Eidos 2 (4) 2018

A JOURNAL FOR
PHILOSOPHY
OF CULTURE

DOI: 10.26319/4722

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Cultural Values and Mental Health: A Manifesto for International Values-based Practice

Abstract:
This article sets out a manifesto for the development of an international values-based practice fully engaged with the diversity of cultural values and implemented through the resources of the international movement in philosophy and psychiatry. Anticipated by mid-twentieth century ordinary language philosophy of the "Oxford School," the last three decades have witnessed a remarkable flowering of cross-disciplinary work between philosophy and psychiatry. The article indicates the scope and scale of this work and then describes the emergence of contemporary values-based practice as its philosophy-into-practice cutting edge. Values-based practice although originating in philosophy and psychiatry is currently being developed mainly in areas of bodily medicine such as surgery. As such, it has been criticized for focusing, as contemporary health care has largely focused, on the individual at the expense of cultural values. Hence arises the need for extending values-based practice internationally. The resources available from international philosophy and psychiatry for so extending values-based practice are outlined and some of the challenges are indicated. The article concludes with the hope that psychiatry in supporting the development of international values-based practice will by the same token take poll position in the development of contemporary science-led clinical care.

Keywords:
health care, philosophy, philosophy and psychiatry, ordinary language philosophy, science, psychiatry, values, values-based practice

It is only in recent years and still only through somewhat gritted teeth that psychiatry has recognized the importance of culture. Similarly, it is only in recent years, and only through gritted teeth, that psychiatry has recognized the importance of values. Both concepts – culture and values – continue to be perceived negatively by many in psychiatry as undermining the status of their discipline as an objective medical science. Small wonder then that the composite "cultural values" has received little attention. In contrast to these negative perceptions, this article argues that engaging with cultural values, properly understood through the lens of values-based practice, and effectively implemented through the resources of the international movement in philosophy and psychiatry, far from prejudicing the scientific status of psychiatry, would place it at the leading edge of contemporary science-led clinical care.

The article is split into three main sections. Section I looks at the links between contemporary international philosophy and psychiatry and ordinary language analytic philosophy of the "Oxford School." Section II introduces values-based practice and traces its origins by way of contemporary philosophy and psychiatry to ordinary language philosophy. As the section describes, values-based practice, although developing strongly across a range of clinical areas, including surgery, remains subject to a number of challenges. Key among these challenges is its focus on individual rather than cultural values. Section III sets out a manifesto for the development of a future more culturally attuned form of values-based practice implemented through the resources of international philosophy and psychiatry. Finally, in a brief concluding section, the opportunities offered by this manifesto indicate psychiatry should take a poll position as a lead discipline in the development of contemporary science-led clinical care.

I. International Philosophy and Psychiatry

The current dramatic expansion of interdisciplinary work between philosophy and psychiatry dates from the early 1990s.[1] Yet nearly thirty years earlier, in 1956, Oxford's then Wight's Professor, John Langshaw Austin, had pointed to the potential for partnership between the two disciplines.[2]

Austin was a leading figure in the development of what was to become known as ordinary language philosophy (or sometimes as "the Oxford School"). Ordinary language philosophy is about "ordinary language" in the sense that it focuses on our everyday non-reflective uses of language.[3] This focus makes it a natural partner to practical disciplines like psychiatry.[4] Importantly, the partnership is two-way: ordinary language philosophy informs practice and practice provides a resource for ordinary language philosophy. Recognizing the importance of this two-way partnership, Austin argued for teamwork between philosophers and non-philosophers;[5] and he picked out psychiatry in particular as a potentially fruitful target area for philosophical enquiry: "there is," he said, in characteristically aphoristic style, "gold in them thar (psychopathological) hills."[6]

Austin died relatively young and before he could follow through on his agenda for partnership with practice. But in advancing this agenda he anticipated contemporary developments in philosophy and psychiatry.

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1) K.W.M. Fulford et al., eds., *Nature and Narrative: An Introduction to the New Philosophy of Psychiatry* (Oxford: Oxford University Press, 2003).

2) J. L. Austin, "A Plea for Excuses," *Proceedings of the Aristotelian Society* 57 (1956–1957). Reprinted in: Alan R. White, *The Philosophy of Action* (Oxford: Oxford University Press, 1968), 19–42.

3) Geoffrey J. Warnock, *J.L. Austin* (London: Routledge, 1989).

4) K.W.M. Fulford, "Philosophy and Medicine: The Oxford Connection," *British Journal of Psychiatry* 157, no. 1 (1990): 111–115.

5) See: Warnock, *J.L. Austin*.

6) See: Austin, "A Plea for Excuses," 24.

Joint work between philosophy and psychiatry is of course not new. The early twentieth century psychiatrist, Karl Jaspers, for example, in a clear parallel with contemporary developments, was also an internationally recognized philosopher: and his foundational *General Psychopathology,*[7] although written over a century ago, remains a testament to the heuristic value of bringing together philosophy and psychiatry.[8] Karl Jaspers, too, in a further parallel with contemporary developments, was working at a time, and partly in response to, rapid advances in the neurosciences.[9]

The parallels between Jaspers work in philosophy and psychiatry at the start of the twentieth century and contemporary twenty-first century developments are important. Among other consequences they show that philosophy, far from being made redundant by scientific advances, is brought by them more fully into play. At the start of the twentieth century, when Jaspers was working in philosophy and psychiatry, the neurosciences of the day were bacteriology and differential staining techniques. At the start of the twenty-first century, brain imaging and genetics are the corresponding technologies driving progress. But the principle, as no less a present-day champion of the neurosciences than Nancy Andreasen has argued,[10] is the same.

Contemporary philosophy and psychiatry, however, if no different in principle from its counterpart a century ago, is distinctive both in scale and in scope. As to scale, Jaspers worked largely in isolation and, indeed, for much of his life, apart from updating *General Psychopathology*, he moved away from psychiatry altogether (he became Professor of Philosophy at Heidelberg University). Contemporary developments in philosophy and psychiatry by contrast represent the outputs from an extended international community of researchers from both sides of the discipline.

Contemporary philosophy and psychiatry, moreover, although launched over thirty years ago, shows no sign of following Jaspers in running out of steam. Among other marks of the growing international reach of the discipline, the quarterly international journal, *Philosophy, Psychiatry & Psychology*, is in its twenty-sixth year;[11]the Oxford University Press book series, *International Perspectives in Philosophy and Psychiatry*, now comprises well over fifty volumes, including, in a new joint project with philosophy, a sub-series of major Handbooks;[12] and the annual meetings of the *International Network for Philosophy and Psychiatry,* have now, with this year's conference in Hong Kong, been held in every major continent of the world.[13] Academically, too, the subject has

7) Karl Jaspers, *Allgemeine Psychopathologie* (Berlin: Springer-Verlag, 1913). Karl Jaspers, *General Psychopathology*, trans. J. Hoenig and Marian W. Hamilton (Chicago: University of Chicago Press, 1963). Karl Jaspers and Paul R. McHugh, *General Psychopathology*, trans. J. Hoenig and Marion W. Hamilton, vol. 1–2 (Baltimore, MD: Johns Hopkins University Press, 1997).

8) Giovanni Stanghellini and Thomas Fuchs, eds., *One Century of Karl Jaspers' General Psychopathology* (Oxford: Oxford University Press, 2013).

9) Mario Maj, "Introduction: the Relevance of Karl Jaspers' General Psychopathology to Current Psychiatric Debate," in *One Century of Karl Jaspers' General Psychopathology*, xxiv–xxviii.

10) Nancy C. Andreasen, *Brave New Brain: Conquering Mental Illness in the Era of the Genome* (Oxford: Oxford University Press, 2001); also, Nancy C. Andreasen, "DSM and the Death of Phenomenology in America: An Example of Unintended Consequences," *Schizophrenia Bulletin* 33, no. 1 (2007).

11) See *Philosophy, Psychiatry and Psychology* at: http://www.press.jhu.edu/journals/philosophy_psychiatry_and_psychology/.

12) See *International Perspectives in Philosophy and Psychiatry* at*:*
http://ukcatalogue.oup.com/category/academic/series/medicine/ippp.do.

13) See: *International Network for Philosophy and Psychiatry at:* http://inpponline.com.

shown continued growth: there are a number of teaching programs at the MA and PhD levels;[14] Europe has several professors of philosophy and psychiatry; Africa has the first non-European Chair (Werdie van Staden is the Nelson-Mandela Professor at Pretoria University); and Oxford philosophy has a recently endowed tutorial fellowship for the field (Philip Koralus at St. Catherine's College is the first holder of the fellowship).

As to the scope of contemporary philosophy and psychiatry, where Jaspers worked mainly in phenomenology, contemporary developments, while including phenomenology, have extended to no less than five main areas – philosophy of mind, philosophy of science, history of ideas, conceptual analysis, and philosophical value theory.[15] There have been in addition significant individual contributions from many other fields: Philip Koralus, for example, at St. Catherine's College, works in semantic logic.[16]

These developments of course go well beyond the ordinary-language focus of the original "Oxford School." Austin, again, anticipated this. He was ever at pains to emphasize that ordinary language philosophy should be understood only as a s t a r t i n g p o i n t for philosophical enquiry. "Ordinary language philosophy," he argued, is "sometimes the first word, never the last"[17]; and, at greater length, perhaps prompted by persistent misreading of ordinary language as some kind of philosophical panacea: ordinary language philosophy "is s o m e t h i n g about o n e w a y of p o s s i b l y doing o n e p a r t of philosophy" (reported by Austin's literary executor, Geoffrey Warnock, from one of Austin's Saturday morning seminars).[18]

Ordinary language philosophy has certainly given us an effective first word in contemporary philosophy and psychiatry. With values-based practice, it has done more than this. With values-based practice, ordinary language philosophy has delivered substantive outcomes.

II. Values-Based Practice

Values-based practice is a new skills-based approach to working with values in healthcare.[19] As its name implies, values-based practice is a partner to evidence-based practice. Both are clinical support tools. As such, neither offers ready-made answers. Instead, both provide processes that support decision-makers in finding answers for themselves in the particular circumstances presented by a given clinical situation. Evidence-based practice provides a process that supports clinical decision-making where the e v i d e n c e in play is complex and/or conflicting. Values-based practice provides a different though complementary process that supports clinical decision-making where the v a l u e s in play are complex and/or conflicting.

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14) Examples include: 1) A Masters available by local teaching and/or distance learning is available at University of Pretoria, South Africa: see *MPhil in Philosophy & Ethics of Mental Health*: www.up.ac.za/pemh. Pretoria also offers a PhD program. 2) A Masters by distance learning is available at the University of Central Lancashire, UK: see http://www.uclan.ac.uk/information/courses/ma_pgdip_pgcert_philosophy_and_mental_health.php. 3) Biennial Oxford Summer Schools on *Philosophy and Psychiatry: Mind, Values and Mental Health*. See: https://www.conted.ox.ac.uk/courses/details.

15) K.W.M Fulford, Tim Thornton, and George Graham, "Chapter 1: Progress in Five Parts," in *Oxford Textbook of Philosophy and Psychiatry* (Oxford: Oxford University Press, 2006).

16) Philipp Koralus and Salvador Mascarenhas, "The Erotetic Theory Of Reasoning: Bridges Between Formal Semantics And The Psychology Of Deductive Inference*," *Philosophical Perspectives* 27, no. 1 (December 2013). Available online at: http://onlinelibrary.wiley.com/doi/10.1111/phpe.12029/abstract.

See, also: Matthew Parrott and Philipp Koralus, "The Erotetic Theory of Delusional Thinking," *Cognitive Neuropsychiatry* 20, no. 5 (2015).

17) For more, see: Warnock, *J.L. Austin*, 1–8 [chapter 1].

18) See Ibid., 6. My emphases added.

19) K. W. M. Fulford, Ed Peile, and Heidi Carroll, *Essential Values-Based Practice: Clinical Stories Linking Science with People* (Cambridge: Cambridge University Press, 2012).

Figure 1: A Flow Diagram of Values-based Practice

Premise of Mutual Respect for Differences of Values		
Ten Key Process Elements • 4 Clinical Skills • 2 Aspects of the model of service delivery • 3 Strong links between VBP and EBP • Partnership in decision-making	Together these support	Balanced dissensual decisions made within frameworks of shared values

The process of values-based is shown diagrammatically in Figure 1. The left-hand side of the figure lists the process elements of values-based practice. The right-hand side shows how these process elements together support the outputs of values-based practice in balanced decisions within locally agreed frameworks of shared values. The underpinning premise of values-based practice, represented in Figure 1 as a headline banner running across both process and outcomes, is mutual respect.

Table 1: Brief Definitions of the Process Elements of Values-based Practice

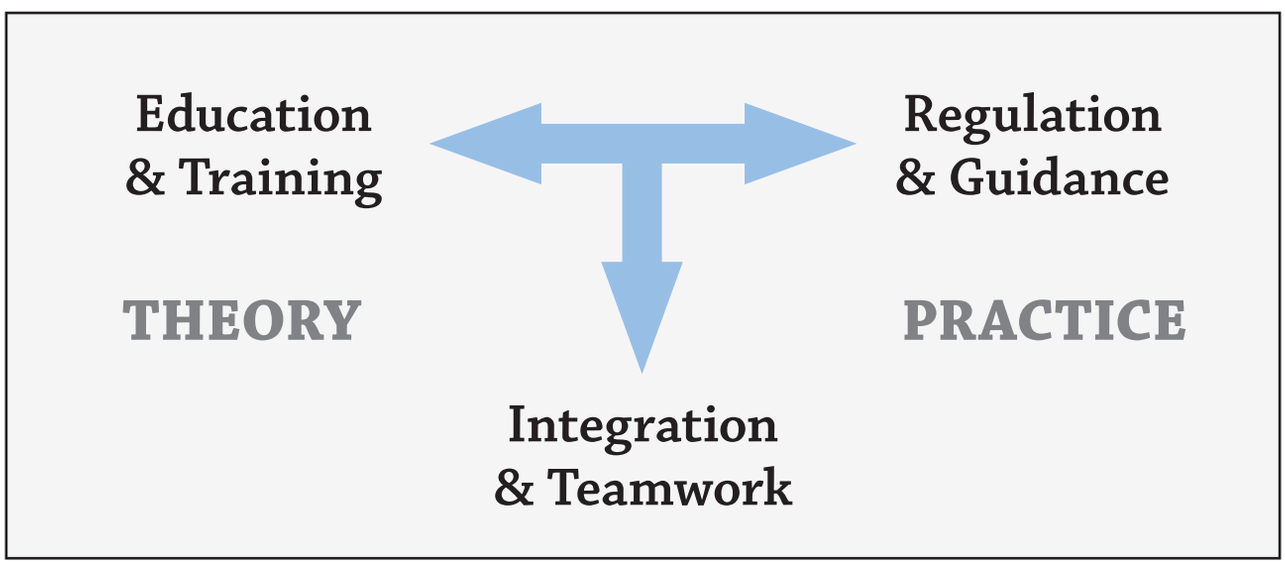
Values-based Practice	Brief definition
Premise of mutual respect	Mutual respect for differences of values
Skills – awareness	Awareness of values and of differences of values
Skills – knowledge	Knowledge retrieval and its limitations
Skills – reasoning	Used to explore the values in play rather than to provide answers
Skills – communication	Especially for eliciting values and conflict resolution
Patient-values-centered care	Care centered on the actual rather than assumed values of the patient
Extended MDT	MDT role extended to include a range of value perspectives as well as of knowledge and skills for interagency working
Two feet principle	All decisions are based on the two feet of values and evidence
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
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	Decisions in VBP (although informed by clinical guidelines and other sources) are made by those directly concerned working together in partnership
Frameworks of shared values	Values shared by those in a given decision making context and within which balanced decisions can be made on individual cases
Balanced dissensual decision-making	Decisions in which the values in question remain in play to be balanced sometimes one way and sometimes in other ways according to the circumstances of a given case

Further information including a detailed reading guide is given in the website of the *Collaborating Centre for Values-based Practice* given at the end of this article.

The Collaborating Centre for Values-Based Practice

Values-based practice was developed first in mental health, but recent initiatives have been in areas of bodily medicine such as surgery.[20] Key to these initiatives has been the establishment in 2015 of (to give it its full title) *The Collaborating Centre for Values-based Practice in Health and Social Care* at St Catherine's College, Oxford. Building on seed funding, used to support a website and exploratory day-seminars, the Centre has brought together around two hundred collaborative partners (individuals and groups) working on a range of both theoretical and practical projects.

Figure 2: Key Areas of Collaboration in Values-based Practice



The figure shows how these collaborative projects together amount to a "whole system" approach to values-based practice encompassing three main areas: education and training, regulation, law and guidance, and integration and teamwork. As Figure 2 further indicates, the work of the Centre as a whole, reflecting Austin's two-way partnership between philosophy and practice, is set within and supported by theoretical as well as practical perspectives. Again, further details, including full-text downloadable training manuals, can be found on the Centre's website given at the end of this article.

The Origins of Values-Based Practice in Philosophy and Psychiatry

Values-based practice represents the practical cutting edge of contemporary developments in philosophy and psychiatry. Work in any area of philosophy and psychiatry, reflecting the two-way nature of the partnership between them, necessarily carries implications for practice. Values-based practice has come good on these

20) Ashok I. Handa et al., "The Importance of Seeing Things from Someone Else's Point of View," *BMJ Careers On-line Journal* (August 2016). Published in hard copy as "Learning to Talk about Values." Available online at: http://careers.bmj.com/careers/advice/The_importance_of_seeing_things_from_someone_else's_point_of_view.

philosophy-into-practice implications. Drawing on ordinary language philosophy of values,[21] applied to the language of medicine,[22] and combined where appropriate with empirical methods,[23] ordinary language philosophy has contributed in one way or another to every aspect of values-based practice.[24]

Thus, referring to Figure 1 and Table 1 (above), ordinary language philosophy, 1) provides a semantic (hence non-question-begging) basis for the premise of values-based practice in mutual respect; 2) is the inspiration for many of the key skills-training exercises for values-based practice (especially those concerned with the foundational skill of raised awareness of values); 3) supports a model of teamwork (Austin's model) that, translated into the combined philosophical-empirical methodology referenced in footnote 23, helped to establish the distinctive values-based model of service delivery; 4) generates an account of the logical relationship (the relationship of meaning) between descriptive and evaluative language summarized in the three principles of values-based practice linking values with evidence; and, 5) through its relationship with particularist moral reasoning, frames the outputs of values-based practice in balanced decisions on particular cases within frameworks of shared values.

Yet if values-based practice has been in this way comprehensively philosophy-led it remains by the same token, and no less comprehensively, open to on-going challenge. Well-made challenges, while acknowledging the extent to which values-based practice has been effective in connecting with contemporary clinical care, have been made in respect of every aspect of the model, ranging from the semantic derivation of its premise[25] through to the liberal pluralism implicit in its commitment to process over pre-set outcomes.[26] This range of criticisms is entirely to be welcomed as driving the development of values-based practice as an open and continuously evolving discipline. One such criticism in particular, made by the British philosopher, Sridhar Venkatapuram, has been a crucial spur to the development of an international values-based practice through engagement with cultural values.

Unlike most other challenges to values-based practice, Venkatapuram's challenge arises from the very extent to which values-based practice has engaged successfully with contemporary healthcare. His point is essentially that values-based practice, in so engaging in contemporary health care, has taken on the limitations as well as the strengths of contemporary health care. In particular, Venkatapuram points out, values-based practice reflects contemporary healthcare in focusing on the individual at the expense of the community.[27] The default model of clinical decision making in both is of an individual patient in dialogue with an individual clinician. This focus on the individual is not absolute – team work, for example, is important in values-based practice just as it is in contemporary healthcare; and public health is a major discipline in its

21) R.M. Hare, *The Language of Morals* (Oxford: Oxford University Press, 1958); R.M. Hare, "Descriptivism," *Proceedings of the British Academy* 49 (1963): 115–134. Reprinted in: R.M. Hare, *Essays on Moral Concepts* (London: MacMillan Publishers Limited, 1972). Also: Geoffrey J. Warnock, *The Object of Morality* (London: Methun and Company, 1971).

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

23) A. Colombo et al., "Evaluating the Influence of Implicit Models of Mental Disorder on Processes of Shared Decision Making within Community-Based Multi-Disciplinary Teams," *Social Science & Medicine*," 56 (2003): 1557–1570. Also, K.W.M. Fulford and A. Colombo, "Six Models of Mental Disorder: A Study Combining Linguistic-Analytic and Empirical Methods," *Philosophy, Psychiatry, & Psychology*, 11, no. 2 (2004): 129–144.

24) K.W.M. Fulford, "Chapter 13: Living with Uncertainty: A First-Person-Plural Response to Eleven Commentaries on Values-Based Practice," in *Debates in Values-Based Practice: Arguments for and Against*, ed. Michael Loughlin (Cambridge: Cambridge University Press, 2014).

25) Tim Thornton, "Chapter 4: Values-Based Practice and Authoritarianism," in *Debates in Values-Based Practice: Arguments for and Against*, 50–61.

26) Bob Brecher, "Which values? And whose? A reply to Fulford," *Journal of Evaluation in Clinical Practice* 17 (2011): 996–998.

27) Sridhar Venkatapuram, "Chapter 11: Values-Based Practice and Global Health," in *Debates in Values-Based Practice: Arguments For and Against.*

own right. Yet the focus on individuals, as Venkatapuram indicates, neglects the growing evidence, from the work of Michael Marmot[28] and others, that the major determinants of disease are not individual and biological, but, instead, social and political. Venkatapuram's challenge then for values-based practice, is to extend its scope from the individual values on which it has focused thus far, to the cultural values of the collective.

Venkatapuram is well placed to raise this challenge. As a moral philosopher he runs a program in *Global Health & Social Justice* at King's College, London, established originally with support from Michael Marmot himself to raise awareness of the social and political determinants of disease. The next and final section of this article sets out a manifesto for the development of an international values-based practice addressing in equal measure cultural as well as individual values.

III. A Manifesto for International Values-Based Practice

A helpful starting point for the development of international values-based practice is to recognize that the Western focus on individual values is itself a reflection of a cultural value. This section first sets out this starting point in more detail and then looks at how we can move beyond it.

Individualism as a Cultural Value

The primacy of the individual over the collective as a "Western" cultural value is reflected in healthcare equally in its models of disease (as identified by Marmot, Venkatapuram, and others) and in its ethics (as reflected in the emphasis on individual autonomy in bioethics[29] for example, and in the primacy of the individual in medical law.[30]) It would be a mistake to forget just how hard-won were the successes of the scientific world-view.[31] Yet so dominant has this worldview become that its underpinning individualism has transformed into what might be called an assumption of objectivity: individualism, that is to say, has come to be assumed to be, somehow, an objectively correct perspective from which other worldviews may be studied and critiqued. It is after all not so very long ago that non-Western cultures were written off as "primitive" and their peoples as "savages."

Psychiatry reflects this objectivist assumption in its classifications. These offer what is taken to be a universally correct set of categories that may, perhaps, be modified, but not essentially changed, by "culture." The American Psychiatric Association's DSM (Diagnostic and Statistical Manual)[32] was among the first to acknowledge the importance of cultural factors in the presentation of psychiatric disorders. Yet, although demonstrably values-laden throughout,[33] its "cultural values section" appears as a diagnostic modifier, no more, of the categories making up the main sections of the classification.

The assumption of objectivity is understandable given psychiatry's self-perception (noted at the start of this article) as an objective medical science. Is pneumonia, many would ask, defined by Western cultural values?

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28) See for, example: Michael Marmot, "Health in an Unequal World: Social Circumstances, Biology and Disease," *Clinical Medicine* 6 (2006): 559–572.

29) Made explicit for example in: Tom L. Beauchamp and James F. Childress, *Principles of biomedical ethics*, 7th ed. (Oxford University Press: New York, 2012).

30) Recently re-asserted for example in UK law building on international legal precedents, in *Montgomery v Lanarkshire Health Board* (judgment delivered March 11, 2015): see: https://www.supremecourt.uk/cases/uksc-2013-0136.html

31) Paolo Rossi, "Chapter 17: Magic, Science, and Equality of Human Wits," in *Nature and Narrative: An Introduction to the New Philosophy of Psychiatry.*

32) *Diagnostic and Statistical Manual of Mental Disorders: DSM-5*, 5th ed. (Arlington, VA: American Psychiatric Association, 2013).

33) John Z. Sadler, *Values and Psychiatric Diagnosis* (Oxford: Oxford University Press 2004).

To this question many in psychiatry (and in medicine generally) would answer unhesitatingly "no." But we should beware of any such quick answers to this question. Properly understood the question takes us into the long-running debate about how concepts of disease are defined,[34] and, from there, into the even longer running debate about the relationship between evaluative and descriptive meaning.[35] Further reading on these debates is included in the resources indicated at the end of this article. The issues they raise are important not least to the theory behind values-based practice. For present purposes, though, rather than attempting to engage with these issues directly, a case study will be offered of the clinical importance of recognizing the role of cultural values in psychiatry.

The case study concerns the abuses of psychiatry as a means of social control. One consequence of the objectivist assumption is to assume that such abuses arise from a failure of psychiatric science. In the former Soviet Union, for example, there was widespread use of a diagnosis of "sluggish schizophrenia" based on "delusions of reformism" as a way of silencing dissident voices. This was at the time believed by psychiatrists in other parts of the world to be a result of inadequacies in Soviet psychiatric science. Direct inspection, however, of the Soviet psychiatric literature from the period, suggested to the contrary that Soviet models of disorder and associated diagnostic concepts were essentially similar to those employed over the same period in Britain and North America.[36] The implication therefor was that, while professional and organizational factors no doubt contributed to the spread of such abuses, the vulnerability of psychiatry to abuse lay not in its science but rather in a failure to recognize the extent to which the prevailing cultural values (in this case of Soviet socialism) influenced the way the science (as reflected in its models of disorder and diagnostic concepts) was applied in the context of clinical decision making.

Similar abuses of psychiatric concepts have been identified in many other contexts.[37] Venkatapuram's challenge to values-based practice generalizes the concern. His argument is to the effect that, in sharing with contemporary healthcare its individualist cultural values, values-based practice is at risk of sharing with it also responsibility for the abusive consequences arising from neglect of the political and social determinants of disease.

So, how to respond? What are the resources available for building an international values-based practice fully reflective of the variety of cultural values? And how are these resources to be deployed for successful implementation?

Resources for International Values-Based Practice

First among resources for international values-based practice is ordinary language philosophy. This might seem on first inspection an unlikely claim. After all, ordinary language philosophy just in starting from non-reflective uses of language must mirror the individualism inherent in contemporary healthcare. This is indeed why values-based practice derived as it is from ordinary language philosophy mirrors contemporary

34) See footnote 22.

35) K.W.M. Fulford, "Nine Variations and a Coda on the Theme of an Evolutionary Definition of Dysfunction," *Journal of Abnormal Psychology* 108, No. 3 (1999): 412–420; K.W.M Fulford, "Teleology Without Tears: Naturalism, Neo-Naturalism and Evaluationism," in the Analysis of Function Statements in Biology (and a Bet on the Twenty-first Century), *Philosophy, Psychiatry, & Psychology* 7, no. 1 (2000): 77–94.

36) K.W.M. Fulford, A.Y.U Smirnov, and E. Snow, E., "Concepts of Disease and the Abuse of Psychiatry in the USSR," *British Journal of Psychiatry* 162, no. 6 (1993): 801–810.

37) Robert Van Voren and Rob Kreukens, "Chapter 48: Political Abuse of Psychiatry," in *The Oxford Handbook of Psychiatric Ethics*, ed. John Z. Sadler, C.W. Van Staden, and K.W.M. Fulford (Oxford: Oxford University Press, 2015).

healthcare in being individualistic in focus. But there is no reason why ordinary language philosophy should be limited to ordinary Western-languages, still less (as it has thus far been mainly limited) to ordinary English-language philosophy. Proof of concept is provided by the Oxford philosopher Rom Harré's[38] explorations of the rich resources for philosophy offered by non-Western languages. Specifically, there is also proof of concept of values-based practice in the work of the philosophers of psychiatry Drozdstoy Stoyanov and Werdie van Staden, respectively from Balkan[39] and African[40] cultural traditions.

Two further features of ordinary language philosophy that are important as resources for the development of international values-based practice, are its role as a starting point and its model of teamwork. These features allow ordinary language philosophy to connect naturally with other resources both philosophical and empirical. As to philosophical resources, the Norwegian philosopher, Anna Bergqvist, in her role as convener of the Theory Group in the Oxford VBP Collaborating Centre, has identified a wide range of new resources for values-based practice just from recent work in the philosophy of values: traditional areas of engagement for philosophy of values, such as action theory and political philosophy, remain important, she argues, but we should look beyond these as well to new areas such as the philosophy of perception.[41] To these we should of course add philosophy of culture. There are rich resources too from many of the other areas of philosophy with which international philosophy and psychiatry has already engaged (see Section I above): contemporary phenomenology, for example, as the Italian psychiatrist Giovanni Stanghellini has shown,[42] adds a crucial dimension and depth of content to the study of values in psychopathology.

As to empirical resources, the importance of combining philosophical with social science methodologies has already been indicated (in the development of values-based teamwork, Section II above[43]). For international values-based practice many other empirical disciplines will come into play. Austin encouraged philosophers to work with linguists (Warnock, 1989, chapter 1). Cultural anthropology and sociology will clearly be crucial partners to philosophy in this regard.

There is thus no shortage at least of academic resources for international values-based practice. But how are these to be accessed? How is international values-based practice to be implemented?

Implementing International Values-Based Practice

The key to international implementation is for values-based practice to reconnect with its origins in the international movement in philosophy and psychiatry. Again, this may seem on first inspection counter-intuitive. As indicated in Section II values-based practice although originating in psychiatry has developed in recent years mainly in areas of science-led bodily medicine such as surgery. This has been important furthermore in marking the essentially complementary relationship between values-based practice and medical science.

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38) Rom Harré, *Personal Being* (Oxford: Basil Blackwell, 1983).

39) K.W.M. Fulford and Drozdstoj Stoyanov, "Chapter 1: Living at the Edge of Compromise: Balkan Pluralism as a Resource for New Philosophy of Mental Health," in *Towards a New Philosophy of Mental Health: Perspectives from Neuroscience and the Humanities*, ed. Drozdstoj Stoyanov (Newcastle upon Tyne, UK: Cambridge Scholars Publishing, 2015).

40) C.W. van Staden and K.W.M. Fulford, "Chapter 28: The Indaba in African Values-Based Practice: Respecting Diversity of Values without Ethical Relativism or Individual Liberalism, "*The Oxford Handbook of Psychiatric Ethics*.

41) Anna Bergqvist and Robert Cowan, *Evaluative Perception*, Mind Association Occasional Series (Oxford: Oxford University Press), forthcoming.

42) Giovanni Stanghellini and Milena Mancini, *The Therapeutic Interview in Mental Health: A Values-Based and Person-Centered Approach* (Cambridge: Cambridge University Press, 2017).

43) Also references in footnote 23.

It might seem therefor somewhat perverse to suggest reversing these welcome developments in the cause of implementing international values-based practice. The suggestion though rests on the observation that (whatever the limitations of national psychiatric organizations) the international movement in philosophy and psychiatry remains, as the academic achievements noted in Section I indicate, an exemplar of hybrid vigor. The *INPP* was started precisely in order to capture and build on the wide range and diversity of expertise from both theoretical and practical perspectives available around the world. This it has done and continues to do. Moreover, the organization continues to flourish not through the imposition of rules and regulations, but through mutual respect, supporting and encouraging engagement. It does so across not only national but also cultural and intellectual traditions. There is no settled corpus, no central dogma, no dominant tradition. The strength of the movement is in its unwavering pluralism. The result is a surely unique community, decentralized and spread around the world. While as to engagement with cultural values, *INPP* offers indeed precisely what a former President of the Royal College of Psychiatrists, Jim Birley, called for in response to the recognition of the vulnerability of psychiatry to abuse, a psychiatric "open society."[44] The INPP conference series (noted in Section I) presents an ideal forum for continuing to bring together the outputs of this pluralistic discipline: the conference planned for 2019 in Warsaw on "Experts and Representations" offers a timely opportunity to explore the role of cultural values in mental health.[45]

Yet if pluralism is at the heart of the strength of international philosophy and psychiatry, it is also a potential barrier to wider implementation of values-based practice. There are of course many practical barriers to implementation: difficulties in obtaining funding; misdirected policy initiatives; lack of educational and training resources, and so forth. Beyond and behind all these however is the challenge of pluralism. As the moral and political philosopher Isaiah Berlin pointed out while writing in the 1950s in the shadow of National Socialism, our default position is not pluralism but monism.[46] People gravitate away from open questions. People want answers. Yet this is precisely what values-based practice refuses to give them. Values-based practice is top-to-bottom pluralistic. As noted in Section II, values-based practice offers in place of answers a process that supports clinicians and patients in coming to answers for themselves according to the particular circumstances presented by each individual case. Therefore, carry over the pluralism of values-based practice as developed in one cultural tradition to the varying degrees of evaluative freedom available internationally, and the challenge of pluralism becomes a challenge indeed.

Yet, all that being said, there are early signs of positive steps towards an international values-based practice: in the academic developments noted above in this section; in translations of values-based practice into both European and non-European languages (see Further Reading below); and in the institutional support offered by such organizations as the World Psychiatric Association. There are further positive signs in the development in many countries of models of clinical decision-making, supported by developments in medical law,[47] requiring precisely the close partnership between evidence and values to which values-based practice is directed. In leading these developments, psychiatry could thus find itself in poll position in contemporary science-led clinical care. While, therefor, in implementing international values-based practice, we should recognize and be

44) Jim Birley, "Chapter 11: Psychiatric Ethics: An International Open Society," in *In Two Minds: A Casebook of Psychiatric Ethics*, ed. K.W.M. Fulford and Donna Dickenson (Oxford: Oxford University Press, 2000).

45) For the first call for INPP 2019 please see the INPP website in Further Reading below.

46) Isaiah Berlin, *Two Concepts of Liberty* (Oxford: Clarendon Press, 1958).

47) Jonathan Herring et al., "Elbow Room for Best Practice? Montgomery, Patients' Values, and Balanced Decision-Making in Person-Centred Clinical Care," *Medical Law Review* 25, no. 4 (2017). Available on advice view online at: https://academic.oup.com/medlaw/advance-articles.

prepared for the challenge of pluralism, we should not, as another mid-twentieth century philosopher, Bertrand Russell, put it, be "paralyzed into inaction."[48]

Conclusions: Who "Wears the Trousers?"

This article started with psychiatry's negative conception of both culture and values as being somehow anti-scientific. It ended with the hope that in embracing cultural values psychiatry might take a leading role in the development of contemporary science-led clinical care.

There are, as has been indicated, many potential barriers for that hope to be fulfilled. Not least among these barriers is the essentially pluralistic nature of values-based practice. In over-coming these barriers, I have suggested values-based practice will need to reconnect with its origins in international philosophy and psychiatry. There is clear "marriage value" in bringing these two disciplines back together. Values-based practice provides a proof of concept and a model for translating philosophy into practice in the context (as exemplified by surgery) of contemporary science-led clinical care. International philosophy and psychiatry, while sharing the challenge of pluralism, by the same token, provides the resources for shifting the focus of values-based practice, and with it that of contemporary clinical care from the personal to the collective.

Of course, it may be that psychiatry – burdened as it is by its negative self-image as a medical science will fail to embrace the challenge of pluralism presented by international values-based practice. It may be that it will leave the running to other clinical disciplines such as (currently in Oxford) surgery. Surgery after all has the advantage over psychiatry in having an entirely positive self-image as a medical science and is thus better placed to abandon the assumption of objectivity. Yet in this, too, ordinary language philosophy has a message for psychiatry. For in ordinary language philosophy, as Austin himself pointed out, it is often the negative concept that takes the lead: in ordinary language philosophy it is often, as Austin put it in the metaphor of his day,[49] the negative concept that "wears the trousers."

Further Reading

For information about the journal, book series, conferences, and other activities in international philosophy and psychiatry, noted in this article, see notes 11–14. The website of the INPP is at: *http://inpponline.com*.

The website of the *Collaborating Centre for Values-based Practice* is at: *valuesbasedpractice.org*. The website includes a detailed reading guide to both the theory and practical applications of values-based practice together with a number of full-text free downloads of training manuals and policy reports.

Case studies from various areas of medicine illustrating the clinical impact of each of the elements of values-based practice are given in Fulford, Peile and Carroll's (2012) *Essential Values-based Practice* (also available in French and Japanese translations).[50]

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48) Bertrand Russell, *The History of Western Philosophy* (London: George Allen and Unwin, 1946), 14.

49) See Footnote 2, page 32.

50) See also Footnote 19. Japanese edition, Medical Sciences International, 2016; French edition Trans: Arnaud Plagnol, Bernard Pachoud, Frédéric Advenier, Marie Darrason, Rémi Tévissen, Jean-Baptiste Trabut. Preface: Bernard Granger. Montrouge: John Libbey Eurotext, 2017).