ETYKA 54, 2017

Values and Values-based Practice: a Model for Partnership between Philosophy and Science in 21st Century Psychiatry

KWM Fulford, St Catherine's College, Oxford

The second half of the twentieth century was an exciting time for psychiatry. Remarkable advances in the neurosciences, building on the carefully laid empirical foundations of descriptive classifications, and culminating in the 1990's 'decade of the brain', held out the promise of psychiatry following bodily medicine towards lesion--based etiological theories of psychiatric disorder with corresponding breakthroughs in treatment. Yet by the start of the twenty-first century disenchantment had set in. The North American psychiatrists, David Kupfer, Michael First and Daryl Regier, captured the mood in the introduction to their (2002) *Research Agenda for DSM-V*. Noting that clinical advances had failed to materialize from Twentieth Century descriptive classifications, they argued for 'an as yet unknown paradigm shift' that would 'transcend the limitations of the current DSM paradigm' (2002, p. xix).

So where should we look for the required new paradigm? Kupfer, First and Regier in their *Agenda* look to the neurosciences. In this article I argue that while the neurosciences will indeed be irreducibly important the risk is that without philosophy, instead of a new paradigm they will produce just more of the same. Starting with a case study, of delusion and spiritual experience, I show how philosophy (specifically philosophical value theory) has been a partner to clinical science in developing what has become known as values-based practice. I give a brief introduction to values-based practice and illustrate its clinical impact in contexts ranging from psychiatry to surgery. The philosophy-plus-science partnership of values-based practice, I suggest in the final section of the paper, is a template for the new paradigm to which Kupfer, First and Regier aspire. I review the resources for and some of the challenges involved in taking forward a successful partnership between philosophy and science in twenty-first century psychiatry.

A Case Study in Philosophical Value Theory

Philosophical value theory is a branch of the mid-twentieth century movement in Oxford analytic philosophy called ordinary language philosophy. The 'Oxford School', as it has come to be called, has many connections with clinical practice (Fulford, 1990). One such connection is that ordinary language philosophy like clinical practice starts with the stories of real people (Austin, 1956-7).

Simon's story

Simon, aged 40, was a black, American lawyer whose previously successful career was now threatened by legal action from a group of colleagues. Although he had long-since given up his religious faith, he responded to this crisis by praying at a small altar that he set up in his front room. After an emotional evening's „outpouring", he discovered that the candle wax had run down marking certain words and phrases of his bible.

He described his experiences thus. „I got up and I saw the seal [the wax marked words and phrases] that was in my father's bible and I called X and I said, you know, ,something remarkable is going on over here.' I think the beauty of it was the specificity by which the sun burned through. It was … in my mind, a clever play on words." The marked words and phrases had no explicit meaning but Simon interpreted them as direct communications from God signifying that he had a special purpose or mission: that „I am the living son of David … and I'm also a relative of Ishmael, and … of Joseph". He was also the „captain of the guard of Israel".

Simon so described has 'delusional perceptions' as defined in empirically reliable psychiatric diagnostic schedules such as the PSE (Present State Examination, Wing, Cooper and Sartorius, 1974, pps 172 - 173). The presence of delusional perception is sufficient for a diagnosis of schizophrenia (or related psychotic disorder) in the ICD (World Health Organization's, 1992, Diagnostic and Statistical Manual).

Yet in Simon's case his experiences far from being symptoms of a serious mental disorder turned out to be empowering. He was guided by the marked passages in his bible from this and subsequent similar episodes to defend and in the event win his case. The result was that his reputation as a lawyer was much enhanced. He went on to make a great deal of money with which he established a research trust for the study not of psychotic illness but of religious experience.

Psychiatric diagnostic values in Simon's story

Values are widely thought to be somehow at odds with the scientific basis of medicine. Simon's story shows to the contrary that in psychiatry at any rate values and science are closely linked. The link is evident in no less a context than psychiatry's explicitly science-based diagnostic manual, the DSM (Diagnostic and Statistical Manual, American Psychiatric Association, 2013). In DSM, as in ICD, delusional perception is among the symptoms for schizophrenia and related psychotic disorders. DSM however differs from ICD in requiring in addition to the relevant symptoms, impairment in occupational or social functioning.

DSM's Criterion B, as it is called, requires that in addition to the requisite symptoms the person concerned must show a 'level of functioning in one or more major areas, such as work, interpersonal relations, or self-care, (that) is markedly below the level achieved prior to the onset …' (DSM, p 99). In Simon's case, then, his work functioning (as a lawyer) was above rather than (as required by this criterion) below the level previously achieved. So DSM unlike ICD leaves diagnostic space for understanding Simon's story (as Simon himself understood it) not in terms of pathology but of religious or spiritual experience.

But now notice this. The diagnostically critical criterion in Simon's story, Criterion B, is a *value* criterion. DSM's Criterion B requires not just a change in Simon's functioning but one or more value judgments about whether the change is *below* the level previously achieved, ie a change *for the worse*. In Simon's story as recounted above it is clear that his work functioning was iif anything *above* his previous level, ie., it was a change *for the better* (in that he won his court case, etc). It may be of course that with further information the diagnostic picture will become less clear-cut. His interpersonal functioning for example might have taken a turn for the worse. But this makes still more obvious the evaluative nature of DSM's criterion of functioning. For this mixed picture then requires evaluations of Simon's level of functioning not just within a given area but between areas as well. It requires that is to say evaluations not just of his work functioning (whether this is enhanced or reduced) but also of how his enhanced work functioning compares with deterioration in his inter-personal relations.

Three ways of understanding psychiatric diagnostic values

One way of understanding the diagnostic importance of values in Simon's story is simply to dismiss his experiences as a one-off. But recent epidemiological work shows

that adaptive (or at any rate non-harmful) psychotic experiences are far from unusual (Johns and van Os, 2001). Nor are psychiatric diagnostic values limited to Criterion B. Values are critical to how mental disorder is understood (Fulford, 1989) and this is reflected in their diagnostic importance throughout both DSM (Sadler, 2005) and ICD (Fulford, 1994). Nor are the value judgments in question clinically trivial. Negatively, they are central to abuses of psychiatry (as in the former USSR, Fulford et al., 1993). Positively, they are key to contemporary person-centered approaches to recovery (Allott et al., 2005).

A rather different way of understanding the values in Simon's story is to accept that here as elsewhere in psychiatric diagnosis, they are important but to regard them as in one way or another irrelevant to psychiatric science. Surprisingly, perhaps, this has been the approach equally of opponents and of supporters of psychiatry as a medical discipline. For opponents of psychiatry, like Thomas Szasz' (1960), psychiatric diagnostic values show psychiatry to be out-with medical science. Supporters on the other hand, such as RE Kendell (1975) and Christopher Boorse (1975 and 1976), regard diagnostic values as a merely temporary reflection of (what they take to be) the primitive stage of development of psychiatric science and thus due to disappear once psychiatric science catches up with other areas of medicine.

Philosophical value theory offers a third and very different way of understanding psychiatric diagnostic values. For philosophical value theory suggests that psychiatric diagnostic values far from being in one or another way irrelevant to psychiatric science are at the very heart of it. It will be worth looking at the point a little more closely as it is central to understanding how neuroscience and values come together in developing a clinical science for twenty-first century psychiatry.

Philosophical value theory and psychiatric diagnostic values

We owe a clear statement of the key insight from philosophical value theory to a former White's Professor of Moral Philosophy in Oxford, RM Hare (1952). Hare's insight can be summed up as 'visible values = diverse values'. What this means is that while values are in play much of the time we tend to notice them only when they are diverse and hence cause trouble. Values are in this respect like the air we breathe – all around us, and essential, but remaining largely unnoticed until (as when it is in short supply) it causes difficulties. Hare illustrated his point by comparing 'good strawberries' with 'good pictures'. 'Good strawberry' and 'good picture' are both evaluative concepts. But 'good picture' is more explicitly evaluative than 'good strawberry' because whereas we tend to agree about what makes for good strawberries ('red, sweet, grub free, etc')

our views about what makes for a 'good picture' are highly diverse. Hence we tend not to notice the values in 'good strawberry' whereas disagreements about 'good picture' make the value judgments in question all too visible.

Applying Hare's insight to medicine (Fulford, 1989) suggests that psychiatric diagnostic values directly reflect the engagement of psychiatric science with the diversity of human values. If Hare is right, that is to say, diagnostic values although important in all areas of medicine remain (like the air we breathe) unnoticed. In cardiology for example the concept of impaired heart functioning is evaluative in the same way as DSM's criteria of social and occupational functioning: both require a judgment that the function in question is reduced. The difference is that in the case of hearts everyone has more or less the same criteria of good or bad functioning. So we don't notice the values because they are homogeneous and hence don't cause trouble. But psychiatry is concerned with areas of human and experience and behavior – such as emotion, desire, belief, sexuality and so forth - in which our criteria of good and bad functioning are highly diverse. Hence the value judgments required for distinguishing good and bad functioning in psychiatry are difficult in ways and to an extent that the corresponding value judgments for heart functioning are not. Hence the values in psychiatric diagnosis become visible (as in DSM's Criterion B) while the corresponding values in cardiological diagnosis do not.

Hare's point is important for theory. It shows the clinical science of psychiatry to be (in respect of values) identical in principle with the clinical sciences of any other area of medicine. But it is also important practically. For it switches attention from one or another attempt to exclude values from psychiatric diagnosis to developing the skills to work with them more effectively. This is where values-based practice comes into play.

Values-based Practice

There are of course many resources for working with values in medicine: ethics, health economics, decision analysis, and so forth. Derived by applying philosophical value theory to the language of medicine (Fulford, 1989), and building on empirical work on values (Colombo et al., 2003), values-based practice adds to these resources a skills-based approach to balanced clinical decision-making where diverse values are in play (Fulford, 2004). The skills and other process elements of values-based practice are shown diagrammatically in Figure 1. As this indicates, values-based practice is a partner to evidence-based practice. Together they support balanced decision-making on individual cases within frameworks of shared values. (See generally, Fulford, Peile and Carroll, 2012.)

Based as it is on learnable clinical skills, values-based practice is better understood by 'doing than saying'. The following exercise, which is taken from the training programme in values-based surgical care described below, illustrates the crucial link between values-based and evidence-based approaches. You may want to try this for yourself before reading on.

The exercise shown in Figure 2 is taken from the programme in values-based surgical care described below. The task is to imagine what you would do if you had to choose between two competing treatments for an otherwise fatal disease. If you try this for yourself think about your answer not in an abstract way but in a way that is personal to you. This isn't easy. But ask yourself, 'given me as I am now, at my age and in my life circumstances, what would I choose?'

Write down your own answer before reading on. You may be surprised where you would come compared with the range of answers shown in Figure 3. As this indicates people choose very different periods in this exercise. Often people sitting next to each other and who know each other really well are really surprised with their very different answers. But they soon come to see that this is because they have different values. What *matters to* one person, for example, may be that they have a young family and want enough time to see them safely grown up – so their minimum is twenty years. But their neighbour goes for only six months because the most important thing to them is to finish their PhD. (These examples are based on an actual seminar, Handa et al., 2016.)

The message of this exercise is thus about diversity of individual values. The evidence base is the same for everyone taking part in the exercise. But they all make very different choices because their values are very different. This is why values-based practice and evidence-based practice are partners in clinical decision-making. We need the evidence to inform our choices. But the choices we actually make will vary widely reflecting the diversity of our values as unique individuals.

Developments in values-based practice

With its combined philosophical and empirical roots (Fulford and van Staden, 2013), it is perhaps not surprising that the development of values-based practice should have been driven primarily by way of skills training for frontline staff. The first training manual, '*Whose Values?*'(Woodbridge and Fulford, 2004), was launched by Rosie Winterton, at the time the Minister of State with responsibility for mental health, at a conference in London in 2005. *Whose Values?* Subsequently became the basis for a series of national policy, training and service developments in the UK co-produced

by service users with service providers: these included a national framework of values for mental health policy development (National Institute for Mental Health in England, 2004), good practice guidance on mental health assessment (National Institute for Mental Health in England (NIMHE) and the Care Services Improvement Partnership, 2008; described in Fulford et al., 2015a), and a training manual to support implementation of the UK's Mental Health Act 2007 (concerned with involuntary treatment) (Care Services Improvement Partnership (CSIP) and the National Institute for Mental Health in England (NIMHE), 2008, described in Fulford et al., 2015b). There have been similar initiatives in a number of other countries (Fulford et al., 2004) including work drawing on non-European (in particular African) philosophy (Crepaz-Keay et al., 2015; and van Staden and Fulford, 2015).

A book series on values-based medicine launched by Cambridge University Press includes an introduction to values-based practice (Fulford, Peile and Carroll, 2012), volumes on values-based teamwork (Thistlethwaite, 2012) and values-based service commissioning (Heginbotham, 2012), and an edited collection debating various aspects of the theory and practice of values-based approaches (Loughlin, 2014). An early volume in the series focused on recovery practice in psychiatry (Slade, 2009).

The recently established Collaborating Centre for Values-based Practice at St Catherine's College in Oxford provides a forum for bringing together these diverse initiatives and extending values-based approaches from their origins in mental health to other areas of medicine and social care. In its first year the Centre has established a programmes in three main areas: education and training, regulation and guidance, and integration and teamwork; these initiatives are supported by an international Theory Network. Education and training initiatives include a programme in values-based surgical care run in partnership with the Nuffield Department of Surgical Sciences in Oxford. This includes a training manual and resource base for similar developments in other areas of medicine. (See generally, the Centre's website at valuesbasedpractice.org)

Philosophy, Psychiatry and Neuroscience

Values-based practice illustrates the potential for partnership between philosophy and science in responding to the research and clinical challenges of psychiatry. Drawing on the resources primarily of just one relatively neglected area of analytic philosophy, philosophical value theory, the partnership as indicated in the last section has delivered both for theory and for practice. For theory, it has produced new understanding of the significance of values in psychiatric diagnostic concepts

(as a reflection not of scientific inadequacy but of the diversity of human values). For practice, it has produced the skills training and other process elements of values-based practice that together with the corresponding processes of evidence-based practice, support clinical decision-making where diverse values are in play.

In this final section of the paper I outline the scope for building on the model of values-based practice in other areas of philosophy. I summarize the resources for partnerships between philosophy and neuroscience available from the newly emergent field of philosophy and psychiatry; I note a particular opportunity for developing such partnerships arising from the perhaps unlikely quarter; and I indicate a major challenge in the way of success.

Philosophy and psychiatry

The rapidly expanding field of philosophy and psychiatry represents a ready-made resource for partnership between philosophy and neuroscience. Cross-disciplinary work between philosophy and psychiatry is of course not new. The recently celebrated centenary of Karl Jaspers' *General Psychopathology* is a sufficient reminder, if reminder were needed, of the seminal role of philosophy in the origins of contemporary psychopathology (Stanghellini and Fuchs, 2013). Less well known though no less significant for contemporary psychiatry was the (*de facto*) partnership between the psychiatrist Aubrey Lewis and philosopher of science Carl Hempel in the origins of our current symptom-based diagnostic classifications (Fulford and Sartorius, 2009).

Aside though from continuing work in phenomenology it was not until the last decade of the twentieth century that philosophy and psychiatry took off as a significant international research-led discipline (Fulford et al., 3003). Developments in the field are summarized in Figure 4. Highlights include: new academic and professional organizations in many parts of the world including sections in major international psychiatric organizations such as the *World Psychiatric Association* and the *European Psychiatric Association*; annual conferences in partner counties of the *International Network for Philosophy and Psychiatry* established at a conference in Florence in the millennial year and launched from Cape Town in 2002 (a conference in Warsaw is planned for 2019); a vigorous programme of publication through both peer-reviewed journals and book series from major publishers - the quarterly *PPP* (*Philosophy, Psychiatry and Psychology*) from The Johns Hopkins University Press recently celebrated its twenty-first year; the Oxford University Press *IPPP* (*Inter-*

national Perspectives in Philosophy and Psychiatry) launched in 2003 has published over fifty volumes including major Oxford Handbooks on *Philosophy and Psychiatry* (Fulford et al., 2013), *Psychiatric Ethics* (Sadler et al., 2015) and *Phenomenological Psychopathology* (a forthcoming volume edited by Giovanni Stanghellini); and new academic programs including Professorial Chairs in many parts of the world and a recently endowed tutorial post at St Catherine's College in Oxford (the *Fulford-C-larendon Fellowship* held by Philip Koralus) .

Among academic disciplines phenomenology and the philosophy of mind illustrate the potential of the new cross-disciplinary field for meeting the research and clinical challenges of psychiatry. As such these fields continue Jaspers' agenda. Trained in the neurosciences Jaspers was nonetheless concerned that the neurosciences of his day although producing major breakthroughs (such as the discovery of Alzheimer's disease and neurosyphilis) had become unbalanced. His *General Psychopathology* was thus intended to balance the empirical methods of the brain sciences with a correspondingly powerful phenomenological method for studying subjectivity. It is this balancing up agenda that has been taken up afresh in today's philosophy and psychiatry with innovative work across a range of psychopathologies and drawing on a variety of phenomenological approaches from both established and up-and-coming figures in the new field (Fulford et al., 2003).

I do not have space here to list let alone do justice to the many other areas of the new field already making potentially important contributions to psychiatry. One indication however of the richness of the resource that collectively they represent is the structure of the *Oxford Handbook of Philosophy and Psychiatry* (noted above). Oxford Philosophy Handbooks offer comprehensive edited collections reflecting the state of development of a given philosophical field. Standardly the Handbook of Philosophy and Psychiatry would thus have been organized around traditional philosophical disciplines (philosophy of mind, philosophy of science, etc.,). But it was organized instead around the stages of the clinical encounter with sections running from 'staying well' through 'diagnosis' to 'treatment, cure and care'. Aside from a brief historical introductory section all the major contributions to the new philosophy and psychiatry (over seventy in all) mapped naturally onto this essentially clinical framework. The origins of the structure furthermore reflected the power of partnership between philosophy and psychiatry. Although a clinical structure, it was two philosophers in the editorial team, Martin Davies (at the time Head of the Oxford Philosophy Faculty) and Will Davies, who suggested it; but it was developed and shaped by psychiatrist and phenomenologist Giovanni Stanghellini.

An opportunity and a challenge

The recently published RDoC (Research Domain Criteria) Framework offers a timely opportunity for philosophy and psychiatry to work in partnership with the neurosciences.

To some RDoC may seem an unlikely ally for philosophy. RDoC was published by the North American neuroscience funding organization, NIMH (National Institute for Mental Health), as a direct response to concerns about the failure of DSM to produce clinically useful research. The Director of NIMH at the time, Thomas Insel, made this clear in a blog post announcing the publication of RDoC just a few weeks before the American Psychiatric Association was due to launch DSM-5 (Insel, 2013). RDoC, Insel explained, was not a classification. Its aim was rather to break away from the restrictions of the DSM by providing a framework for bringing together and correlating the results of neuroscientific research on brain systems as these came in over the next few years. From these results in turn, he anticipated, would come new insights into the brain mechanisms underpinning psychiatric disorders and, hence, improved treatments.

RDoC is thus a framework for neuroscientific research on changes in brain systems underlying mental disorders. The opportunity though for partnership between neuroscience and philosophy comes in the detail of the RDoC framework. For the framework does indeed focus on brain systems but it also includes *patients' experiences of mental disorder*. The DSM classification system is limited to pre-defined symptoms. RDoC by contrast has space for incorporating into research the new insights into patients' experiences of mental disorder provided by phenomenology and the philosophy of mind. RDoC thus opens up the possibility of new and clinically relevant findings by making it possible in principle to take equally seriously the subjective as the objective aspects of mental disorder.

Whether NIMH will actually provide funding for joint research between philosophy and neuroscience remains to be seen. In an article describing NIMH's hopes for RDoC, psychologist Bruce Cuthbert (who had spearheaded the development of RDoC in NIMH) called for innovation: the success of the new framework, he said, would be measured by the extent to which new research projects actually outstrip the RDoC framework (Cuthbert, 2014). But Cuthbert's focus in his article was predominantly on the brain science side of the objective/subjective balance. And the exemplars RDoC gave on its website of research techniques for studying patients' experiences in the relevant units of analysis ('self reports' and 'behavior') were confined to symptom check lists and questionnaires of the kind familiar from DSM (Fulford, 2014).

The challenge then is to turn the opportunity for partnership between philosophy and neuroscience in psychiatry offered by RDoC into reality. We should not underestimate the size of this challenge. Jaspers' after all was in much the same position as contemporary philosophy and psychiatry in seeking to balance the power of the neurosciences of his day with equally powerful methods for studying subjectivity. Yet for all Jaspers' efforts subjectivity remained for much of the twentieth century firmly in second place to objectivity. True, there are reasons to be more hopeful of progress today (Fulford et al., 2014): philosophy and psychiatry are represented not by one man but by a whole community of researchers; the range of philosophical expertise available is correspondingly wider; and the range of practical expertise is wider as well extending as it does to the expertise-by-experience of patients as well as the expertise-by-training of traditional research disciplines.

Conclusions

This has been a paper in two halves separated by an excursus. Starting from a case example, Simon's story, the first half of the paper showed how philosophical value theory provides a key insight into the diagnostic values characteristic of psychiatric classifications such as the DSM. Philosophical value theory shows psychiatric diagnostic values to be a reflection not as had previously been supposed of a primitive or underdeveloped psychiatric science but rather of the engagement of psychiatry with the diversity of individual human values.

This conclusion led into a brief excursion into values-based practice as a new resource for working with diverse values in healthcare. A key point that was made about values-based practice is that although derived philosophically (from philosophical value theory) it works always in close partnership with the scientifically derived evidence-based practice.

Building on the model of partnership between values-based and evidence-based practice the second half of the paper explored the potential for wider partnership between philosophy and science in psychiatry. The explosion of work in philosophy and psychiatry over the last two decades provides a rich resource for such a partnership; and the publication of the RDoC framework with its recognition of the importance of subjectivity in the brain sciences offers a timely opportunity for developing the partnership; but there remain a number of challenges in the way of successful implementation.

The challenges notwithstanding, the paper concluded, there are good reasons to anticipate ultimate success. As to the required timeline for success, however, we

would do well to recall Max Plank's (1950, p 33) observation from his perspective as a Nobel-laureate physicist, that new sciences aren't born, old scientists die.

Acknowledgments

Simon's story is based on one of a number of cases collected by Mike Jackson as part of his doctoral work and published in Jackson, M., and Fulford, K.W.M., (1997) Spiritual Experience and Psychopathology. Philosophy, Psychiatry, & Psychology, 4/1, 41-66.

References

Austin, J.L. (1956-7) A plea for excuses. Proceedings of the Aristotelian Society 57:1-30. Reprinted in White, A.R., ed. (1968). The Philosophy of Action. Oxford: Oxford University Press, pps 19-42.

Boorse, C. (1975) On the distinction between disease and illness. Philosophy and Public Affairs, 5: 49-68.

Boorse, C. (1976) What a theory of mental health should be. Journal for The Theory of Social Behaviour, 6: 61-84.

Care Services Improvement Partnership (CSIP) and the National Institute for Mental Health in England (NIMHE) (2008) Workbook to Support Implementation of the Mental Health Act 1983 as Amended by the Mental Health Act 2007. London: Department of Health.

Colombo, A., Bendelow, G., Fulford, K.W.M. & Williams, S. (2003) Evaluating the influence of implicit models of mental disorder on processes of shared decision making within community-based multidisciplinary teams. Social Science & Medicine, 56: 1557-1570.

Cuthbert B. N., (2013) The RDoC framework: facilitating transition from ICD/DSM to dimensional approaches that integrate neuroscience and psychopathology. World Psychiatry. 13(1): 28-35

Crepaz-Keay, D., Fulford, K.W.M., van Staden, W., (2015) Putting both a person and people first: interdependence, values-based practice and African Batho Pele as resources for co-production in mental health. Ch 4 in Sadler, J.Z., van Staden, W., and Fulford, K.W.M., (Eds) The Oxford Handbook of Psychiatric Ethics. Oxford: Oxford University Press

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

Fulford, K.W.M., (1990) Philosophy and Medicine: The Oxford Connection. British Journal of Psychiatry, 157, 111-115.

Fulford, K.W.M. (2004) Ten Principles of Values-Based Medicine. In Radden, J. (Ed) The Philosophy of Psychiatry: A Companion. New York: Oxford University Press.

Fulford, KWM (2014) RDoC+: Taking Translation Seriously (commentary on Cuthbert, 2014). World Psychiatry 13(1): 54 – 55

Fulford, K.W.M. and Sartorius, N. (2009), A Secret History of ICD and the Hidden Future of DSM. Chapter 2 in Broome, M. and Bortolotti, L. (eds) Psychiatry as Cognitive Neuroscience: Philosophical Perspectives. Oxford: Oxford University Press, Ppp29-48

Fulford, K.W.M., and van Staden, W., (2013) Values-based practice: topsy-turvy take home messages from ordinary language philosophy (and a few next steps) chapter 26, pps 385 – 412 in Fulford, K.W.M., Davies, M., Gipps, R., Graham, G., Sadler, J., Stanghellini, G., and Thornton, T. (Eds). The Oxford Handbook of Philosophy and Psychiatry. Oxford: Oxford University Press

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

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

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

Fulford, K. W. M., Bortolotti, L., and Broome M. (2014) Taking the long view: an emerging framework for translational psychiatric science. Special Article for World Psychiatry. 13/2, 108 – 117.

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

Fulford, K.W.M., Dewey, S., and King, M. (2015b) Values-based Involuntary Seclusion and Treatment: Value Pluralism and the UK's Mental Health Act 2007. Ch 60, in

Sadler, J.Z., van Staden, W., and Fulford, K.W.M., (Eds) The Oxford Handbook of Psychiatric Ethics. Oxford: Oxford University Press

Handa, IA., Fulford-Smith, L., Barber, ZE., Dobbs, TD., Fulford, KWM., and Peile, E (2016) The importance of seeing things from someone else's point of view. BMJ Careers on-line journal http://careers.bmj.com/careers/advice/The_importance_of_seeing_things_from_someone_else's_point_of_view

Heginbotham, C (2012) Values-Based Commissioning of health and Social Care. Cambridge: Cambridge University Press

Insel TR. (2013) Transforming diagnosis. www.nimh.nih.gov.

Kendell, R.E., (1975) The concept of disease and its implications for psychiatry. British Journal of Psychiatry, 127: 305-315.

Kupfer, D.J., First, M.B. and Regier, D.E. (2002) Introduction. Pps xv – irreduciblyiii In Kupfer, D.J., First, M.B. and Regier, D.E. (eds) A Research Agenda for DSM-V. Washington: American Psychiatric Association.

Loughlin, M (2014, Ed) Debates in Values-based Practice: arguments for and against. Cambridge: Cambridge University Press

National Institute for Mental Health in England (2004) The National Framework of Values for Mental Health. London: Department of Health. (Reproduced in full in Woodbridge and Fulford, 2004, and in Fulford, 2011).

National Institute for Mental Health in England (NIMHE) and the Care Services Improvement Partnership (2008) 3 Keys to a Shared Approach in Mental Health Assessment. London: Department of Health.

Planck, M. (1950) Trans. F. Gaynor. Scientific Autobiography and other papers. London: Williams & Norgate.

Sadler, J.Z., van Staden, W., and Fulford, K.W.M., (Eds) (2016) The Oxford Handbook of Psychiatric Ethics. Oxford: Oxford University Press

Slade, M (2009) Personal Recovery and Mental Illness: A Guide for Mental Health Professionals (Values-Based Medicine) Cambridge: Cambridge University Press

Stanghellini, G., and Fuchs, T., (2013) (Eds) One Century of Karl Jaspers' General Psychopathology. Oxford: Oxford University Press

Szasz, T.S.: 1960, "The myth of mental illness", American Psychologist, *15*, pp. 113-118.

Thistlethwaite, J. E., (2012) Values-Based Interprofessional Collaborative Care: Working Together in Healthcare. Cambridge: Cambridge University Press

van Staden, W and Fulford, K.W.M., (2015) The Indaba in African Values-based practice: respecting diversity of values without ethical relativism or individual liberalism. Ch 28, in Sadler, J.Z., van Staden, W., and Fulford, K.W.M., Eds The Oxford Handbook of Psychiatric Ethics. Oxford: Oxford University Press

Wing, J.K., Cooper, J.E. and Sartorius, N. (1974) Measurement and classification of psychiatric symptoms. Cambridge: Cambridge University Press.

Woodbridge, K., and Fulford, K.W.M. (2004) Whose Values? A workbook for values-based practice in mental health care. London: Sainsbury Centre for Mental Health.

World Health Organization (1992) The ICD-10 Classification of Mental and Behavioural Disorders: Clinical Descriptions and Diagnostic Guidelines. Geneva: World Health Organization.