K.W.M. (BILL) FULFORD
St Catherine's College
University of Oxford
University of Warwick Medical School
valuesbasedparctice.org/contact

THE STATE OF THE ART IN PHILOSOPHY AND PSYCHIATRY: AN INTERNATIONAL OPEN SOCIETY OF IDEAS SUPPORTING BEST PRACTICE IN SHARED DECISION-MAKING AS THE BASIS OF CONTEMPORARY PERSON-CENTRED CLINICAL CARE[1]

abstract

The state of the art of contemporary philosophy and psychiatry is reviewed. Section 1 *describes the new field as an international open society of ideas.* Section 2 *introduces values-based practice. Although originally a philosophy-into-practice initiative, values-based practice is now developing more strongly in areas of bodily medicine such as surgery. An example from surgery illustrates how values-based practice has been implemented as a partner to evidence-based practice in supporting shared clinical decision-making as the basis of best practice in contemporary person-centered clinical care.* Section 3 *explores the difficulties presented by implementing values-based practice in mental health as illustrated by a case example of anorexia. This shows that these difficulties derive from the particularly intense challenges of values pluralism presented by anorexia. The resources of phenomenology provide the basis for an effective response to these challenges. Section 4 generalizes the argument of Section 3 showing that an effective response to the wider range of challenges of values pluralism arising across the board in mental health is available from the resources of the international open society of ideas of contemporary philosophy and psychiatry. The article concludes with a promissory note on values and a cautionary note on science.*

keywords

philosophy and psychiatry, values-based practice, evidence-based practice, shared decision-making, person-centred care, values pluralism, recovery practice, open society

1 **Acknowledgements**: The story of Mrs Jones' Knee is adapted from Handa *et al.*, 2016 and Anna's story from Stanghellini and Fulford, forthcoming.

Phenomenology and Mind, n. 18 - 2020, pp. 16-36
DOI: 10.17454/pam-1802
Web: http://www.rosenbergesellier.it/elenco-libri?aaidriv=14

ISSN 2280-7853 (print) - ISSN 2239-4028 (on line)

1. Introduction

Recent decades have witnessed a dramatic resurgence of cross-disciplinary work between philosophy and psychiatry. The state of the art of this dynamic new field is that of an international open society of ideas. This article explores the significance of the open society of ideas represented by contemporary philosophy and psychiatry for best practice in person-centred mental health care.

The article is in four main sections. *Section 1, Philosophy and Psychiatry,* describes the open society of ideas established by developments in the new field particularly as represented by its collegial organizing body, The International Network for Philosophy and Psychiatry (INPP). *Section 2, Values-based Practice,* provides a brief introduction to a novel skills-based way of working with values in health care called values-based practice. Although derived originally from analytic philosophy of values within philosophy and psychiatry, the implementation of values-based practice has recently been mainly in bodily medicine.

The story of 'Mrs Jones' Knee' illustrates the role of values-based practice as a partner to evidence-based practice in supporting shared decision-making as the basis of contemporary person-centered surgical care. Shared decision-making is noted to be equally important in person-centered mental health (particularly in recovery practice). Yet values-based practice is proving harder to implement in mental health than in bodily medicine.

Section 3, Values Pluralism in Anorexia, explores the difficulties of implementing values-based practice in mental health as illustrated by anorexia. A second clinical example, 'Anna's Story', shows that at least in anorexia the difficulties implementing values-based practice are a consequence of the challenges of values pluralism presented by this condition. An enriched model of values-based practice combining the resources of analytic philosophy with those of phenomenology provides the basis for an effective response to the challenges of values pluralism presented by anorexia.

Section 4, Values Pluralism in Mental Health, generalizes the argument of Section 3. Drawing on background work in philosophical value theory, it shows that across mental health as a whole there is a wider range of challenges of values pluralism of the kind illustrated by anorexia. Meeting this wider range of challenges will require extending the resources of values-based practice to embrace not only phenomenology but the full range of resources available from the international open society of ideas that is the state of the art of contemporary philosophy and psychiatry.

The article as a whole is concerned with the role of the international open society of ideas represented by contemporary philosophy and psychiatry in working alongside science in supporting best practice in mental health. It concludes with a promissory note on a second article to be written about the role of the international open society of ideas in preventing bad practice. This in turn leads to a cautionary note on science. In both its roles, in supporting good practice and in preventing bad practice, the international open society of ideas of contemporary philosophy and psychiatry is in effect bringing mental health into line with the new medical sciences of the Twenty-first Century. As such we should be mindful of what one of the founders of what the new science of quantum mechanics, Max Plank, said about the birth of new sciences generally having to wait for old scientists to die.

2. Section 1, Philosophy and Psychiatry

Contemporary cross-disciplinary work between philosophy and psychiatry is not unprecedented. The recent centenary of Karl Jaspers' *General Psychopathology* (Jaspers, 1913) is a sufficient reminder of the seminal role of philosophy in the origins of contemporary psychopathology (Stanghellini and Fuchs, 2013). Another less widely recognized though no less significant precedent is the (*de facto*) partnership between the psychiatrist Aubrey Lewis and philosopher of science Carl Hempel in the origins of our current symptom-based diagnostic classifications (Fulford and Sartorius, 2009). Aside however from continuing work in phenomenology it was not until the last decade of the twentieth century that philosophy and psychiatry took off as a significant and sustained international research-led discipline (Fulford *et al.*, 2003).

- New Groups Around the World
- Sections in WPA and AEP
- Annual Conferences of the International Network for Philosophy and Psychiatry (launched Cape Town, 2002)
- New 'Chairs' (UK, Netherlands, Italy, South Africa)
- Training Programmes and Research
- PPP (Philosophy, Psychiatry, & Psychology)
  - Oxford philosophy
  - DPhil scholarship
  - Post-doc Fellows in Philosophy of Psychiatry
  - Summer Schools (2013/15)
  - IPPP book series over 50 volumes
  - Endowed tutorial fellowship (£2m endowment)
- Philosophy into practice
  - Phenomenology, psychopathology and neuroscience
  - Responsibility without blame
  - Values-based practice

Table 1 – International Developments in Philosophy and Psychiatry

Developments in as it has come to be called the 'new' philosophy and psychiatry are summarized in Table 1. As this indicates these developments are distinctively international in nature. There are new organizations concerned in one way or another with the new field in many parts of the world. These include sections in major international psychiatric organizations such as the *World Psychiatric Association* and the *European Psychiatric Association*. Annual conferences of the umbrella organization for the field, the *International Network for Philosophy and Psychiatry (INPP),* have been held in every major continent. The INPP was

established at a conference in Florence in the millennial year, 2000, and launched from Cape Town in 2002. A vigorous international programme of publications has developed with both peer-reviewed journals and book series from major international publishers. The book series from Oxford University Press, for example, *International Perspectives in Philosophy and Psychiatry (INPP)*, has published over fifty volumes since its launch in 2003, including major Oxford Handbooks on *Philosophy and Psychiatry* (Fulford *et al.*, 2013), *Psychiatric Ethics* (Sadler *et al.*, 2015) and *Phenomenological Psychopathology* (Stanghellini *et al.*, 2019). New academic programs in philosophy and psychiatry include Professorial Chairs in many parts of the world (including South Africa) and a recently endowed tutorial post at St Catherine's College in Oxford (the *Fulford-Clarendon Fellowship* held by the UK/USA educated German philosopher, Philip Koralus).

Emblematic of the internationalism of the new field is the quarterly peer-reviewed journal published by The Johns Hopkins University Press, *Philosophy, Psychiatry and Psychology (PPP)*. Recently celebrating its twenty-first year as a joint venture between the USA-based *Association for the Advancement of Philosophy and Psychiatry* and the UK-based *Philosophy Special Interest Group in the Royal College of Psychiatrists*, PPP has now become the official journal of the *INPP*. As such PPP has ambitious plans for extending and developing its representation of traditions of thought and practice in mental health beyond those of Europe and North America.

This resurgence of philosophy and psychiatry has seemed to many in psychiatry the more remarkable for the fact that it should have started in the 1990s, celebrated as this period was as the 'decade of the brain'. In this however history is repeating itself. Just as Karl Jasper's work in philosophy and psychiatry coincided with psychiatry's 'first biological phase' at the turn of the twentieth century (marked by such discoveries as Alzheimer's disease and neurosyphilis), so the 'new' philosophy and psychiatry coincides with psychiatry's second biological phase at the turn of the Twenty-first century. There are good reasons for these parallel developments. Jaspers' General Psychopathology was written in response to what he regarded as the deficiencies of the neurosciences of his time. His aim in writing General Psychopathology was not to undermine neuroscience (he was a trained neuroscientist as well as a philosopher) but rather to balance their empirical methods for studying the brain with a correspondingly powerful phenomenological method for studying subjectivity. This balancing up agenda continues in today's philosophy and psychiatry with innovative work across a range of psychopathologies drawing on a variety of phenomenological approaches from both established and up-and-coming figures in the new field (Stanghellini *et al.*, 2019).

But there are also important differences between psychiatry's first philosophical phase in the work of Karl Jaspers and contemporary developments in the field. First, with Jaspers the relationship between philosophy and psychiatry was mainly one way; in General Psychopathology, philosophy is employed as a resource for psychiatry. In the contemporary field the relationship is instead *two*-way: this is why the field is philosophy *and* psychiatry not philosophy *of* psychiatry; philosophy continues as a resource for psychiatry and mental health but psychiatry and mental health are also resources for philosophy. This two-way relationship is reflected in the publications from the field: the contents of the *Oxford Handbook of Philosophy and Psychiatry* (Fulford *et al.*, 2013), for example, although a *philosophy* handbook, are organized around the stages of the *clinical* encounter (its sections run from 'staying well' through 'diagnosis' to 'treatment, cure and care').

This two-way relationship may be one reason why thirty years on contemporary philosophy and psychiatry continues to expand vigorously where, by contrast, Jaspers' work in the field more or less finished with General Psychopathology[1]. But a second and perhaps more powerful reason has been that whereas Jaspers worked in isolation, contemporary philosophy and psychiatry has from the start been a strongly collegial international discipline. As is evident from Table 1, the contemporary field encompasses an extensive group of researchers from every part of the world representing very diverse areas of both philosophical and practical expertise. As in both its parent disciplines those working in philosophy and psychiatry often have very different views on their respective areas of specialism. But the field has developed thus far without major factional splits and guided by a principle of mutual respect for differences of view. The collegiality of the field notwithstanding its diversity - its ethos of collaboration within a shared enterprise - is as we will see key to its importance clinically.

The state of the art of contemporary philosophy and psychiatry thus amounts to what is best described as an international open society of ideas. To understand the importance of this open society in supporting best practice in person-centered clinical care, we need to look first at one of the philosophy-into-practice outputs from contemporary philosophy and psychiatry, values-based practice.

3. Section 2, Values-based Practice

Values-based practice is a new skills-based approach to working with complex and conflicting values in health care. It is one of a number of philosophy-into-practice initiatives arising from the new interdisciplinary field of philosophy and psychiatry including the rapidly expanding field of contemporary phenomenological psychopathology (Stanghellini *et al.*, 2019).

Values-based practice, although it has links with phenomenological psychopathology (see below), is derived principally from work in analytic philosophy of values. As an abstract or formal area of philosophy, analytic philosophy of values is concerned not with solving substantive practical problems involving values, but with the logic (the meanings and implications) of the value terms within which such problems are couched (Fulford, 1989). Consistently with its formal origins values-based practice offers no 'solutions' as such. It offers instead a process made up of a number of elements that together support clinicians, patients and others concerned in clinical care, to come to decisions for themselves where (as is so often the case in health care) complex and conflicting values are in play. Also consistently with its formal origins, values-based practice is concerned not just with ethical values but values of all kinds as they impact on health care. This full range of values can be summed up as the full range of *what matters or is important to* those concerned in a given clinical situation.

Premise of Mutual Respect for Differences of Values

Ten Key Process Elements	**Together these support**	**Balanced** decisions made within **frameworks of shared values**
4 Clinical Skills 2 Aspects of clinical relationships 3 Principles linking VBP and EBP 4 Partnership based on dissensus		

Figure – A Flow Diagram of Values-based Practice

1 Aside from a number of new editions of his General Psychopathology, Jaspers went on to work essentially as a philosopher rather than as a philosopher and psychiatrist.

Values-based Practice	Brief definition
PREMISE	
Respect	Mutual respect for differences of values
TEN PROCESS ELEMENTS	
Four areas of Clinical Skill	
1) Awareness	Awareness of values and of differences of values
2) Knowledge	Knowledge retrieval and its limitations
3) Reasoning	Used to explore the values in play rather than to close down on ' right answers'
4) Communication	Especially for eliciting values and of conflict resolution
Two Aspects of the Service Model	
5) Person-*values*-centered care	Care centered on the actual rather than assumed values of the patient
6) The *ex*tended Multidisciplinary Team	MDT role extended to include values as well as knowledge and skills
Three Principles linking values and evidence	
7) Two feet principle	All decisions are based on the two feet of values and evidence
8) Squeaky wheel principle	We notice values when they cause difficulties (like the squeaky wheel) but (like the wheel that doesn't squeak) they are always there and operative
9) Science-driven principle	Advances in medical science drive the need for VBP (as well as EBP) because they open up choices and with choices go values
Partnership in decision-making	
10) Shared decision making based on dissensus	Shared decision-making based on evidence (clinician) and values (patient or service user) – dissensus means the values of those concerned remain in play to be balanced sometimes one way and sometimes in other ways according to the circumstances of a given case
OUTPUTS	
Frameworks of shared values	Values shared by those concerned in a given decision making context (eg a GP Practice) and within which balanced decisions can be made on individual cases as the basis of shared decision making
Balanced decisions within frameworks of shared values	Decisions made by balancing the relevant shared values according to the circumstances presented by the case in question

Table 2 – Brief Definitions of the Elements of Values-based Practice

As its name suggests values-based practice is a partner to the more familiar evidence-based practice. Evidence-based practice provides a process that supports clinical decision-making where complex and conflicting evidence is in play. Values-based practice provides a process that supports clinical decision-making where complex and conflicting values are in play. The processes on which they rely are of course very different. The process of evidence-based practice involves computer-based meta-analyses of high-quality research findings. The corresponding process of values-based practice is more clinically focused. Its component elements are summarized in the Flow Diagram in the Figure and defined briefly in Table 2. As these indicate, at the top of the list of elements making up the process of values-based practice are a number of learnable clinical skills. It is on these that the training programmes described later in this article have focused. Together with the other elements of values-based practice their aim is to support those concerned in coming to balanced decisions within locally agreed frameworks of shared values according to the particular circumstances presented by the situation in question[2].

The importance of the partnership between values-based practice and evidence-based practice has come to particular prominence in contemporary health care with the development of shared decision-making as the basis of person-centered clinical care. This is illustrated by following story of 'Mrs Jones' Knee'. The story is based on that of a real person but with biographical details changed. As the title of her story suggests, 'Mrs Jones' had a bodily not mental health problem, and the consultation described is with an orthopedic surgeon not a psychiatrist. This is because as will be described in the next section although shared decision-making is in principle the same in all areas of health care it is considerably more challenging in mental health than in bodily medicine. It is the additional challenges presented by shared decision-making in mental that will bring us back in the final section of the article to the need for the open society of ideas represented by contemporary philosophy and psychiatry.

3.1 Mrs Jones' Knee – Shared Clinical Decision-Making in Surgery[3]

Mrs. Jones was referred to an orthopedic surgeon, Mr. Patel (not his real name), with a painful arthritic knee for assessment for knee replacement surgery. After the usual 'work up' Mr. Patel confirmed to Mrs. Jones that they could go ahead with giving her an artificial knee joint – yes, she would need about eighteen months physiotherapy post-op; but the end result was that she would very likely end up pain free.

Looking pleased Mrs. Jones got up to leave. As she reached to door she turned to thank Mr Patel saying 'I'm so pleased, doctor, I'll be able to garden again'. Hearing this Mr Patel invited Mrs Jones to sit down again. 'Tell me about your gardening', he said. Mrs. Jones explained that the reason she was concerned about her knee was that she could not bend down well enough to weed her garden. It was true as everyone kept saying that her knee was painful. She found this unpleasant but what really mattered to her was that it stopped her doing her gardening.

'I understand' Mr Patel replied, and then went on to explain to Mrs Jones that while she would in all probability be pain free after her operation, unfortunately with the artificial joints currently available, she would end up post-op no more mobile and possibly less so. So after some further discussion they agreed to go for conservative management (anti-inflammatory medication and physiotherapy) in the first instance. This was successful. A few months later Mrs. Jones still had a painful knee but her mobility was restored sufficiently that she could manage her garden again.

2 The process of values-based practice is described in detail elsewhere (see for example, Fulford, Peile and Carroll, 2012) and further sources including free-to-download training materials are available from the website of the Collaborating Centre for Values-based Practice at St Catherine's College in Oxford (valuesbasedpractice.org).

3 This story is based on a version published in Handa *et al.*, 2016.

The story of Mrs Jones' knee and the way Mr Patel worked with her in deciding what to do illustrates many of the key features of values-based practice and its role in shared clinical decision-making. First, it shows the importance of the individuality of personal values in clinical decision-making. For most people like Mrs. Jones with arthritis of the knee what matters is to be free of pain. But as a keen gardener Mrs. Jones was more concerned about being able to garden again than about being free from pain. This meant regaining mobility. Her story shows, second, the importance of the clinical skills supporting values-based practice. In this instance the key skill shown by Mr Patel was listening. This sounds simple but really listening is all too rare in practice. It was because Mr Patel really listened to Mrs Jones and picked up on the significance of her parting comment about gardening that he was able to offer her the person-*values*-centered care of values-based practice.

Mr Patel's ability to offer Mrs Jones person-values-centered care was however also dependent on his knowledge of the evidence as an experienced orthopedic surgeon. It was because Mr Patel understood the advantages and disadvantages of the currently available prosthetic knee joints that he was able to offer Mrs Jones an approach to management that was likely to be consistent with the values driving her request for treatment for her arthritic knee (with what mattered or was important to her about the outcomes of the treatment). It was this same expertise that allowed Mr Patel to pick up in the first place on the significance of Mrs Jones' passing comment about gardening.
Mrs Jones' story thus illustrates the essential partnership between values-based practice and evidence-based practice in the shared decision-making that is the basis of contemporary person-centered clinical care. Mr Patel came through dialogue with Mrs Jones to a shared decision about how to manage her arthritic knee. The decision was based on his knowledge of the advantages and disadvantages of the reasonable options available. But it was based on the advantages and disadvantages of these options as judged not from the perspective of most patients but specifically from the perspective of Mrs Jones' (ie not from the perspective of what matters or is important to most people with arthritis of the knee, but from the perspective of what mattered or was important about arthritis of the knee specifically to Mrs Jones).

Shared decision-making as this story illustrates offers a 'win' for everyone involved. It was a 'win' for Mrs Jones in that she avoided an unnecessary operation and instead got the outcome for which she had sought help in the first place; it was a 'win' for the funding body (the UK National Health service in this instance) who avoided the considerable cost of an operation that was at best unnecessary and at worst mismatched to the patient's real needs; and it was a 'win' for the surgical team that had avoided a disappointed patient while at the same time freeing up scarce resources to reduce their waiting list for knee replacement surgery. This is why shared decision-making has become widely adopted as the norm for best practice in contemporary person-centered clinical care. In the UK it has for some time been the basis of both regulatory[4] and evidence-based practice guidelines[5]; and this guidance has recently (2015) been incorporated into law by a ruling from the UK's Supreme Court called the *Montgomery* judgement (Herring *et al.*, 2017)[6].

4 See General Medical Council, 2008.
5 See for example, National Institute for Health and Care Excellence (2015/2017).
6 Although a UK ruling the Montgomery judgement reflects in part international law precedents including aspect of European Human Rights legislation.

3.2 From Surgery to Mental Health

Consistently with the growing regulatory and legal priority afforded shared decision-making, the role of values-based practice as a partner to evidence-based practice in delivering shared decision-making is becoming increasingly widely recognized. In the UK this is reflected in the rapid growth of the Collaborating Centre for Values-based Practice at St Catherine's College in the University of Oxford. Supported by senior figures in the UK Health Service (including the Chief Executives of both the PFA and NICE[7]), the Centre has since its launch in 2014, developed a range of training materials in a number of areas of bodily care, including surgery, radiography, occupational therapy, pharmacy and emergency medicine[8].

Mental health has not been neglected. Indeed, the Centre's programmes in bodily medicine have been built on foundations laid by earlier work on values-based practice in mental health supported by the UK's Department of Health[9]. The Collaborating Centre has follow-on programmes from this earlier work in mental health for example on Child and Adolescent Mental Health, on addiction, and on first episode psychosis[10]. This work is important not least because shared decision-making in mental health is important to recovery practice[11]. But in these and other areas of mental health, implementing values-based practice in the context of shared decision-making has turned out to be far more challenging than in areas of bodily medicine such as surgery[12]. The next section explores through the example of anorexia why this should be so.

4. Section 3, Values Pluralism in Anorexia

This section starts with an example from mental health, the story of 'Anna'. As with the story of Mrs Jones' knee, Anna's story is not a philosophical invention but derived in biographically disguised form from clinical practice ('Anna' is a composite character based on a number of clinical stories).

Anna's story as retold here focuses on the features she presented on referral. As you read the description of these features you may find it helpful to compare them with the corresponding

7 The PFA (Professional Standards Authority) is the 'regulator of regulators' in the UK with oversight responsibility for discipline-based regulators including the General Medical Council (whose guidance on shared decision-making as the basis of consent is cited at Footnote 3); NICE (National Institutes for Health and Care Excellence) is responsible for issuing evidence-based guidelines for the UK National Health Service.

8 This work has been led by the College of Paramedics – paramedics' responsibilities in the UK include ambulance services.

9 The work of the Department of Health programme built on a training programme produced in a joint venture between Warwick Medical School and a mental health NGO, the Sainsbury Centre for Mental Health (Woodbridge and Fulford, 2004). Besides a range of policy initiatives, outputs from the programme included best practice guidance on contentious areas such as involuntary psychiatric treatment and assessment in mental health.

10 Collaborating Centre Advisory Board member, Professor Dame Sue Bailey, during her time as President of the Royal College of Psychiatrists, launched a national Commission for Values-based CAHMS (child and adolescent mental health services). Its co-produced report, *What Really Matters in Child and Mental Health Services* (The Royal College of Psychiatrists, 2016), is available to download from the Collaborating Centre website and the work of the Commission continues through a Network for Values-based CAHMS supported by the Centre. The training programme on prescribing in first episode psychosis was developed by pharmacist, Camilla Sowerby, and is given at: valuesbasedparctice.org.

11 The aim of 'recovery practice' is recovery of a good quality of life as defined by reference to the values of the individual concerned (Slade *et al.*, 2014). Hence without shared decision-making of the kind illustrated by Mrs Jones' story (ie based on the individual's values as well as the clinicians knowledge) recovery so defined cannot even get started.

12 The Department of Health programme included for example training programme respectively on values-based implementation of the UK's new Mental Health Act and on shared decision-making in mental health assessment. Both were well received in principle but failed to gain traction in practice (see respectively Fulford *et al.*, 2015a and 2015b).

features presented by Mrs Jones to the orthopedic surgeon, Mr Patel. With the challenges for clinical decision-making in mind, think about three related questions: In what ways are the two stories similar and in what ways are they different? How might the differences result in shared decision-making presenting more acute challenges in Anna's story than in that of Mrs Jones' Knee? On what resources might we draw in responding to these more acute challenges? The section that follows will examine the extent to which our answers to these questions may be generalized from Anna's story to mental health as a whole.

4.1 Anna's story[13]

Anna was a young woman whose clinical picture satisfied DSM[14] *criteria for anorexia nervosa. She showed: A) significantly low body weight for her age due to 'restriction of energy intake'; B) 'Intense fear of gaining weight or of becoming fat'; and C) 'Disturbance in the way (she experienced her) body weight or shape, undue influence of body weight or shape on self-evaluation, or persistent lack of recognition of the seriousness of (her) current low body weight.' Anna also showed a number of associated features highlighted by DSM: her 'self-esteem ... (was) highly dependent on (her) perceptions of body weight and shape.' Also, 'weight loss (was) ... viewed (by her) as an impressive achievement and a sign of extraordinary self-discipline, whereas weight gain (was) perceived as an unacceptable failure of self-control.' Like many others she 'lacked insight' into her condition and was brought to 'professional attention by family members'.*

4.2 The challenges of values pluralism in anorexia

Anna's story is similar to that of Mrs Jones in that the respective clinical decision about what to do should in both cases be (at least in the UK) shared between clinician and patient (or service user). 'Should' because throughout the UK the regulatory and legal provisions noted above make consent to treatment dependent on shared decision-making based on evidence and values. As already noted shared decision-making is no less important in mental health than in bodily medicine if only because of its role in recovery. Yet in Anna's story both sides of the shared decision-making process – both the evidence side and the values side - will be more challenging than in the situation presented by Mrs Jones. As to the evidence side of shared decision-making, there is more uncertainty about the interventions available (their advantages and disadvantages, even which interventions are appropriate at all) for anorexia than there is for arthritis of the knee. So the evidence-base for shared decision-making in anorexia is more challenging because it is less certain than the corresponding evidence-base for arthritis of knee. But the challenges for the evidence-base of shared decision-making in anorexia pale into insignificance compared with the corresponding challenges for its values-base. These challenges can be understood as various aspects of the greater degree of values pluralism presented by anorexia compared with arthritis of the knee.

In the first place the values operative in Anna's story are more complex. In Mrs Jones' story her values (in so far as they related to her presenting issue) were relatively simple and straightforward. What mattered to Mrs Jones was, simply and straightforwardly, to recover mobility so that she could return to her gardening. This was the outcome that mattered most or was of most importance to her. If she could have become pain free as well she would have welcomed that. To this limited extent her values were pluralistic. But given the limitations of

13 Anna's story is based on a version published in Stanghellini and Fulford, forthcoming.

14 The DSM (the Diagnostic and Statistical Manual of Mental Disorders, American Psychiatric Association, 2013) is the American Psychiatric Association's diagnostic classification. It is one of two symptom-based classifications widely adopted internationally, the other being the World Health Organisation's ICD (International Classification of Diseases). Symptom-based classifications have been much criticised particularly by neuroscience researchers but remain in general use for clinical and epidemiological purposes.

the interventions available, she had to choose – and her choice (of mobility over pain relief) was unambiguous. Anna's values, by contrast, are more complex and considerably less transparent. True, she had an overwhelming wish to lose weight. But that the values involved in this were far from transparent becomes evident if we ask to what end Anna wanted to lose weight. If her desired outcome was to look good or to get fit the extent of her self-starvation was self-defeating.

The complexity of the values involved in Anna's story moreover extended to the way her condition was understood. In Mrs Jones' story the operative values (even to the extent of pain versus mobility) were confined to outcomes. In Anna's story by contrast the operative values extended to the way her what would be called in medicine her 'diagnosis'. To be clear, 'diagnostic' values are present in Mrs Jones' story too. Mrs Jones' had arthritis of the knee: as a *dis*ease this is (arguably[15]) defined in part but essentially by negative value judgements - a *dis*ease so this line of argument goes, is a *bad* condition. The value judgements in question, furthermore, marking as they do what is bad about arthritis of the knee, are operative in Mrs Jones' story to the extent that they motivated her request for help and corresponding the responses of Mr Patel and the surgical team. But because the diagnostic values in Mrs Jones' story were *shared* among all those concerned (everyone shared the negative value judgements about pain and loss of mobility associated with arthritis of the knee) they presented no challenges of pluralism to the shared decision-making process and indeed went unnoticed.

In Anna's story by contrast the operative diagnostic values were highly contested. This is evident in the way she came to the attention of services. Mrs Jones came to see Mr Patel of her own volition requesting help. Anna by contrast '*was brought to professional attention by family members'*. So it was her family's values by which the consultation was motivated. Anna was in consequence said to 'lack insight'. But what this means is that she valued her anorexia very differently from her family. So this adds a whole new dimension to the additional plurality of the values operative in Anna's story. Compared with those operative in Mrs Jones' story, Anna's values are complex and far from straightforward. But not only that, they are also in conflict with the values of others. This conflict of values is indeed such that if Anna were to refuse treatment she could well end up being treated on an involuntary basis under the relevant mental health legislation. A far cry then from the recovery practice based on the values of the person concerned that as noted above is the aim of shared decision-making as the basis of contemporary person-centred care in mental health.

4.3 A phenomenological response to the challenges of values pluralism in anorexia

One way of responding to the challenges of values pluralism presented by Anna's story is to add to the analytic resources of values-based practice insights into psychopathology from contemporary phenomenology. This is the basis of the work of the Italian psychiatrist and phenomenologist, Giovanni Stanghellini and colleagues, on anorexia and related disorders.

The essence of Stanghellini's insight is that the presenting features of anorexia reflect a deeper underlying disturbance in how the person concerned experiences their body. Stanghellini captures this underlying disturbance using the French phenomenologist Jean Paul Sartre's phenomenology of the body. Anorexia, Stanghellini has argued reflects a disturbance in what Sartre characterised as the lived-body-for-others. Sartre recognised that in addition to the body-as-object (the body that for example we study in anatomy) and the body-as-subject (the body that we experience) there is a body that we experience through the gaze of others. It is

15 See footnote 16.

a failure to establish a stable sense of this third aspect of our bodily experience, of the lived-body-for-others, that Stanghellini has identified as being at the core of anorexia.

Stanghellini has supported this insight into the nature of anorexia with an impressive range of clinical observations of individual cases of anorexia together with a qualitative study using a standardised interview schedule (Stanghellini and Mancini, 2017). The result is a growing understanding of the relevant evidence base. Equally, though, and more to the point for present purposes, the theory allows treatment to be informed by a growing understanding of the relevant values base.

Thus, in Anna's story as recounted above, her values were complex notably in being (as expressed by her) inconsistent. Her values were also in conflict with those of her family (recall that it was at the insistence of her family that she 'came to the attention of services'). None of this is surprising once we adopt Stanghellini's insight that the values expressed by people like Anna reflect a deeper set of values connected with their disturbed lived-body-for-others. So long therefor as we engage with Anna only at the surface level of her values there will be no way of coming to a balanced understanding as the basis of a shared approach to clinical management. At this surface level, however well developed are our skills for values-based practice, they will be ineffective because they will be not be engaging with what really matters to Anna. These skills will still be important. Combined with evidence-based practice, the elements of values-based practice will still be required to support shared decision-making as the basis of a person-centred approach to working with Anna. Skills of conflict resolution for example will still be required. But without what Stanghellini and I have called elsewhere the 'depth dimension' of understanding provided by phenomenology (Stanghellini and Fulford, forthcoming), values-based practice will spin emptily because it will be disengaged from the reality of Anna's values.

With Anna then, and with other people with anorexia so understood, an extended model of values-based practice is required. The analytically derived form of values-based practice that has proven so effective in areas of bodily medicine (as illustrated by the story of Mrs Jones' knee) has to be extended to include the depth dimension provided by phenomenological understanding. Stanghellini has followed through on the implications of this extended model of values-based practice by developing (with colleague Milena Mancini) a values-based therapeutic interview built on phenomenological principles (Stanghellini and Mancini, 2017). Again, the aim here is not to displace but to extend the resources of the standard analytically derived form of values-based practice to include phenomenology.

Stanghellini' work thus provides an effective response to the challenge of pluralism presented by anorexia. The next section looks at how far this approach can be generalized to other areas of mental health. As will be seen this will brings us to the cutting edge of developments in values-based practice within the wider state of the art of contemporary philosophy and psychiatry.

5. Section 4, Values Pluralism in Mental Health

Once you start looking for them values are written all over mental disorders. We noted in the last section the value judgements by which the DSM's diagnostic criteria for anorexia are (in part) defined (American Psychiatric Association, 2013). An ordinary language study by the North American philosopher and psychiatrist, John Sadler, has shown the pervasiveness of such diagnostic values throughout DSM (Sadler, 2005). Similar if less explicit values are evident in the World Health Organisation's ICD (International Classification of Diseases, 1992/2003).

There has been much debate about how the presence of these values in psychiatric diagnostic classifications should be understood.[16] An early exponent of one side in this debate was the psychiatrist, Thomas Szasz, who famously dismissed mental disorders as a 'myth' on the grounds that they were defined by what he called 'psychosocial, ethical and legal norms' (Szasz, p. 114) rather than what he took to be the value-free norms of anatomy and physiology. One of Szasz' opponents, on the other hand, the psychiatrist and epidemiologist, Robert Kendell (1975), was among the first to argue that psychiatric diagnostic values were a sign, merely, of the underdeveloped status of psychiatric science that with future progress in the field would disappear. With a fully developed science of mental disorders, Kendell and others argued, psychiatric diagnostic classifications would end up looking no different from their counterparts for bodily disorders (ie value free).

Variations on the theme of these two positions have been adopted in the extensive (and unresolved) debate that has continued over subsequent decades. There is though a third and entirely different way of understanding the prominence of diagnostic values in mental health suggested by the work of RM Hare and others working in the analytic tradition of value philosophy. As noted above this tradition is foundational to contemporary values-based practice (see also footnote 16) and it was indeed Hare's 'third way' that led to the early development of values-based practice in mental health. The bottom line of this third way can be summed up in the aphorism that 'visible values = diverse values'. Values that is to say become visible (we notice them) when they are diverse and hence come to our notice because they cause trouble[17]. Values can be thought of in this respect as being like the air we breathe - they are around us all the time and essential but we notice them only when they cause difficulties.

This third way of understanding the significance of psychiatric diagnostic values - that 'visible values = diverse values' - is not specific to medicine but rather applies across the board to values of all kinds. Hare for example compared 'good strawberries' with 'good pictures' in his original work on the logic of values (Hare, 1952). Although he later went on to develop his ideas in medical ethics, at this stage in his career Hare was not directly interested in applying his ideas in particular contexts. His strategy was rather to determine the formal features of value terms thus developing a general logic that could be applied to any case framed in the language of values. I had the good fortune to be taught by Hare as one of my DPhil supervisors towards the end of this formal phase in the development of his work. This gave me the opportunity to apply his ideas and the ideas of my other supervisors (GJ Warnock and Mary Warnock) to the language of medicine in my *Moral Theory and Medical Practice* (1989). It was in this book that I pointed out the parallels between Hare's examples of 'visible values = diverse values' and the corresponding features of 'mental disorders' (more overtly value-laden) and 'bodily disorders' (less overtly value-laden).

16 The argument presented in summary form here is based on the theoretical work in analytic philosophy of values that as noted above underpins values-based practice (see in particular Fulford, 1989). Within philosophy of medicine there is considerable and on-going debate whether diagnostic concepts are or can be defined value-free – see Bortolotti, 2013) for a helpful review. This debate turns on the wider 'is-ought' debate in philosophy running back to the eighteenth century Scottish Enlightenment philosopher, David Hume's dictum 'no ought from an is' (Hume, 1972). Values-based practice is based on contemporary versions of this dictum as in the work for example of the Oxford philosophers, RM Hare (1952) and GJ Warnock (1971), and the American philosopher, Hilary Putnam (2002).

17 Diverse values 'cause trouble' because they are individually complex to deal with and (often) collectively conflicting.

5.1 Psychiatric diagnostic values as a signal of the challenges of values pluralism across mental disorders as a whole

As already noted there is on-going debate about the status of psychiatric diagnostic values. But Hare's third way of understanding them, besides being (at the very least) no less rigorous than any other way of understanding them, offers a number of *prima facie* advantages when it comes to practice. First, it puts mental health issues on an equal footing with their counterparts in bodily medicine: If 'visible values = diverse values' then diagnostic values are present in bodily medicine as they are in mental health, the difference being that they are remain largely invisible in bodily because they are largely unproblematic. Second, this leaves open the option of accruing to mental health the benefits of biology-based scientific medicine: there being no differences of principle between them there is no reason to exclude mental health from medical science as Szasz would have excluded it (as a myth). Which is not to say that the implementation of biological science in mental health should follow slavishly its implementation in bodily medicine: no more should the implementation of quantum mechanics follow slavishly the implementation of hydromechanics. Third, and most significantly, Hare's third way reverses the expectation of Kendell and others that with future advances in medical science and technology mental health will come increasingly to look like bodily medicine in being value free. The 'visible values = diverse values' way of understanding diagnostic values suggests to the contrary that with such advances bodily medicine will come increasingly to *look like mental health in being overtly value laden*. This is because the practical impact of advances in medical science and technology is to widen the choices available to stakeholders thus bringing an increasingly diverse range of values into play[18].

Again, these implications of the third way of understanding the significance of psychiatric diagnostic values are nothing to do with the particular contingencies presented by this or that particular area of medicine, bodily or indeed mental. The implications are analytic. They are a consequence of the very logic of values.

Being derived in this way from the formal properties of value terms rather than the contingencies of this or that particular situation makes these implications heuristically helpful at a number of levels. This is why they are embodied in the three principles of values-based practice defining its relationship with evidence-based practice (see Table 2 above). Given their grounding in the logic of values, the three principles apply across the board in healthcare. They apply equally in surgery as in psychiatry. True, in the current state of the development of medical science the practical impact of these principles is felt more urgently in psychiatry. This is why as noted earlier values-based practice was developed first in psychiatry: it was in psychiatry that the diversity of human values impacting on health care decision-making was (and remains) most challenging for practice. But, to come to a second implication, this is not because of any deficiency in psychiatric science. It is because the challenges of values pluralism are greater in psychiatry than in most areas of bodily medicine. Thus, where surgery is concerned (at least in Mrs Jones' case) with areas of human experience and behaviour (such as pain and mobility) where our values are largely shared, psychiatry is concerned with areas of human experience and behaviour (such as emotion, desire, volition, belief and the like) where human values are highly diverse. It is for this reason then, to come to a third implication – it is because of the

18 The impact of advances in medical science in increasing the diversity of values in play in bodily medicine is evident for example in the ever more challenging ethical and other values issues arising in areas of rapid technological advance such as infertility treatment and genetic medicine.

greater challenges of values pluralism arising from the diversity of human values impacting on psychiatry - that values-based practice has turned out to be harder to implement in psychiatry than in surgery.

To repeat, all this follows not from anything inherent in the sciences respectively of mental and of bodily health, but from the logic of values, specifically Hare's observation that 'visible values = diverse values'. This is why consistently with Hare's argument the visibility of values in psychiatric diagnostic classification is a signal that the challenges of values pluralism illustrated by Anna's story in Secton3 are not confined to anorexia but a feature of mental disorders as a whole. No advance in neuroscience can forestall these challenges. Such advances according to the implications of Hare's observation will make them still more challenging. The challenges therefor must be addressed from the resources of the value theory underpinning values-based practice.

5.2 Responding to the challenges of values pluralism across mental disorders as a whole

An essential starting point for any response to the challenges of values pluralism presented by mental disorders is the recognition that these challenges are themselves highly diverse. The challenges vary widely across mental health issues. The challenges in anorexia are different from those presented for example by the differentiation of psychosis from religious experience (Jackson and Fulford, 1997); these challenges are different from those presented by affective disorders such as depression (Fulford, Crepaz-Keay and Stanghellini, forthcoming); the challenges of values pluralism are different again in voice hearing (Austin and Hopfenbeck, forthcoming); and so on. To these differences between groups furthermore must be added an even greater diversity of individual differences within each group.

Exactly how the resources of philosophical value theory can be harnessed in response to the challenges of pluralism presented by mental disorders will thus vary with the challenges in question. But a broad strategy for how this might be done is suggested by the approach developed by Stanghellini and set out in summary form in Section 3 in relation to anorexia. This strategy as we will see depends critically on the state of the art of contemporary philosophy and psychiatry as an international open society of ideas.

Stanghellini's approach as we saw in Section 3 was based on adding a depth dimension of phenomenological understanding to the analytic-philosophy-derived resources of the original model of values-based practice. This approach is impressive theoretically and significant practically. The theoretical significance of Stanghellini's approach is that it brings together two major philosophical traditions that had previously been separated into distinct (geographical and intellectual) traditions. Throughout much of the Twentieth Century the Anglo-American tradition of analytic philosophy and 'Continental' phenomenology had little contact one with the other.

There was no barrier of principle involved here. JL Austin (from whose work in the ordinary language tradition of Oxford analytic philosophy values-based practice is ultimately derived, once described his approach as 'a kind of linguistic phenomenology' (cited by Warnock, 1989, p25). There has indeed been something of a truce between the two traditions in the Twenty-first Century. Stanghellini's theoretical work in phenomenological psychopathology has made a significant contribution to building brides between the two traditions (Stanghellini and Fulford, forthcoming). The practical implications of his work, though, as summarised in Section 3, have been equally important to this bridge building. There has been similar bridge building between phenomenology and neuroscience (see below). There are other clinical

initiatives underway[19]. But Stanghellini's approach has led the way with translational research drawing on rigorous phenomenological theory to deliver potentially significant improvements in clinical care. As described in Section 3 an important further feature of the practical implications of Stanghellini's work on anorexia is that its potential clinical applications are fully open to empirical test[20].

All of which suggests that generalising from Stanghellini's approach offers a promising strategy for responding to the variety of challenges of values pluralism presented by mental disorders as a whole. Such generalisation, reflecting the variety of these challenges noted above, may proceed in a number of ways and at a number of levels. First, phenomenology itself offers many further resources (Stanghellini and Fulford, forthcoming). These resources as represented by different traditions of thought and practice from around the world are readily accessible from within the internationally distributed community of philosophy and psychiatry. The Oxford based philosopher, Katherine Morris, for example, has applied Sartre's phenomenology of the body to dysmorphophobia (Morris, 2003); a number of neuroscience programs – for example with Joseph Parnas in Denmark, Thomas Fuchs in Germany, and Matthew Broome in the UK - draw in part but importantly on phenomenology. Continental philosophy as a whole furthermore offers still further resources: the Dutch philosopher and clinician team, for example, respectively Widdershoven and Widdershoven-Heerding (2003) have used hermeneutics in their work on resolving conflicts on mental health wards. In Dutch philosophy and psychiatry furthermore, Gerrit Glas, has drawn attention to the untapped potential for improved clinical care from distinctively Dutch philosophical insights into the relationship between mind and brain – these have remained inaccessible largely because it has never been translated into English (Glas, 2003). To all the other challenges of responding to the values pluralism of mental health must be added the challenges of translation.

Anglo-American Analytic and Continental philosophy as a whole, furthermore, represent only about a quarter of the great traditions of thought and practice available from around the world. This is where the open society represented by contemporary philosophy and psychiatry comes fully into play. The resources indeed of the open society of contemporary philosophy and psychiatry are already making an impact in enriching the model of values-based practice. First in the field to recognise this was the Mandela Professor of Philosophy and Psychiatry at Pretoria Medical School in South Africa, Werdie van Staden. Van Staden as noted above hosted the official launch of the International Network for Philosophy and Psychiatry from Cape Town in 2002. Since then he has gone on to draw on the resources of African philosophy in developing what he has called *Batho Pele* or *African VBP* (van Staden and Fulford, 2015). Batho Pele in van Staden's model draws on African traditions of thought and practice that in effect dissolve the division between the individual and collective in values-based practice. Like Stanghellini, van Staden has followed through on the practical implications of Batho Pele, in his case for policy as well as clinical work in mental health. Other African resources include its highly developed tradition of narrative understanding and its role in mental health. Examples from other parts of the world include Balkan cultural pluralism, Dharma therapy based on Buddhist philosophy (refxx), and the xx of Islamic medicine[21].

19 For example in Poland and in Brazil.

20 As noted in Section 3 Stanghellini and his colleagues are currently involved in a program of empirical research testing their model in anorexia and other disorders of eating and feeding.

21 These and many other examples are all in Stoyanoff *et al.* (forthcoming).

6. Conclusions

This article has given an overview of the state of the art of contemporary interdisciplinary work between philosophy and psychiatry. *Section 1* of the article described how the field has brought together a wide range of ideas about mental health from around the world producing what now amounts to a collegial international open society of ideas. *Section 2* introduced a philosophy-into-practice initiative that has developed out of a particular strand of work within the new field concerned with analytic philosophy of values, called values-based practice. As its name implies, values-based practice works as a partner to evidence-based practice. Together they support shared decision-making between clinician and patient as the basis of best practice in person-centred clinical care. Although developed first in mental health, values-based practice is now being deployed particularly in areas of bodily medicine such as surgery. *Section 3* explored through the story of 'Anna' the challenges to implementing values-based in mental health as illustrated by anorexia. This showed the challenges to be essentially challenges of values pluralism. The section described how work in phenomenology has provided insights into the values of people with anorexia that form the basis for an effective response to the challenges of values pluralism presented by this condition. Finally, *Section 4* generalized the argument of Section 3, showing, first, that a wider range of challenges of values pluralism arises across the board in mental health, and, second, that the resources for responding to this wider range of challenges are available from the international open society of ideas represented by the current state of the art of contemporary philosophy and psychiatry.

An Ariadnean golden thread running through the article has been the complementary relationship between philosophy (specifically philosophy of values) and science as resources for mental health practice. I conclude with a brief note on each of the two strands in this thread, a promissory note on values and a cautionary note on science.

6.1 A promissory note on values

As to values, there is still more to say about the importance for practice of the international open society of ideas of contemporary philosophy and psychiatry. I am grateful to the editors of this special issue for the generous word length they have allowed me. Even so I have had to limit myself to what might be described as the 'low hanging fruit' available from the new field of international philosophy and psychiatry. The resources of the new field – from phenomenology, from African philosophy, from Balkan cultural values, from Buddhism, and so forth – are in the terms of this metaphor, hanging there waiting to be assimilated into an enriched model of values-based practice fit for purpose in its role of supporting shared decision-making in mental health. This is important. As the basis for best practice in person-centred clinical care, shared decision-making is as I have indicated of particular significance in mental health in being crucial to contemporary understandings of recovery.

There is though a whole second side to the importance of the international open society of ideas for mental health practice. Just as the open society has a role in supporting best practice in mental health, so it has an equally important role in preventing bad practice. To spell out fully why this is so would require a second article of similar length to this one. The story line of the article would start from the long (and continuing) history of abuses of psychiatry for purposes of political or social control; it would set out evidence of the role of unacknowledged values in making psychiatry particularly vulnerable to abuses of this kind; it would cite a leading campaigner against these abuses on the need for an international open society of ideas to counter them; it would indicate how contemporary philosophy and psychiatry could fill this role not (directly) by way of the resources it offers but through an enhanced empathic engagement across and between the diverse perspectives of its component members; it would

show that developing this enhanced empathic engagement will require further development of the skills base of values-based practice aimed at raising awareness of values; and it would illustrate the role of philosophy in supporting this further development through the work of the Swedish philosopher (and Theory Lead for the Collaborating Centre in Oxford), Anna Bergqvist, on the nature of empathy as an open ended dialogue between perspectives (Bergqvist, forthcoming)[22].

The vulnerability of psychiatry to abuse is of particular concern in the UK at the present time with continuing disproportionate use of involuntary psychiatric treatment in particular ethnic groups and epidemiological evidence that the extent of this disproportion follows administrative boundaries (Weich *et al.*, 2014). There is though no adequate short cut to the above story line. Which is why, for now, any more detailed comments on the role of the international open society of ideas in preventing bad practice must remain no more than a promissory note.

6.2 A cautionary note on science

As has been emphasised, values-based practice, in conception and in realisation, is a partner to the sciences as represented by evidence-based practice. It is through this partnership model that shared decision-making has become the basis for successful translation of research into improvements in clinical care in areas of bodily medicine such a surgery (witness the story of Mrs Jones' Knee in Section 2). One conclusion therefor that might be drawn from the arguments presented in this article, is that current concerns about the corresponding *failures* of the neurosciences to translate into improvements in clinical care, may have less to do with the science side of shared decision-making and more to do with its values-side.

This conclusion would not sit easily with those concerned. True, the concerns about translation have come (inter alia) from within the neuroscience community itself. Thomas Insel, for example, in his time as Director of the world's largest neuroscience research funder, the USA-based National Institute for Mental Health, launched a wholly new framework for psychiatric research (the RDoC framework) motivated by these concerns about translation: 'patients', he said in a blog announcing RDoC, 'deserve better.' (Insel, 2014; also Cuthbert, 2014). Some years earlier, three leaders of the neuroscience research community within psychiatry, David Kupfer, Michael First and Daryl Regier, made essentially the same point in the introduction to their *Agenda for DSM-5*. They, like Insel, called for a new scientific paradigm (Kupfer, First and Regier, 2002, p. xix).

Even in their own terms however such calls should not perhaps be grounds for optimism. As one of the founders of quantum mechanics, no less, Max Planck, quipped in his intellectual autobiography, 'new sciences aren't born, old scientists die!' (Planck, 1950, p. 33) And it is after all nothing less than a new medical science with which this article has been concerned. The medical science of the Twentieth Century was based on a 'doctor decides' model of translating research into practice. Again, there was nothing wrong with this in its day. In Insel's terms, it delivered great results for patients. But the medical science of the Twenty-first Century is based on a 'shared decision-making' model in which evidence from generalized science is brought together

22 The further article anticipated above in this paragraph is now forthcoming in a Special Issue (edited by Louis Sass] of the Polish journal *EIDOS* celebrating the 2019 INPP conference in Warsaw, as Fulford, KWM., King, C., and Bergqvist, A., *Hall of Mirrors: how an international open society of mental health stakeholders can help to overcome values auto-blindness thus reducing the vulnerability of psychiatry to abuse.*

with the unique values of individual people. The delivery of this Twenty-first Century model in bodily medicine (as illustrated for surgery in this article by the story of Mrs Jones' Knee) is relatively straightforward. Its delivery in mental health is considerably more challenging. The challenges are indeed partly scientific. The brain after all is a more difficult organ to study than the knee. But as Anna's story in Section 3, and the wider considerations of Section 4, together indicated, the challenges in mental health are also challenges of values pluralism.

The international open society of ideas that I have argued is the state of the art of contemporary philosophy and psychiatry offers in principle the resources needed for responding to the challenges of values pluralism inherent in the shared decision-making that is at the heart of best practice in Twenty-first Century mental health care. But in moving from principle to practice, from theory to implementation, we should be mindful of Max Plank's caution that we may have to wait for old scientists to die.

REFERENCES

American Psychiatric Association (2013) *Diagnostic and Statistical Manual of Mental Disorders* (fifth edition, DSM-5). Washington, DC: American Psychiatric Association;

Austin R., and Hopfenbeck M., (Eds) (forthcoming, 2020) *The Practical Handbook of Hearing Voices*. PCCS Books;

Bergqvist A., (forthcoming) *The Phenomenology of Mutual Trust in Self-Ownership: Reassessing Hope in Recovery, for Special Issue of Philosophical Psychology* (ed. Franz Knappik and Nivedita Gangopadhyay) on 'The Phenomenology of Joint Action: Structure, Mechanisms and Functions';

Bortolotti L. (2013) *Rationality and Sanity: the Role of Rationality Judgements in Understanding Psychiatric Disorders*. Chapter 30, pp. 480-496 in Fulford, K.W.M., Davies, M., Gipps, R., Graham, G., Sadler, J., Stanghellini, G., and Thornton, T. (Eds). *The Oxford Handbook of Philosophy and Psychiatry*. Oxford: Oxford University Press;

Cuthbert B. N. (2014) The RDoC framework: facilitating transition from ICD/DSM to dimensional approaches that integrate neuroscience and psychopathology. *World Psychiatry*. 13(1): pp. 28-35;

Fulford K. W. M. (1989, reprinted 1995 and 1999) *Moral Theory and Medical Practice*. Cambridge: Cambridge University Press;

Fulford K. W. M., Morris K. J., Sadler J. Z. and Stanghellini G. (2003) *Past Improbable, Future Possible: the renaissance in philosophy and psychiatry*. Chapter 1 (pps 1-41) in Fulford K. W. M., Morris K. J., Sadler J. Z. and Stanghellini G. (eds.) *Nature and Narrative: an Introduction to the New Philosophy of Psychiatry*. Oxford: Oxford University Press;

Fulford K. W. M. and Sartorius N. (2009), *A Secret History of ICD and the Hidden Future of DSM*. Chapter 2, pp. 29-48, in Broome M. and Bortolotti L. (eds) *Psychiatry as Cognitive Neuroscience: Philosophical Perspectives*. Oxford: Oxford University Press;

Fulford K. W. M., Peile E. and Carroll H. (2012) *Essential Values-based Practice: clinical stories linking science with people*. Cambridge: Cambridge University Press;

Fulford K. W. M., Davies M., Gipps R., Graham G., Sadler J., Stanghellini G. and Thornton T. (2013). *The Oxford Handbook of Philosophy and Psychiatry*. Oxford: Oxford University Press;

Fulford K. W. M., Duhig L., Hankin J., Hicks J. and Keeble J. (2015a) *Values-based Assessment in Mental Health: The 3 Keys to a Shared Approach between Service Users and Service Providers*. Ch 73, in Sadler J. Z., van Staden W., and Fulford K. W. M., (Eds) *The Oxford Handbook of Psychiatric Ethics*. Oxford: Oxford University Press;

Fulford K. W. M., Dewey S. and King M. (2015b) *Values-based Involuntary Seclusion and Treatment: Value Pluralism and the UK's Mental Health Act 2007*. Ch 60, in Sadler J. Z., van Staden W. and Fulford K. W. M., (Eds) *The Oxford Handbook of Psychiatric Ethics*. Oxford: Oxford University Press;

General Medical Council (2008) *Consent: patients and doctors making decisions together*. London: General Medical Council;
Fulford K. W. M., Crepaz-Keay D. and Stanghellini G. (forthcoming);
Depressions Plural: Pathology and the Challenge of Values, in Foster, C., and Herring, J. (eds) *Depression and the Law*, Oxford: Oxford University Press;
Glas G. (2003) *Anxiety - animal reactions and the embodiment of meaning*. Chapter 15 in Fulford K. W. M., Morris K. J., Sadler J. Z. and Stanghellini G. (eds.) *Nature and Narrative: An Introduction to the New Philosophy of Psychiatry*. Oxford: Oxford University Press;
Hare R. M. (1952) *The language of morals*. Oxford: Oxford University Press;
Handa I. A., Fulford-Smith L., Barber Z. E., Dobbs T. D., Fulford K. W. M. and Peile E. (2016) *The importance of seeing things from someone else's point of view. BMJ Careers on-line journal* (published in hard copy as 'Learning to Talk about Values') http://careers.bmj.com/careers/advice/The_importance_of_seeing_things_from_someone_else's_point_of_view;
Herring J., Fulford K. W. M., Dunn D, and Handa A. (2017) *Elbow room for best practice? Montgomery, patients' values, and balanced decision-making in person-centred care. Medical Law Review,* Volume 25, Issue 4, Autumn 2017, Pages 582–603, https://doi.org/10.1093/medlaw/fwx029;
From 19.07.17: available on advice view online https://academic.oup.com/medlaw/advance-articles;
Hume D. (1972) *A Treatise of Human Nature*. Books II and III. Edited by Pall. S. Ardal. London: Fontana/Collins; [The is/ought debate 'no ought from an is' comes at the end of book III, section I pp. 202-204 in this edition];
Insel TR. (2014) *Transforming diagnosis*. www.nimh.nih.gov;
Jackson M. and Fulford K. W. M. (1997) Spiritual Experience and Psychopathology. *Philosophy, Psychiatry, and Psychology,* 4: pp. 41-66. Commentaries by Littlewood, R., Lu, F. G. *et al*, Sims, A. and Storr, A., and response by authors, pp. 67-90;
Jaspers K., (1913) *Allgemeine Psychopathologie.* Berlin, Springer-Verlag. (trans. J. Hoenig, and M.W. Hamilton (1963) *General Psychopathology*. Chicago: University of Chicago Press. New edition (two volumes, paperback), with a Foreword by Paul R McHugh, (1997) Baltimore: The Johns Hopkins University Press;
Kendell R. E. (1975) The concept of disease and its implications for psychiatry, *British Journal of Psychiatry*, 127, pp. 305-315;
Kupfer D. J., First, M. B. and Regier, D. E. (2002) Introduction. pp. xv-xxiii In Kupfer, D.J., First, M.B. and Regier, D. E. (eds) *A Research Agenda for DSM-V*. Washington: American Psychiatric Association;
Morris K. J. (2003) The phenomenology of body dysmorphic disorder: a Sartrean analysis. Chapter 11 in Fulford K. W. M., Morris K. J., Sadler J. Z. and Stanghellini G. (eds.) *Nature and Narrative: An Introduction to the New Philosophy of Psychiatry*. Oxford: Oxford University Press, pp. 270-274;
National Institute for Health and Care Excellence (2015/2017) *Suspected cancer: recognition and referral: NICE guideline NG12* (published date: June 2015. Last updated: July 2017);
See: https://www.nice.org.uk/guidance/ng12 [and scroll down the page to the statement 'Your Responsibility'];
Planck M. (1950) Trans. F. Gaynor. *Scientific Autobiography and other papers*. London: Williams & Norgate;
Putnam H. (2002) *The Collapse of the Fact/Value Dichotomy and other Essays*. Cambridge, Mass., and London, England: Harvard University Press;

Royal College of Psychiatrists (2016) *What really matters in children and young people's mental health, Report of the Values-based Child and Adolescent Mental Health System Commission*. London: The Royal College of Psychiatrists;
Available at the Royal College of Psychiatrists' website at: http://www.rcpsych.ac.uk/pdf/Values-based%20full%20report.pdf; or via the Collaborating Centre website at: valuesbasedpracice.org/More about VBP/full text downloads [CHECK 08.02.17];
Sadler J.Z. (2005) *Values and Psychiatric Diagnosis.* Oxford: Oxford University Press;
Sadler J.Z., van Staden W. and Fulford K.W.M., (Eds) (2015) *The Oxford Handbook of Psychiatric Ethics*. Oxford: Oxford University Press;
Slade M., Amering M., Farkas M., Hamilton B., O'Hagan M., Panther G., Perkins R., Shepherd G., Tse S., and Whitley R. (2014) Uses and Abuses of Recovery: Implementing Recovery-oriented practices in mental Health Systems. *World Psychiatry*, 13: 12-20;
Stanghellini G. and Fuchs T., (2013) (Eds) *One Century of Karl Jaspers' General Psychopathology*. Oxford: Oxford University Press;
Stanghellini G. and Mancini M., (2017) *The Therapeutic Interview in Mental Health: a Values-based and Person-centered Approach*. Cambridge: Cambridge University Press;
Stanghellini G., Broome M., Fernandez A.V., Fusar-Poli P., Raballo A. and Rosfort R. (Eds) (2019) *Oxford Handbook of Phenomenological Psychopathology*. Oxford, Oxford University Press;
Stanghellini G. and Fulford K. W. M. (Bill), (forthcoming) Values and Values-based Practice in Psychopathology: Combining Analytic and Phenomenological Approaches. For Moran, D., Cummins, F., Daly A., and Jardine J., (eds) *The Inhuman Gaze.* Routledge;
Stoyanoff D., *et al.*, (eds) (forthcoming) *International Perspectives in Values-based Mental Health Practice: Case Studies and Commentaries* (Springer);
Szasz T. S. (1960) The myth of mental illness. *American Psychologist*, 15: pp. 113-118;
van Staden W and Fulford K. W. M., (2015) The Indaba in African Values-based practice: respecting diversity of values without ethical relativism or individual liberalism. Ch 28, in Sadler J. Z., van Staden W. and Fulford K. W. M., Eds *The Oxford Handbook of Psychiatric Ethics.* Oxford: Oxford University Press;
Warnock G. J. (1971) *The Object of Morality*, Methuen & Co Ltd, London;
Warnock G. J. (1989) *J L Austin*, London: Routledge;
Weich S., McBride O., Twigg L., Keown P,. Cyhlarova E,. Crepaz-Keay D., Helen Parsons, Jan Scott and Kamaldeep Bhui (2014) Variation in compulsory psychiatric inpatient admission in England: a cross-sectional, multilevel analysis. *Health Services and Delivery Research*: Vol 2, No 49;
Widdershoven G. and Widdershoven-Heerding I. (2003) Understanding Dementia: a Hermeneutic Perspective. Chapter 6 in Fulford K. W. M., Morris K. J., Sadler J. Z. and Stanghellini G. (eds.) *Nature and Narrative: An Introduction to the New Philosophy of Psychiatry.* Oxford: Oxford University Press, pp.103-112;
Woodbridge K. and Fulford K. W. M. (2004) *'Whose Values?' A workbook for values-based practice in mental health care*. London: The Sainsbury Centre for Mental Health.
World Health Organization (1992, second edition 2003) *The ICD-10 Classification of Mental and Behavioural Disorders: Clinical Descriptions and Diagnostic Guidelines.* Geneva: World Health Organization.