

Mental Symptoms

Whether medical or mental, individual complaints or clusters thereof were listed side by side by eighteenth-century nosologies. The concept of 'mental symptom' as an autonomous unit of analysis (1) holding a relationship with a specific area/function of the brain and (2) being able to cluster up with different symptoms, thereby giving rise to various mental disorders, was only constructed during the early nineteenth century. This does not mean to say that mental

sufferings were not complained about before this period. The issue is that each complaint was treated as a nosological entity and listed accordingly. This was to change during the 1800s when Griesinger started to call such units of analysis *Die Elementarstörungen der psychischen Krankheiten* and suggested that each might be related to a specific mental function (e.g. hallucinations to perception; delusions to thinking; depression to affect; etc.).[27]

Conceptual and social forces led to the construction of the concept of mental symptom. Firstly, there was the new concept of 'medical symptom' constructed as part of the medical discipline of *Séméiologie*[28] or *Séméiotique*.[29] Secondly, there was the popularity in general science of the 'analytical method' (as per Bacon, Locke, Newton, and Hartley) according to which objects and concepts are best understood when teased out into their constituent parts.[30] Thirdly, there was the ongoing linguistic debate on the referential function of names and on the interaction of language and thought (featuring Rousseau, Herder, Monboddo, Humboldt, Dégerando, etc.).[31]

The concept of mental symptom in psychiatry was not free from aporias. For example, if it was the same units of analysis (mental symptoms) that when combined in different clusters gave rise to different diseases, then *what* determined the peculiar nature of each disease? Was it just (1) the *sui generis* nature of the combination or (2) the presence of differences in the quality or quantity of some of the symptoms constituting the disease? The latter option gave rise to what was called 'pathognomonic' symptoms, that is, symptom-presentations whose specific features signified only one diagnosis.[32] But if 'pathognomy' was a clinical reality then: (1) some mental symptoms had to be considered as semantically more important, that is, as *primus inter pares*; and (2) the idea that all mental symptoms had the same analytical value had to be abandoned.

Once the concept of mental symptom had become available, madness itself and its varieties (later called mental diseases, conditions, disorders, illnesses) were redefined as 'clusters' thereof. This in turn gave rise to the problem of having to give an account of the nature of the 'glue' that kept the symptoms together (neurobiological, genetic, statistical, social, symbolic, cultural, etc.). This issue has not yet been resolved. It seems clear that current neuroscientific accounts of schizophrenia, bipolar disorder, obsessive compulsive disorder, and so on do not provide separate explanations for *each* of the symptoms constituting the cluster. One or two are chosen as representative and most of the research effort goes into explaining them; the presence of all others is left unexplained. In other words, for all its predominance, neuroscience has not yet provided a general theory for each mental disease which, starting with its genetics, would then provide accounts for each of the mental symptoms present in the manifold.

Descriptive Psychopathology

Crucial to the professionalization of alienism was the construction of a proprietary language for the description/construction/capture of mental symptoms. This process took place during the first half of the nineteenth century and gave rise to what is now called descriptive psychopathology (DP).[33]

The relationship between DP and madness can be conceived in two ways. One is to consider DP as merely carving madness at its joints and then capturing in neutral words (one of the meanings of 'description') the resulting components (mental symptoms), thereby offering a 'theory-free' picture of madness. Another approach is to consider these stages as being theory-bound because it cannot be claimed that madness has joints to carve and because words, rather than capturing mental symptoms, actually construct them.

In other words, a theory is needed to break up madness in a particular way, and another to construct the mental symptom (prefer certain features to others, etc.).

One of the issues in play here concerns the meaning of 'description'. Started in classical Greece as a metaphorical conceptualization of the amanuensis (*ὑπογρἄφεύς*)[34] who is expected to write down exactly what she is dictated, it was translated into the Latin *Descriptio*, which meant write down, transcribe, trace, draw, represent, and prescribe (in the sense of establishing laws).[35] The dimension of metaphysical creativity[36] built into these last two meanings was replaced during the early twentieth century by a 'logical' definition according to which description was a 'theory-free copy'.[37] Whether DP describes in this new logical sense or in the earlier metaphysical (constructive) sense needs to be determined, as all neuroscientific research is based upon it. Given the fact that the objects of psychiatry can be defined as ideal, virtual, and conceptual (rather than as natural kinds), it is unlikely that DP can but contribute to their construction.[38]

The construction of DP was also attended by social and conceptual factors. Driven by philanthropic ideas and in response to scandals affecting the treatment of the insane,[39] early in the nineteenth century a programme for the building of mental asylums was started in various European countries, and as part of this process medical doctors found themselves working in the new mental institutions.[40] Although their primary duty was to look after the physical health of the inmates, to comply with hospital regulations their case notes needed to include comments on mental state. This created the need for a semiology of madness (or DP).

Asylums allowed for the accumulation of patients with similar complaints and this made possible their classification based both on cross-sectional and on longitudinal observation. The latter offered clear evidence that patients got better and this forced a review of the old metaphysical definition of madness. One such change concerned its temporalization, that is, the view that madness needed to be replaced in a 'time' dimension.[41] This in turn allowed for (1) the differentiation between 'acute' and 'chronic' madness, and (2) the uncovering of relationships between mental disorders and infancy, adulthood, and old age.[42]

Like medicine, psychiatry also needed criteria to differentiate the normal from the abnormal. By the 1850s, medicine had developed 'objective' signs and biological markers to do so. Alienists did not have such help, although for most of the nineteenth century some physical signs (fever, pain, tolerance to cold, changes in bowel habit, etc.) were considered to be part of some forms of madness. This led alienists to resort to criteria borrowed from the social sciences and their definition of mental 'abnormality' was based on social deviance (i.e. deviation from what at the time was considered proper, ethical, and socially acceptable). Mad behaviour was primarily demarcated by social criteria and only secondarily by speculative neuroscientific claims as to what was wrong with the patient's brain. This means that DP was from the start based on a hybrid conceptual platform in which the 'descriptions' already carried some clear claims of social deviance (which is a social, not a biological marker). In a way, this has continued to our own day as psychiatry remains bereft of strong biological markers.[43] Neither in the nineteenth century nor since has the diagnosis of madness been based on brain-related criteria alone.

Alienism Becomes a Profession

Each European country professionalized alienism at a different pace and with different resources. By the second half of the nineteenth century, England, Germany, France, Italy, and several other countries had founded professional societies and journals and started

training procedures for alienists. In spite of the bellic interruptions, exchanges between nations continued to the point where, by the 1890s, textbooks and classifications in the main European countries carried similar information.

To discharge their duties, alienists (or mad-doctors, as they were called) needed to create for themselves a physical, social, and legal space. It is not surprising then that after the 1820s they participated in all national debates relating to lunacy legislation and the housing and management of the insane.[44] In the asylums themselves, social hierarchies were also established with doctors at the top, followed by keepers (later called mental nurses) and supporting staff, and then inmates at the bottom.[45] Likewise, functional dichotomies were proposed to facilitate patient control: public versus private, male versus female, agitated versus quiet, acute versus chronic, rational versus irrational, continent versus incontinent, epileptic versus non-epileptic, organic versus functional, criminal versus non-criminal, and so on. These categories later influenced asylum architecture.[46] Asylum building was often governed by financial convenience. For example, English counties shared costs by building asylums on territorial boundaries, and, regardless of the local weather, asylums in the colonies were often built on plans used in the metropolises.[47] Fashion was occasionally influential and at least two asylums[48] followed the ideology of Bentham's panopticon.[49]

By accumulating ever-growing cohorts of chronic patients and making possible regular post-mortem examinations,[50] asylums brought about a minor epistemological revolution. This, given the type of neurological patient that was often collected, strengthened the organic theory of madness.[51]

Alienists plied their trade in a complex social and political context and had to use local resources. For example, in Roman Catholic countries, general hospitals and mental asylums were run by religious congregations.[52] Frictions developed when (as happened in France) the alienist in charge was not religious and objected to practices such as regular prayer, overly modest clothing, and other religious duties. Similar frictions developed in the interface between psychiatry and the law. Insanity and dementia were traditional legal categories and lawyers used simple tests for them.[53] Alienists had a less black and white view of such disorders and on occasions this caused major disagreement.[54]

The Fragmentation of Madness

The nineteenth century had inherited Cullen's claim that from an aetiological viewpoint the *vesaniæ* (insanities) were a form of neuroses, that is, 'disorders of the sense and movement of the nervous system without fever or focal lesion'.[55] In other words, madness was just another bodily disease. Cullen's views influenced the French concepts of madness. They also provided the criterion on the basis of which neurology (as a new specialism) started to be constructed after the 1850s by collecting 'neuroses' in which focal brain lesions had been found (e.g. Parkinson's disease, multiple sclerosis, etc.).[56] This erosion of the originally large class of Cullean neuroses continued until the end of the nineteenth century, by which time it contained only the insanities, hypochondriasis, hysteria, anxiety disorders, obsessional-compulsive disease, neurotic depressions, and Raynaud's phenomenon. Soon enough the insanities were reconceptualized as 'psychoses'[57] and removed from the group. Only the remaining conditions continued to be called 'neuroses' but were reconceived as functional diseases, the expression of 'nervous irritation'.[58] Soon enough Freud was to offer yet another explanation, to wit, that the remaining neuroses were symbolic expressions of a psychological conflict.[59]