Towards a New Philosophy of Mental Health

Towards a New Philosophy of Mental Health:

Perspectives from Neuroscience and the Humanities

Edited by

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TABLE OF CONTENTS

ACKNOWLEDGEMENTS

FOREWORD

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This new volume, edited by Stoyanov et al., contains a very useful and informative collection of papers on psychopathological issues, written by leading figures from neuroscience, psychology, and phenomenology.

Over the last decade, we have been witnessing in psychiatry a vibrant (re)-birth of interest in the conceptual, theoretical, philosophical, and phenomenological dimensions of psychopathology. Each year several books on these topics are being published by prestigious publishing houses.

Such fervent (re)-examination of the theoretical foundations of psychiatry is an unmistakable sign that our profession undergoes what Thomas Kuhn described as a period of crisis. We may talk about a Kuhnian crisis when the so far dispersed and isolated voices of dissent or discontent, gradually, or more suddenly, coalesce and jointly amplify into an explicit, nearly consensual acknowledgement that the discipline itself is in fundamental trouble. Stated in a simplified way, the crisis of psychiatry, consists in a realization that the theoretical paradigm, so far dogmatically dictating the empirical and pragmatic functioning of our discipline (e.g. choice of research topic, methods, funding and editorial policies etc), suddenly appears glaringly out of touch with the reality of clinical psychiatry while at the same time, the narrow focus of the neurobiological (mainly psychopharmacological) component of this paradigm becomes increasingly out of sync with the rapidly progressing and diversified neuroscience.

It is beyond the scope of this preface to articulate that crisis in more detail. Briefly however, the "operational revolution", emblematized by the publication of the DSM-III in 1980, assumed a behavioristic approach to psychiatric description, with symptoms and signs viewed as mutually independent, atomic, thing-like entities, devoid of meaning and constituting

disease entities by a syndromatic contingency (Parnas and Bovet 2014). Any overall psychological perspective on the human mind (e.g. a la Jaspers) was eliminated. The study of mental pathology was (and sometimes still is) not seen to be dissimilar in kind from the concerns of e.g., hepatology. This conceptual revolution was believed to bring along improved descriptive reliability and thereby clear the road to rapidly forthcoming etiological discoveries "carving nature at its joints." The latter was hoped to constitute the nosological foundations of the future DSM-IV classification. As we know today, this promise did not materialize, not even with the arrival of the DSM-5. Whether reliability, assessed in an ecologically adequate manner, i.e. in a daily clinical praxis, has really improved is an open question; the periodic "epidemics" of mental disorders (e.g. dissociation, Borderline Personality Disorder, autistic spectrum disorders) may suggest otherwise. In the meantime, the psychopathological knowledge among clinicians diminished dramatically. Our profession is increasingly viewed (and not only by a reborn academic anti-psychiatry) as being dehumanized and mainly driven by managerial concerns. In other words, we witness not only a purely Kuhnian crisis of ideas but also face a more mundane question of *survival* of psychiatry as a medical-academic discipline (Katchnig 2010).

Perhaps, a more cynical view would claim that psychiatry *always* found itself in a kind of larval crisis since its very inception; a crisis of its self-understanding, either as basically medical or basically human science. It is now time to abandon this dichotomy, which is useless and partly false for all practical and theoretical reasons. Psychiatry has been, is, and will remain an interdisciplinary endeavour, even though the notion of interdisciplinarity is a relatively recent invention.

This volume, written at the intersection of neuroscience, psychology, and philosophical phenomenology offers the reader a possibility to familiarize herself with a representative selection of crucial themes for psychiatry as a science and as a practical profession. The book should be of interest to a broad variety of professionals engaged in mental health work.

Josef Parnas, Copenhagen, November 2014.

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KEY NOTE

CHAPTER ONE

LIVING AT THE EDGE OF COMPROMISE: BALKAN PLURALISM AS A RESOURCE FOR NEW PHILOSOPHY OF MENTAL HEALTH

KENNETH WILLIAM M FULFORD AND DROZDSTOJ STOYANOV

Abstract

This chapter explores the potential for a new philosophy of mental health arising from the uniquely pluralistic values of Bulgaria and other Balkan states reflecting their long periods of colonisation. Balkan people survived these periods by retaining their own values while at the same time evincing where necessary the values of their colonisers. Living at the edge of compromise in this way has left a legacy of values pluralism. Pluralism like monism carries its own challenges. But in a Balkan context we argue it is the basis for distinctively new contributions to that part of philosophy of mental health called values-based practice. An important strength but also a limitation of values-based practice is its basis in a particular kind of shared decision making called 'dissensus'. But dissensus depends critically on values pluralism whereas our default position in practice, as evidenced by experience at least in the UK, is monism. We illustrate the potential of Balkan cultural pluralism for two key challenges in contemporary mental health: 1) preventing negative abuses of psychiatry, and 2) promoting positive practice. Whether Balkan cultural pluralism will deliver on its potential in these and other areas remains to be tested. But developed like values-based practice itself, within the framework of mid-twentieth century ordinary language philosophy, it could add a key additional resource to the growing tool kit of methods for working with complex and conflicting values in health care.

Introduction

The development of interdisciplinary work between philosophy and mental health in recent decades, although remarkable for the strongly collegial nature of its various programs (Fulford, forthcoming), has been built largely on the resources of Anglo-American Analytic and Continental Philosophy. Impressive as these resources undoubtedly are they represent only some twenty-five percent of the great traditions of thought and practice available across the world as a whole (Fulford et al., 2013). The remaining seventy-five percent thus offers a potential resource for new philosophy of mental health. Values-based practice is a case in point. Developed thus far within the individual-centred analytic philosophical traditions of Britain and North America, it is already being enriched through the more complex individual-cultural concepts of African Batho Pele (Crepaz-Keay, van Staden and Fulford, forthcoming; van Staden and Fulford, forthcoming).

In this chapter, we explore the rather different resources for enriching values-based practice offered by a particularly robust form of values pluralism derived from the Balkan experience of living for many centuries under successive colonial administrations. This experience, of living for so long at the edge of compromise, has resulted in a uniquely Balkan capacity for the values pluralism that, as we describe, underpins the dissensual decision making at the heart of values-based practice. The role of this Balkan 'cultural pluralism' in strengthening values-based practice remains to be tested in practice. But its importance in principle is evident from the limitations of values-based practice and other positive practice initiatives across a range of current challenges in mental health. We describe these challenges and the potential contribution of Balkan cultural pluralism in addressing them later in the chapter. We start with a (biographically disguised) personal story illustrating Balkan pluralism in action.

The Story of Dr Petrov and His Neighbour, Ivailo

Ivailo (not his real name) was a 48 year old psychiatric hospital attendant (orderly) working as a taxi driver on a part-time basis. He had suffered several clinical episodes over the past ten years diagnosed as psychotic mania with associated history of alcohol abuse. His mother left Bulgaria in the early 1990s to immigrate to New Zealand. His father although remaining in Bulgaria had been a major source of various traumatic experiences throughout Ivailo's life. His father was constantly abusive, with both verbal and physical aggressive behavior, and entering

into frequent conflicts about property and relationships. He repeatedly threatened to disinherit Ivailo and leave him and his family practically homeless.

Ivailo lived in the same house with his father, wife and two adolescent children until July 2011 when his father died from a rapidly progressive cancer. His wife had been unsupportive throughout and now set out to antagonize Ivailo's two sons against him. In September 2011, Ivailo stopped taking his medication and gradually returned to abusing alcohol.

A couple of months later during a brief period of sick leave he turned up at the home of a psychiatrist, Dr Petrov (again, not his real name), who was living nearby, asking for a loan. Dr Petrov was not Ivailo's physician but recognized that his behavior was unusual: he was struck by his somewhat awkward and untidy appearance and unusual behaviour. After talking with his wife however he came to the view that Ivailo's presentation was understandable given his complicated family situation and low income. He thus decided to help Ivailo with a loan while encouraging him to take care and to consult his own doctor. Ivailo came back three weeks later asking for a further loan but now in a more obviously disturbed state. On this occasion, Dr Petrov refused the loan but again urged Ivailo as a friend to see his doctor.

Ivailo, however, did not seek medical help and over the following eighteen months, his condition deteriorated to the point that his behavior became destructive and dangerous. Following a further period of sick leave he was finally admitted as a patient to the hospital where he had previously worked as an attendant.

From this point forward Ivailo's situation gradually improved. Over three months of in-patient treatment, he restarted his medication and stopped drinking. Within a few months of discharge he was well enough to return to his job as an attendant in the same acute psychiatric ward on which he had been a patient. Ivailo's family problems continued. However, he now felt more prepared to cope with them while holding down his job.

One of the first things Ivailo did after being discharged from hospital was to return Dr Petrov's loan.

Same Story Different Values

We have presented Ivailo's story here briefly and there are clearly many areas, which the reader may be looking at for further information. The story is short on clinical detail, for example, particularly relevant to Ivailo's differential diagnosis: was his relapse simply a recurrence of his

previous illnesses or, perhaps, a pathological grief reaction to the death of his abusive father. We might reasonably want more information about Ivailo's actual symptoms and indeed about his relationships with his parents, his wife and two sons.

Here, though, we want to focus on Dr Petrov and his decision to help Ivailo with a loan in the early stages of his relapse and the effect of this on the course and eventual outcome of his illness. In this context, the relative lack of information (the facts) on which Dr Petrov based his decision is important. It is typically the case that in day-to-day as well as in clinical decision-making we have to make up our minds what to do under conditions of evidential uncertainty. This is why as we discuss further below, the processes of evidence-based practice are an important resource for medical decision-making. Less well recognized, though no less important, are the values in play. Empirical work in areas such as decision analysis (Dowie, 2004) as well as in analytic philosophy (Fulford, 1989) makes clear that all decisions are values-driven as well as evidence-driven. And if the evidence base of Dr Petrov's decision is uncertain, the values base of his decision is nothing if not controversial.

Thus, from one rather negative perspective, Dr Petrov's decision might be seen as, at best, imprudent. It worked out well in the end (the loan was repaid). But at the time Dr Petrov might well have reflected on the maxim 'never a lender or a borrower be'. Similarly, negative evaluations might be made from a professional perspective. Dr Petrov as we have said was not Ivailo's physician. He nonetheless recognized that Ivailo's behavior was not normal and he accordingly encouraged him to seek medical help. But in not taking a more paternalistic stance, he left himself open to criticism from some of his medical peers. The reaction of one of his senior colleagues when he heard about the loan was 'you did something quite stupid giving him money and not helping the police to catch him'.

Dr Petrov although not 'thinking values' at the time was well aware of these negative perspectives. Balanced against them in his mind though was the positive perspective of his role not as a doctor but as a neighbor. Ivailo and Dr Petrov were more acquaintances than friends, though they had known each other for some time. Dr Petrov had been aware of Ivailo's family problems but he also rated him as a conscientious employee, trustworthy neighbour and open minded and well-mannered person, albeit somewhat vulnerable through lack of family support. As a neighbor then Dr Petrov wanted to help someone who was clearly in trouble and from this humane perspective he felt it was right to give him a loan as he would anyone else who was similarly in trouble.

Balkan Cultural Pluralism

There are clearly many values issues raised by this story. For present purposes, though, the point of the story is to illustrate what in values-based practice is called dissensual decision-making and how this is supported by Balkan cultural pluralism. In this section, we give a very brief description of values-based practice including its basis in dissensus and then show how this is supported by Balkan cultural pluralism, as illustrated by Dr Petrov's decision.

Values-Based Practice and Dissensus

Values-based practice is one of a number of new ways of working with values currently being developed in health care. The most familiar of these is ethics but other tools in the 'values tool kit' include health economics, decision analysis and various aspects of the medical humanities (Fulford, Peile and Carroll, 2012, chapter 2). Many of these approaches aim to reduce differences of values with a view to making them more manageable: ethics characteristically seeks to define 'right outcomes' emphasizing values such as autonomy of patient choice. Values-based practice by contrast adds to the tool kit a particular focus on *diversity* of values.

The approach to diversity adopted in values-based practice relies on 'good process' instead of 'right outcomes'. Rather than giving us answers as such, values-based practice offers a process that supports us in coming to a decision in a given situation. The process of values-based practice is derived mainly from philosophy (though it has also important empirical support, Colombo et al., 2003). The philosophy in question is the perhaps rather unlikely resources of linguistic-analytic philosophy, as exemplified by Oxford philosophers such as J. L. Austin (1956 - 57), and applied to the language of values by, among others, another Oxford philosopher, R. M. Hare (1952, 1963). The Austin-Hare take on the language of values provides a whole series of theoretical insights into medical concepts of disorder both bodily and mental (Fulford, 1989). These insights in turn generate the practical tools of values-based practice (Fulford, 2004; Fulford, Peile and Carroll, 2012).

Although derived philosophically, values-based practice, in relying on good process, is a values-counterpart of evidence-based practice. Evidence-based practice gives us a process that supports decision making where complex and conflicting *evidence* is in play. Values-based practice gives us a process that supports decision making where complex and

conflicting *values* are in play. The processes involved are different of course. Evidence-based practice is based on meta-analyses of the findings from well-conducted research. Values-based practice is based rather on learnable clinical skills together with other practice-oriented process elements. But the principle is the same.

Values-based Practice
Starting Point is …   **Mutual respect for differences of values**
Process involves …   • **Clinical skills**   • **Relationships**   • **Links between values and evidence**   • **Partnership**
Outputs are …   **Balanced decisions in individual situations within frameworks of shared values**

Figure 1-1: Diagram of the Process of Values-based Practice
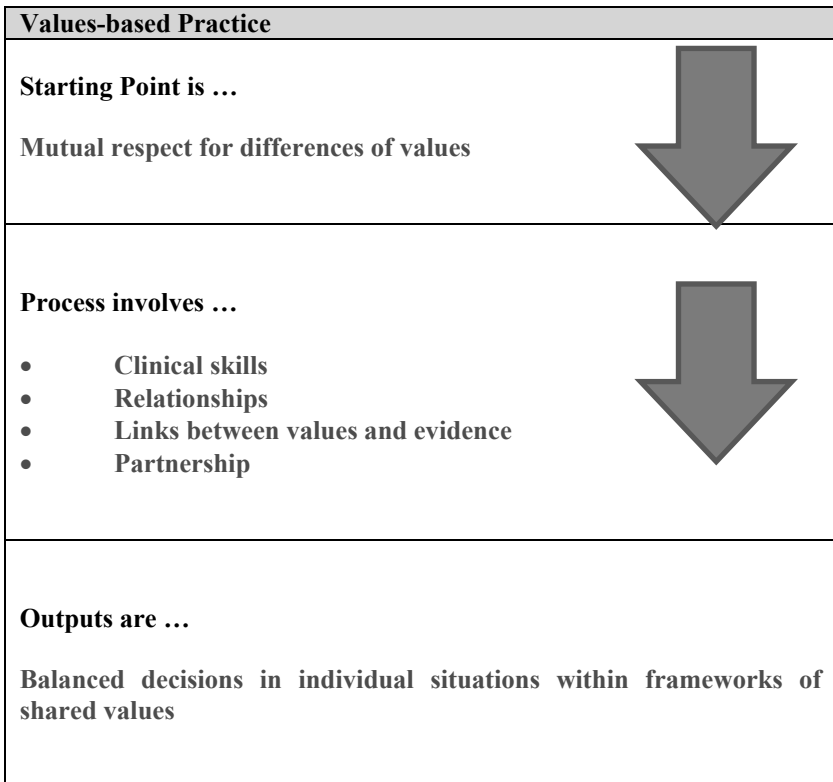
   The process of values-based practice is shown diagrammatically in the Figure 1-1. As this indicates the skills and other process elements of values-based practice together support balanced decision-making within frameworks of shared values. It is in the outputs from this, the balanced decision making in the right-hand side of the diagram, that dissensus comes in.

Dissensus in values-based practice does not mean disagreement. It is perhaps better understood by contrast with consensus. Thus, dissensus and consensus are both ways of coping with difference. In consensual decision making differences are discussed and an agreed position is adopted with other options being dropped or excluded. This is an important process in evidence-based practice for example. The processes of evidence-based practice (meta-analyses etc as above) are used to come to an agreed view on what the evidence in question shows with other views being thereby dropped or excluded. The resulting consensus then becomes a basis for subsequent decision making across all relevant cases.

Consensus has a role too in values-based practice: it is by consensus that the framing shared values of values-based decision-making noted in the Figure 1-1 (under 'outputs') are defined. But in values-based practice, decisions are made by balancing these shared values on a case-by-case basis according to the particular circumstances presented by a given situation. In contrast to consensus then the shared values framing values-based decision making are not dropped or excluded but remain in play to be balanced sometimes one way and sometimes in other ways as the contingencies of the situation demand. This is dissensus.

Dissensus and Dr Petrov's Decision

Dr Petrov, although not trained in values-based practice, shows many of its elements in his interactions with his neighbor, Ivailo. We should not be surprised by this. Values-based practice is about capturing and building on positive practice and this is precisely what we will see Dr Petrov shows.

We summarize the elements of values-based practice shown by Dr Petrol in Table 1-1. The left hand column of this table gives the elements of values-based practice: these are the same as in the figure but now set out in more detail. The right-hand column shows how Dr Petrov reflects these elements in his dealings with Ivailo.

ELEMENTS OF VALUES-BASED PRACTICE		COMPARED WITH Dr Petrov's decision
POINT	Rather than giving us answers as such, values-based practice aims to support **balanced decision making within frameworks of shared values** appropriate to the situation in question.	Dr Petrov's decision to give the loan reflects a balance between values that he shares with his wife and Ivailo (acting prudently, and in a clinically responsible way, but also supportively).
PREMISE	The basis for balanced decision making in values-based practice is the premise of **mutual respect for differences of values**.	Dr Petrov clearly respects Ivailo (he sees him as 'a conscientious employee, trustworthy neighbour', etc); he and his wife also share mutual respect (they discuss and agree what to do); although not explicit in the story Ivailo clearly respects Dr Petrov (thus he turns to him for help; and also makes it a priority to repay the loan when he recovers).
TEN-PART PROCESS	Values-based practice supports balanced decision making through **good process** rather than prescribing preset right outcomes. The process of values-based practice includes four areas of **clinical skills**, two aspects of **professional relationships**, three principles **linking values-based practice with Evidence Based Practice,** and **partnership in decision making** based on 'dissensus'.	Many of the elements of the process of values-based practice are evident in this story – as detailed below.

The four skills areas are		
Awareness	The first and essential skill for values-based practice is raised awareness of values and of the often surprising diversity of individual values.	Dr Petrov is aware not only of Ivailo's possible clinical deterioration but also of his need for support not as a patient but as a neighbour. This is the basis of his person-centred response in making the loan – see text.
Reasoning	Values reasoning in values-based practice may employ any of the methods standardly used in ethics (principles reasoning, case-based reasoning, etc) but with an emphasis on opening up different perspectives rather than closing down on 'solutions'.	Values reasoning as such is not employed here but could be used to explore the values in play and our reactions to them further, for example in teaching sessions based on this story.
Knowledge	A key skill for values-based practice is knowing how to find and use knowledge of values (including research-based knowledge) while never forgetting that each individual is unique (we are all an 'n of 1').	Again, knowledge of values is not used here but could be important in exploring the issues arising – for example, knowing that 'what matters' to a person in Ivailo's situation is often more about people trusting and caring about them than clinical input to control symptoms – see text re recovery later in the chapter.
Communication	Values-based practice communication skills include skills, 1) for eliciting values, in particular StAR values (Strengths, Aspirations and Resources), and, 2) for conflict resolution.	Dr Petrov shows considerable communication skills especially of active listening and observation in coming to understand what help Ivailo needs. Important in this is his understanding of Ivailo's strengths (his resilience with his family problems, his trustworthiness as an employee,

		etc). It is these strengths in particular that is the basis of Dr Petrov's positive decision to help.
The two aspects of professional relationships are		
the extended MDT	The role of the MDT (multidisciplinary team) in values-based practice is extended from its traditional range of different professional skills to include also a range of different value perspectives.	As this is a personal rather than clinical decision there is no multidisciplinary team involved. But note the key role of Dr Petrov's wife in providing a balancing perspective.
patient-values-centered-care	In values-based practice patient-centered care means focusing primarily on the patient's values though other values (including those of the clinician) are important too. .	Dr Petrov's decision directly illustrates the concept of person-values-centred-care – his decision to give Ivailo a loan directly corresponds to his understanding of Ivailo's needs (i.e. for support and etc. rather than just a loan – see text).
The three principles linking values with evidence are		
'Two Feet' principle	The 'two feet' principle of values-based practice is that all decisions are based on values as well as evidence even where (as in diagnostic decisions) the values in question may be relatively hidden.	Dr Petrov's decision directly reflects the two-feet principle – the decision could be seen as a clinical decision - based on the facts of Ivailo's presenting appearance is he or is he not unwell? If not, make the loan; if so, withhold the loan. These clinical facts are clearly important. But Dr Petrov remains throughout fully aware of the key values in play as well.

'Squeaky Wheel' principle	The 'squeaky wheel' principle of values-based practice is that we tend to notice values when they are conflicting and hence causing difficulties (based on the saying 'it's the squeaky wheel that gets the grease').	As the converse of the two-feet principle, the squeaky wheel principle is also in play. For in remaining fully aware of the values in play, Dr Petrov never loses sight of the relevant clinical facts (to the point that with Ivailo's deterioration three weeks later he refuses the second loan).
'Science Driven' principle	The 'science driven' principle of values-based practice is that the need for values-based practice is driven by advances in medical science (this is because such advances open up new choices and with choices go values).	This principle applies more in high-tech areas of decision making so is not directly relevant here.
Partnership in decision making		
… based on dissensus	Consensual decision-making involves agreement on values with some values being adopted and others not. In dissensual decision making by contrast different values remain in play to be balanced sometimes one way and sometimes in others, according to the particular circumstances of a given case.	In balancing different values that remain in play Dr Petrov's decision is dissensual – note that balance comes out one way initially (with the loan being made) but differently three weeks later when the clinical facts have changed (with the loan being refused). Dr Petrov's capacity for dissensual decision making is enhanced by his cultural background of living in a pluralistic society at the edge of compromise – see text.

Table 1-1: Dr Petrov's Decision as Values-based Practice

The standout point that emerges from this is that a majority of values-based elements is in play in one way or another in Dr Petrov's thinking. We should note in particular two of these: first, Dr Petrov's awareness of

what really matters to Ivailo in his present situation; and, second, his understanding of Ivailo's strengths as well as his more obvious difficulties (these are covered between them by skills elements 1 and 4). Both these aspects of the clinical presentation tend to be neglected in clinical assessments: as clinicians we tend to assume we know what matters to our patients rather than actually finding out; and we tend to focus on the negatives (needs and difficulties) while neglecting the positive strengths an individual brings to their situation. Yet both are foundational to positive practice (Ahmad et al., 2014; Fulford and van Staden, 2013). Both are integral also to the balance of values required for Dr Petrov's dissensual decision to give Ivailo a loan.

The balance to be drawn in this instance, as we noted earlier, is between, on the one hand, prudence and clinical concerns, and, on the other hand, the humane values of supporting a neighbor in trouble. These are all values to which Ivailo no less than Dr Petrov and his wife subscribes. They are all in this sense shared values that Dr Petrov has to balance one against another in deciding what to do. When Ivailo first comes to see Dr Petrov, the humane values outweigh the values of prudence and clinical concerns and Dr Petrov decides to give Ivailo a loan. But the values themselves remain fully in play. This is why the decision is a *dissensual* decision. And the same values indeed are balanced differently three weeks later when Ivailo's behavior has become more obviously clinically abnormal. On this occasion, prudence and clinical concerns come to the fore and Dr Petrov refuses the loan.

With the benefit of hindsight (in particular the knowledge that the loan was ultimately repaid) this may all seem obvious enough. But the balancing of values was much trickier when made for real in all the uncertainties particularly surrounding Ivailo's first request. Again, Dr Petrov showed well-developed skills for values-based practice in the way he handled this at the time. Many would have 'played safe'. Many others would have followed Dr Petrov's senior colleague's advice and called the police! But Dr Petrov's balanced approach was vital to Ivailo in affirming his sense of self-worth at this critical point and thus paving the way for his eventual recovery.

Again, this may all seem rather obvious with the benefit of hindsight. But experience in the UK at least suggests that in coming to a balanced dissensual decision in this way Dr Petrov succeeded where many others would have failed. We return to the difficulties of dissensual decision making below. But for now, the point is that dissensual decision-making depends on values pluralism which, for reasons we will come to see, seems to be peculiarly difficult to sustain in practice. This is why Dr

Petrov's story is important. Dr Petrov succeeded where many would have failed because in coming to a balanced dissensual decision he was able to draw on a resource of values pluralism arising from his background cultural tradition of living for so long under colonial rule at the edge of compromise. We will review this cultural tradition briefly in the next section before coming back to its role in supporting Dr Petrov's dissensual decision.

Living at the Edge of Compromise

Bulgaria's history of colonial domination starts with its long period, from 1396 to 1878, was under the Ottoman yoke. During this period many strategies were adopted to make it possible to live together with their oppressors. The Christian population of Bulgaria for example found themselves obliged to build their churches so that they appeared lower than Muslim mosques.

Later, in between 1934 and 1944 the governing dynasty of Sax-Coburg-Gotha and a number of pro-German politicians brought Bulgaria into alliance with the Axis and National-Socialist Germany. It was at this time that King Boris III captured the idea of 'living at the edge of compromise' by famously advising his diplomats to be "*always with Germany and never against Russia*". As a further illustration of Bulgarian compromise Boris III was the father of Simeon II who while reigning as King from 1943 to 1946 went on to become Prime Minister of a republican Bulgaria from 2001 to 2005.

Bulgaria's latest period of colonization came as a satellite of the Soviet Union and member of the Warsaw pact from 1944 until the communist regime was deposed in 1989. Interestingly, the regime in Bulgaria was deposed from inside by a party *coup d'etat* in contrast to other communist regimes in Eastern and Central Europe who were deposed by popular peoples' uprisings. This is an important further example of Bulgarian *"living at the edge of compromise"*.

Cultural Pluralism

The result of this long history is that Bulgarians are culturally attuned to living within a pluralistic set of values often at odds one with another but requiring a pragmatic balance in the realities of day-to-day living. It is this cultural heritage we believe that supported Dr Petrov in his dissensual decision to give Ivailo a loan.

This is speculative of course. But note how different Bulgaria is in this respect from the UK. Where the cultural heritage of Bulgaria as a colonised people has been perforce one of pluralistic values the corresponding heritage of the UK, in which values-based practice was first developed, as a dominant power is essentially monistic: the values of a dominant power are by definition dominant. Similar considerations apply to North America and indeed Russia. But the dissensus of values-based practice as we describe further below has been limited by what one of us has called elsewhere the 'retreat to monism' (Fulford, Dewey and King, forthcoming). It is from this retreat to monism that Dr Petrov's cultural heritage protected him.

Pluralism particularly as a vassal nation is not to be romanticised. But as the political philosopher Isaiah Berlin pointed out in the aftermath of the Second World War, it is the retreat to monism, not the balance of pluralism that has been at the root of the worst abuses of humanity in much of its history (Berlin, 1958). The moral philosopher Jonathan Glover has made a similar point in his (ironically titled) 'Humanity' (Glover, 1999). In the next section we examine the significance of Balkan cultural pluralism both for combating abuses of psychiatry and for promoting positive values-based practice.

Cultural Pluralism and Psychiatric Practice

In focusing on the story of Dr Petrol and Avail it might seem that we have been making too much of just one instance. There is though at least negative evidence of the wider influence of Balkan cultural pluralism in the relative absence of political abuses of psychiatry in Bulgaria during the period of Soviet occupation. In this section, we illustrate the possible significance of this with two studies, one of abuses of psychiatry, the other of positive practice. We then return to the potential role of Balkan cultural pluralism respectively in reducing the risks of abuse and in promoting positive practice in psychiatry.

Abuses of Psychiatry in Soviet Russia

Political abuses of psychiatry became widespread in Russia during the closing decades of the Soviet Union. These abuses, which were at their height in the 1960s and 1970s, have been well documented elsewhere (Bloch and Reddaway, 1997). What they amounted to was the use of psychiatric diagnoses (such as 'sluggish schizophrenia' based on 'delusions of reformism') as a means of political oppression. Psychiatry

seems to be peculiarly prone to sporadic cases of being abused for a variety of non-clinical purposes (van Voren 2010; Van Voren and Keukens, forthcoming).[1] However, in Soviet Russia such abuses became institutionally endemic.

In the late 1980s, one of us (KWMF) had an opportunity to explore the reasons for this institutionalized abuse of psychiatry using a linguistic analytic methodology similar to that underpinning values-based practice (as above). The opportunity arose from a Russian psychiatrist, Alex Smirnov, arriving in Oxford on a one-year visiting scholarship. We had the further support of a Russian-speaking social worker, Elena Snow. Most of the work on Soviet abuses of psychiatry to that time had focused on documenting cases of abuse and seeking to identify their structural causes (in areas such as professional education). This work was clearly important in its own right. We by contrast wanted to get as it were behind the scenes to look directly at the concepts guiding the Soviet psychiatry of the period. Rather therefore than studying cases of abuse as such, our study took the form of a careful linguistic analysis of a representative sample of the Russian psychiatric literature of the period.

The results were a surprise. The assumption among Western commentators had generally been that at the root of Soviet abuses of psychiatry would be found unreliable diagnostic concepts based on unscientific models of disorder. What we found was quite the opposite. The diagnostic concepts and models of disorder evident in the Soviet psychiatric literature were essentially the same as their counterparts in the corresponding British and North American literatures of the day. In both literatures the dominant model was one of descriptively defined symptoms reflecting biological (neuropath logical) disease models. There were indeed close parallels even on the specifics: the 'sluggish schizophrenia' of Soviet psychiatry was closely similar diagnostically to the 'latent schizophrenia' of British/American psychiatry (Guilford, Smirnoff and Snow, 1993). It is noteworthy also that over this period Soviet paradigm of 'nosos' and 'pathos schizophrenia' as developed by Andrey Snezhnevsky and others were published in main stream Western European and American peer-reviewed journals and edited books (see Davidovsky and Snezhnevsky, 1966; Snezhnevsky. 1966 and 1968a and 1968b, and Snezhnevsky and Vartanyan, 1971).

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[1] More extreme forms of abuse should not be forgotten including the social-Darwinist approaches adopted under National Socialism and leading to attempted extermination of the mentally ill under their program of euthanasia (Muller-Hill, 1991).

These findings thus begged the question, 'why Soviet psychiatry?' Why should abuses of psychiatry have become endemic in Soviet psychiatry at this time but not apparently in Britain and America? Various answers are possible. The conclusion we came to in our paper was that while structural factors had indeed been important in allowing abuses of psychiatry to become widespread, the underlying vulnerability of psychiatry arose not from lack of clinical or scientific rigor but rather from a failure to recognize the extent to which values (as well as facts) are important in psychiatric diagnosis. In other Soviet psychiatry, then, so this hypothesis goes, Soviet values were driving the judgment that someone who campaigned to replace the Soviet system was irrational (they had a masked or 'sluggish' form of schizophrenia) and, correspondingly, were suffering from delusions (of reformism).

This is clearly a large and contentious claim that we do not have space here to discuss in detail. Its justification requires at the very least the fine-tuning point (made in the original paper) that risks of abuse arise only when totalitarian regimes become (like the Soviet regime in the 1960s and 1970s) partially liberalized: an all-powerful regime simply represses dissidents. The claim rests furthermore on a body of theoretical work in linguistic philosophy about the relationship between evaluative and factual meanings which itself is unresolved (Fulford and van Staden, 2013). However, given the similar institutionalized abuses of psychiatry in other (partially liberalized) totalitarian regimes (such as China, Human Rights Watch/Geneva Initiative on Psychiatry, 2002) it is at least a reasonable working hypothesis. And as a working hypothesis, it leads directly to the need to take the values in psychiatric diagnosis as seriously as we already take the facts.

What taking the values in psychiatric diagnosis seriously means for practice is to adopt an open and pluralistically balanced approach of the kind that is supported by the several process elements of values-based practice. Such an approach has been developed in the UK (Fulford et al., forthcoming), though, as we will see from the next study, with variable success.

Positive Practice: Values-Based Involuntary Treatment

Our example of positive practice comes from a series of policy and practice initiatives developed under the auspices of the UK's Department of Health where one of us worked for a period as Special Advisor for Values-based Practice (Fulford, Dewey and King, forthcoming). The particular initiative we have chosen to describe is not in diagnosis as such

but the assessments involved in involuntary (or coercive) psychiatric treatment. This might perhaps seem an unlikely source of positive practice. There are after all those who would say that the very possibility of involuntary *psychiatric* treatment puts psychiatry and psychiatric patients at a stigmatizing disadvantage relative to their bodily medicine counterparts (Sayce, L., 1998 responding to Szmukler et al., 1998).

Values-based practice nonetheless has the clear consequence that involuntary no less than voluntary psychiatric treatment demands a positive approach (Fulford, King and Dewey, 2009). Positive practice in involuntary treatment is important moreover as a 'proof of product': if values-based practice can support positive practice in the uniquely challenging decisions involved in involuntary treatment, it surely has a role across psychiatry as a whole. The initiative in question furthermore had every chance of success in that the key elements needed to support values-based involuntary treatment (a set of Guiding Principles operating as a framework of shared values) were embodied in a new Mental Health Act, that practitioners were required to have regard to these elements in any decisions they made under the powers of the Act, and that they were supported in this by an extensive training program rolled out by the Department of Health to support implementation. Yet in the event, despite successful pilot projects, the approach failed to take hold across psychiatric practice as a whole (Fulford, King and Dewey, forthcoming).

Values-based involuntary treatment we should add is not alone among positive practice initiatives in failing to generalize from successful local pilots to mainstream practice: recovery, person-centered care, and latterly co-production, have all suffered similar problems of generalization (Ahmad et al., 2014). Again, we do not have space here to discuss the many possible reasons for this. A key factor though in the case of values-based involuntary treatment, has been what we called earlier the 'retreat to monism'. Positive practice in involuntary treatment, on the model developed in the UK, requires a dissensual approach that, as we saw earlier, in turn depends critically on values pluralism. Values pluralism proved to be relatively easy to sustain in the context of local pilots and training programs. But what happened as the program moved out into the wider world of everyday practice was a dramatic and more or less complete retreat to monism. In place of the required dissensual approach balancing key shared values, decision making under the Act became dominated by one or another *single* value (notably risk and resources, Fulford, Dewey and King, forthcoming).