CHAPTER 29

Histories of the future

There are three kinds of clinical complexity, empirical, valuational, and conceptual. Medicine has traditionally been concerned mainly with complexity of the first kind, with the empirical challenges of the major pathologies, such as infections, cancer, and heart disease. Partly as a result of its growing success in meeting these challenges, however, late twentieth century medicine was marked by the emergence, first of valuational complexity, in the form of bioethics, and then, in the closing decade of the century, of conceptual complexity, in the form of a blossoming of new work in the cross-disciplinary field of philosophy of psychiatry.

The continuities and discontinuities between the new philosophy of psychiatry and the histories of its two parent disciplines in the twentieth century, back to Karl Jaspers and psychiatry's first philosophical phase, are set out in the opening chapter of the launch volume in this series, *Nature and Narrative*. The statistics, as described there, continue to impress: over thirty new academic groups around the world; new courses and training programmes; new book series (in the Netherlands, Germany, and France, as well as Britain and America); annual international conferences, in addition to many national and subject-based meetings; expansion of the journal, *Philosophy, Psychiatry, & Psychology*; the establishment of infrastructure support, in the International Network for Philosophy and Psychiatry and key sections in both the World Psychiatric Association and Association of European Psychiatrists; and, perhaps most significant of all, philosophy based developments in policy, training, clinical practice, and research in mental health.

Precisely why the philosophy of psychiatry should have blossomed at exactly this time is a matter for future historians to debate. After all, as we have indicated at several points in this book, historically there has been no shortage of cross-disciplinary contact. For much of the nineteenth century, as we noted in Part II, philosophy was not sharply distinct from psychology or indeed the psychiatry of the day. A key figure at the birth of biological psychiatry, in the early twentieth century, was Karl Jaspers, as much a philosopher as a psychiatrist, his twin disciplines being clearly reflected in the requirement for meaningful understanding as well as causal explanations in his foundational work on psychopathology, *Allgemeine Psychopathologie*. Meanings are also central to psychoanalysis, a dominant model in several parts of the world at different periods in the twentieth century, and the focus of much philosophical enquiry, both analytic (generally critical) and Continental (generally supportive). Again, outside of Britain and North America, phenomenology flourished through much of the twentieth century as a branch of philosophy crucial to psychiatry. Continental philosophy was important also to the antipsychiatry movement of the 1960s and 1970s, many aspects of which, as we saw in Part I, have been assimilated in modern user-centred and multidisciplinary models of service delivery. Szasz and Laing's critiques of psychiatry were analytic philosophical critiques in all but name, challenging as they did the dominant *conceptual* structures within which mental distress and disorder were understood at the time. Among philosophers in the analytic tradition, there were occasional but repeated calls for engagement with psychiatry—J.L. Austin, Jonathan Glover, Anthony Quinton, Stephen Clark, and Kathleen Wilkes, for example, were all early in the field in this respect. And as we saw in Part III, the philosopher of science, Carl Hempel, made a crucial contribution to the development of modern symptom-based classifications of mental disorder.

Yet with hindsight it is perhaps not so surprising that the blossoming of new work in the philosophy of psychiatry should have started in the 1990s, heralded as this period was as the 'decade of the brain'. For one clear factor driving cross-disciplinary contact between philosophy and psychiatry has been the remarkable new technologies that began to emerge from the neurosciences at this time. As noted in Chapter 2, Nancy Andreasen is among leading figures in the neurosciences who have pointed to the ways in which functional neuroimaging, behavioural genetics, and brain prostheses (for Parkinsonism, for example, and depression), are pushing some of the deepest problems of philosophy to the top of the practical agenda of psychiatry: free will, personal identity, our knowledge of other minds, the structure of consciousness, the mind–body problem itself, are all now problems as much for the neurosciences and clinical psychiatry as for philosophy. And as we saw in Part V, this is an area of true partnership, an area in which psychopathology and the neurosciences have as much to teach philosophy as philosophy has to teach psychopathology and the neurosciences.

If the neurosciences have been one of the drivers of the new philosophy of psychiatry, however, equally important have been developments in our models of service delivery. The traditional doctor-led model is appropriate where the problems we face in health care are predominantly empirical in nature. As noted above, the major pathologies—infections, heart disease, cancer, and so forth—demand interventions that are guided primarily by the biological sciences. Even with such pathologies, of course, social and psychological factors may also be vitally important: public health measures, and high standards of nursing care, as much as antibiotics, are crucial to the control of infectious diseases, for example.

As we move, though, ever deeper into areas of health care in which valuational and conceptual, as well as empirical, problems become increasingly important practically, the dominant medical model must give way to more pluralistic approaches to service delivery. This is partly a matter of the need for a wider range of skills to meet the complex challenges of modern health care. Ethical and legal skills, for example, are increasingly crucial not only to setting policy and to dealing with 'hard cases', but in day-to-day clinical decision-making. It is also, though, and this is where philosophy comes in, a matter of matching services appropriately to the often very different needs and expectations of individual patients, informal carers and their communities.

Valuational complexity is important here. As we saw in Part IV, Values-Based Practice, derived from philosophical value theory,

and drawing on substantive work on values from both empirical and phenomenological research, is currently one of two underpinning sources (the other being evidence-based practice) for training in the generic skills for user-centred and multidisciplinary models of mental health service delivery in the UK. Similarly with conceptual complexity: Tony Colombo's 'philosophical fieldwork', in Austin's phrase, combining linguistic-analytic with empirical social science methods, provides, as we described in Parts I and IV, a powerful policy and training framework for collaborative, rather than competitive, multidisciplinary and multiagency models of service delivery. Continental philosophy, too, as we saw in Part II, provides important exemplars of philosophy-into-practice: these include Pat Bracken's work, for example, with Amnesty International, drawing on Heideggerian phenomenology as the basis of new approaches to helping people who have survived severe trauma; and Rom Harré and Stephen Sabat's use of discursive methods to support communication with people with Alzheimer's disease.

It is important to emphasize how deeply scientific advances and developments in policy and practice in mental health, are intertwined in the new philosophy of psychiatry. Science, and not least medical science, has had an increasingly bad press recently. Bioethics, responding to public anxieties, has thus tended to assume a role, as in research ethics committees, of policing the boundaries of medical science. The new philosophy of psychiatry, by contrast, is a partner to medical science. It is a partner in research—phenomenology, for example, concerned with the structure of consciousness, is a partner to the neurosciences, concerned with brain functioning; and it is a partner also in the applications of the results of research to clinical practice, as in the complementary roles of values-based and evidence-based approaches to clinical decision-making outlined in Part IV.

In the twentieth century, the prominence of valuational and conceptual complexity in mental health was taken by many in medicine to be the mark of a defective, or at any rate primitive, science, the assumption being that with advances in medical science the valuational and conceptual complexities of mental health would recede. As we saw in Part I, such assumptions were the basis of deeply stigmatizing attitudes equally to those who use mental health services and to those who provide them. However, in the physical sciences, as we noted in Part III, conceptual complexity, at least, is a mark not of a deficient science, still less of a primitive science, but of an *advanced* science, a science at the cutting edge—theoretical physics, no less, being a case in point. And in the human sciences (including medicine), as we found in Part IV, advances in science and technology, far from reducing valuational complexity, actually *increase* it. This is because advances in science and technology open up new choices in medicine, and with choices go values—reproductive medicine, our example in Part IV, is an area in which, through the new choices opened up by advances in assisted reproduction, the full diversity of human values is already becoming a major factor in clinical decision-making.

Contrary, therefore, to twentieth century expectations, twenty-first century medicine, if it is to be both science-based and patient-centred, will have to embrace (just as mental health embraced in the twentieth century) valuational and conceptual complexity as well as empirical complexity. In mental health, notwithstanding the late twentieth century blossoming of cross-disciplinary work with philosophy, there is always the danger that we will lapse back into the relative simplicity of one or other traditional model. Biological, psychoanalytic, social, and cognitive-behavioural models are all currently competing for dominance; and the history of mental disorder, as we saw in Part II, is very much a history of repeated collapses into one or another single-message mythology. The new philosophy of psychiatry, just in being open and inclusive, offers no guarantee against ideology. But the inevitable growth of valuational and conceptual complexity, driven by scientific and technological advances, in all areas of twenty-first century medicine, means that in engaging with the new philosophy of psychiatry we are helping to write the histories of the future not only of mental health but of twenty-first century health care as a whole.