

Theories for Mental Health Nursing

A Guide for Practice

edited by

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Philosophy of Mental Health

ALASTAIR MORGAN

Learning Objectives

- Understand the importance of philosophical ideas in mental health theory and practice.
- Understand the four main themes of philosophical controversy in mental health care.
- Apply these themes to concrete examples in contemporary mental health practice.

Introduction

There is a strong case to be made that the discipline of philosophy should be central to all mental health care and practice. What is it about mental health and mental illness that should lead us to philosophical enquiry? Radden (2004) has articulated the centrality of philosophical questions to any interrogation of the concept of mental disorder. She writes that:

Conceptions of rationality, personhood and autonomy, the preeminent philosophical ideas and ideals grounding modern-day liberal and humanistic societies such as ours also frame our understanding of mental disorder and rationales for its social, clinical and legal treatment. (Radden, 2004: 3)

When we think through questions of what it means to experience mental distress we are immediately confronted with a range of philosophical questions. These can be questions about personal identity, ownership of thoughts and experiences and

the nature of the self and its relationship to the world and other people. These can also be questions about how we can classify and label mental health conditions and what our evidence is for labelling them as diseases. How do we understand the biological underpinning of mental illnesses and what is the relationship between the mind and the brain? How are we justified in detaining and treating people with mental illnesses against their will?

Furthermore, the very nature of mental distress and the experiences that accompany it raise questions that are often akin to a process of philosophical questioning. Mental distress can be characterised as a set of experiences that are centrally concerned with meaning and the self in a manner quite different from physical illnesses. Although one might question one's life, identity and relationships when diagnosed with a serious physical illness like cancer, it is not the illness itself that is a repository of such meanings but the impact it has on your life. In contrast, mental illnesses such as depression and psychosis are themselves full of meaning about who one is, how one relates to the world and the significance of one's life and experience. Fulford et al. (2003) argue that the discipline of psychiatry is unique amongst medical specialities in that its central concepts and categories are not only difficult to define but highly contested. A person experiencing psychosis may not label their disorder in medical terms and may actively dispute any medical description of their experience as schizophrenia. Mental distress is thus a field of complex and contested definitions and an experience which itself is a crisis of meaning, identity and relations with the self and the world, hence the centrality of philosophical questions in mental health care and day-to-day practice (Fulford et al., 2003).

What is philosophy?

The literal meaning of philosophy comes from the Ancient Greek meaning 'love of wisdom'. In the *Theaetetus*, Plato outlines a concept of philosophy as a fundamental questioning of the basis of the world in an attitude of wonder (Plato, 1987). This fundamental questioning leads philosophy to a desire to uncover the foundations of knowledge. This philosophical project is encapsulated in the work of Descartes who wrote in his *Meditations* that his philosophical goal was to uncover the solid and certain foundations for all knowledge (Descartes, [1641] 1984). Interestingly, the method by which Descartes attempted to do this was through a radical scepticism; he doubted everything to try and identify a secure and certain foundation for all knowledge. In this project, Descartes united two key elements of philosophy, a

critical and sceptical deconstruction of knowledge, alongside the attempt to provide foundational underpinnings for knowledge.

Later philosophers were critical of this attempt to provide certain foundations for knowledge as the supreme philosophical task. They preferred a more modest description of philosophy as a critical reflection upon the possibilities, justification and limitations of thought. This critical reflection may not produce certainty, only plausible beliefs based upon limited evidence. Hume argues that philosophy cannot provide ultimate foundations for thought and that it can only draw plausible and provisional conclusions based on a critical examination of the evidence of experience (Hume, [1739–40] 2000). This conception of philosophy as critique, as the discipline that outlines the limits and boundaries of rationality became a key task of philosophy in the late eighteenth century and through the nineteenth century.

Philosophy is therefore an abstract enquiry into fundamental questions of existence, knowledge and morality. These areas are often broken down in the following manner as questions of ontology (namely questions about existence – what kinds of things are there in the world), epistemology (questions of knowledge – truth, validity, the limits of reason) and questions of ethics (what is right and what is wrong and how do we characterise a ‘good’ society). This set of definitions makes philosophy sound very withdrawn from everyday life; however, increasingly philosophers have felt it important to be engaged in applications of knowledge and to try to clarify the concepts underpinning institutions, practices and ways of living.

Philosophy of mental health

Philosophy is characterised as the threefold investigation into questions of existence, knowledge and ethics. Therefore, philosophy of mental health can be characterised as an enquiry into these questions as they apply to mental health care (Thornton, 2007). In this chapter, I will focus on four main areas of interest for the philosophy of mental health. As Banner and Thornton (2007) argue that any philosophy of mental health needs to be oriented around practice and become a philosophy of mental health care, I will outline a contemporary issue that applies these philosophical questions in practice in each one of these areas.

The four areas for philosophy of mental health are as follows:

- The question of human consciousness, and particularly the relationship between mind and brain. How do we characterise the fundamental nature of human consciousness and what is the relationship between conceptions of the

human mind or psyche and its biological underpinning in neurochemical processes in the brain? Can we reduce experiences that are attributed to a person to neurochemical reactions in the brain, or are these fundamentally different levels of explanation?

- The question of mental illness as a disease. Can we classify mental distress as a form of disease or is it better understood as a response to societal and individual pressures rather than a form of illness? Should we classify and label forms of mental distress and can these classifications be validated, or should we dispense with all classification and attempt to understand distress in individual or narrative terms?
- The question of understanding the subjective experience of mental distress. How is it possible to understand and empathise with a mad experience? Should we try to explain it through biological processes or is it possible to empathise and understand the content of madness?
- The ethical issues in psychiatry, particularly the question of coercion and care. The ethical underpinning of mental health practice will be addressed in detail in a later chapter of this book, so here I will just consider briefly a contemporary contested ethical issue in mental health practice.

Mind and brain

The background to the mind/brain problem in psychiatry is the question of the biomedical model in psychiatry. The biomedical model remains the dominant model in mental health care, but it has been contested right from the origins of psychiatry as an academic and clinical discipline in the mid-nineteenth century (Double, 2003). Fulford et al. (2006) outline the origins of present-day psychiatry in what is often termed its 'first biological phase' from 1850 through to 1910, when the first professor of psychiatry, Wilhelm Griesinger, famously wrote that all mental illness is a disease of the brain (cited in Fulford et al., 2006: 146). The goal of psychiatry was to define an area of illness for mental disorders that could be analogous with that of physical illness. Therefore, the idea was that all mental illness could be shown to have a biological underpinning in terms of a brain disease, and that the underlying basis of mental illness would be either some form of inherited genetic abnormality or a pathological alteration in neurochemistry. Underlying this belief was a larger philosophical claim for biological reductionism. This is the idea that all experiences of the person can be reduced to their determinants in the brain. A strong reductionism will argue that mental illnesses should not be understood as

experiences occurring in a person, but only explained as biological abnormalities. The German psychiatrist Kurt Schneider gave a very succinct outline of this form of reductionism when he argued that when we assess a person experiencing psychosis:

Diagnosis looks for the 'How' (form) not the 'What?' (the theme or content). When I find thought withdrawal then this is important to me as a mode of inner experience and as a diagnostic hint, but it is not of diagnostic significance whether it is the devil, the girlfriend or a political leader who withdraws the thoughts. Wherever one focuses on such contents, diagnostics recedes; one sees then only the biographical aspects or the existence open to interpretation. (cited in Bentall, 2004: 31)

Schneider, here, expresses a central belief of biological psychiatry. Engagement with the content of experiences is of limited importance. These are just surface expressions of an underlying disease process that is ultimately biologically determined and driven.

A variant of reductionism, which could be termed a weak reductionism, will argue that biological vulnerabilities interact with environmental stressors and personal experiences to produce illnesses. The stress vulnerability model in mental health care is a variant of a weak reductionist approach, in that it hypothesises a biological vulnerability that is then only later expressed or developed due to the stresses the person faces (Zubin and Spring, 1977).

The reductionist approach to human consciousness is based on a philosophical argument that all states of human consciousness can be fundamentally explained by their reduction to neurological states. A prominent exponent of such a view is the philosopher Patricia Churchland. She argues that when we want to explore what it means to think, feel and decide then we should not explore the meanings that a person attributes to such activities. Rather we should look at the neural underpinnings of the activities, and it is these neural underpinnings that ultimately explain our behaviour. Churchland (2004) writes that:

... what I know depends on the specific configuration of connections among my trillion neurons, on the neurochemical interactions between connected neurons, and on the response portfolio of different neuron types. (Churchland, 2004: 42)

This reductionist argument leads to an emphasis on altering our neurochemical makeup through psychiatric drugs to ameliorate problems in our mental health (Moncrieff, 2008). However, many philosophers are critical of reductionist arguments and want to argue that complex human experience cannot be reduced to

brain states and that it does make sense to talk about the mind rather than the brain. The philosopher Alva Noe has written that consciousness can only be understood in terms of an interaction between brains, bodies and environments. The term 'mind' then can be used to refer to what Noe terms a 'living activity' rather than reduced to neural states (Noe, 2009: 7). Neural structures are of course necessary for consciousness to occur, but they are not the whole picture, and consciousness cannot be understood separately from human history, activity and culture, according to this argument. The biomedical model in psychiatry can therefore be seen to reduce minds to brains and to downplay the centrality of experience and society in the construction and causation of mental distress (Double, 2003).

Mind and brain: contemporary issues in neuroscience

One of the key contemporary interfaces where issues of mind and brain have come to the fore is through the growth of neuroimaging technologies. This is an area which is increasingly being used in mental health research if not in practice. Often subjects of research are asked to perform specific activities whilst having their brains scanned and then the results of such scans are produced and attempts are made to correlate brain activity with specific dysfunctions in people labelled with mental illness. These neuroimaging techniques are termed fMRIs (functional Magnetic Resonance Imaging). The use of the term functional relates to the notion of a research subject performing an activity whilst being scanned. The philosophical basis of much of this research is reductionist; the notion that you can reduce a complex set of behaviours, experiences and meanings to a specific activity that can then be correlated with levels of blood flow in the brain. These technologies that function through the production of images produce a powerful force for reductionist philosophies. As Johnson (2008) writes, these images function through producing a representation of a host of activities as reducible to brain states. These images of 'active brains' are powerful cultural icons of our time. As Fernando Vidal (2009) has pointed out, we are replacing a concept of 'personhood' with a concept of 'brainhood', an identity that ultimately refers all meaning to patterns of activity at a neuronal level. Cohn (2004) has indicated how such neuroimaging remains tied to a notion of reductionism due to its isolation of all activity to a specific, calculable and repeatable set of functions that are then, themselves, only loosely mapped on to the production of chemical activity in the brain. The philosopher and physician Raymond Tallis has termed the dominance of neuroscientific discourse a form of 'neuromania' (Tallis, 2011).

A central irony of this reductionist approach is that it has occurred at the time when biological science is moving away from reductionist models. This is particularly the case in genetics where the idea of defined heritable diseases through specific genetic abnormality is increasingly questioned in what has been termed the 'postgenome era' (McInnis, 2009). Following the complete mapping of the human genome in the early twenty-first century, scientists were shocked to discover that there were far fewer human genes than had previously been hypothesised (McInnis, 2009). This has moved research away from the pursuit of discrete genetic abnormalities that could underlie mental disorders and towards the complex relationship between how genes are expressed and the interrelationship between environment and gene expression. As McInnis (2009) writes, this is a move away from the possibility of reducing complex mental disorders to singular genetic causes.

What this brief survey of current controversies in medical research in neuroscience demonstrates is the continuing relevance and importance of philosophical discussions of consciousness to current understandings and conceptualisations of mental distress. Do we understand mental distress as simply the byproduct of a neurochemical misfiring, or as the complex unfolding of human experience in response to interpersonal and societal stresses? Ultimately, in the absence of clear pathological underpinnings for most mental illnesses, this debate becomes one of philosophical argument and justification.

Can we classify mental distress as an illness?

A central philosophical question for the practice of mental health care is the ontological status of mental illness itself. When we talk about mental distress are we discussing a disease process that is akin to physical illnesses, or is it better to conceptualise mental distress as a series of responses to life pressures? If we do dispense with a concept of disease then why do we include psychiatry within the medical sciences? If the classification of mental disorders continues to take place in the absence of underlying biological findings then how can we validate diagnoses and guarantee that clinicians are diagnosing correctly, or should we dispense with the whole process of diagnosing mental disorders?

The historical background to this set of questions lies in the absence of biological markers for most mental illnesses. Although biological markers for diseases affecting the older person such as dementia have increasingly been identified, the major classifications for disease within psychiatry have been developed in the absence of identifiable, underlying biological pathology (Read et al., 2004). Therefore, you

cannot conduct a simple blood test or brain scan to identify schizophrenia, bipolar disorder, depression or ADHD. Even the fact that there are two classification systems for psychiatric disorders testifies to the contested nature of these illnesses. Not only are there two classification systems, but these classification systems themselves are subject to constant historical revisions, and we are currently in the process of a major revision of diagnostic categories leading to the formulation of the DSM-V which will be published in 2013 (APA, 2000; ICD-10, 2010).

The major categories of mental disorder were constructed discursively through the observation and classification of institutionalised people within asylums. At the end of the nineteenth century the German psychiatrist Emil Kraepelin proposed that we could divide the major mental illnesses into two classifications, and these two distinct classifications developed into the diagnoses of schizophrenia and manic depression (later re-termed bipolar disorder) (Kraepelin, 1919). This classification system still broadly stands over 100 years later, although it is purely based on grouping people into observable signs and symptoms rather than any other biological basis, and this has led many people to question the system.

What is a disease?

The peculiar case of mental illnesses leads to a philosophical question as to the nature of disease. If we are to claim that mental illnesses are illnesses in the same way as physical illnesses then we need to try and clarify the concept of disease and how it applies to mental distress. One way of defining mental illness is by a so-called 'lesion' model of disease. Disease occurs if we can find some underlying biological abnormality or pathology, some form of damage or lesion to a bodily part, cell or tissue. In the case of mental illness, we would be looking for 'lesions' in the brain (Thornton, 2007). On this model of disease, most mental illnesses would not count as disease as there are no identifiable underlying biological abnormalities that are universally agreed upon as underlying the major classifications of mental illness. This argument led the writer Thomas Szasz to claim that mental illnesses are a 'myth' (Szasz, 1972).

However, other writers have disputed the 'lesion' model of disease. Kendell (1975) argues that there are many diseases that do not fit the simple model of causation by some easily identifiable 'lesion'. We can think of heart disease, diabetes, asthma or high blood pressure as examples. Kendell proposes a concept of 'biological disadvantage' rather than a 'lesion' model as the source for an all inclusive disease concept. Disease must include a deviation from a norm of health that puts the person at a

'biological disadvantage', which Kendell defines in terms of decreased fertility and life expectancy (Kendell, 1975: 311). Although Kendell claims that this concept of disease is value-free it is difficult to agree, in the sense that the definition of what is a biological disadvantage is highly susceptible to evaluations. Even his stress on fertility as a marker of health is itself a value. Why not pick another aspect of human behaviour, such as artistic ability? Kendell argues that his concept of disease can include specific mental illnesses and does escape the critiques of the 'lesion' model, but his own account is prone to problems.

The philosopher John Sadler has criticised notions of disease based on 'dysfunction'. He argues that any notion of 'dysfunction' will be values-based and therefore includes some kind of evaluation of the right way of living. This has implications for defining dysfunction purely in terms of departure from the norm and therefore of not being objective enough to count as a classification of disease (Sadler, 2005).

This general difficulty with defining diseases within psychiatry is even more complex as the very definition of mental disorder itself is highly contested. Pilgrim (2005) identifies an attempt to provide a legal definition of mental disorder by the UK government in the lead up to proposed changes to the Mental Health Act. Pilgrim cites the following definition of mental disorder by the Department of Health:

Mental disorder means an impairment of or a disturbance in the functioning of the mind or brain resulting from any disability or disorder of the brain, and 'mentally disordered' is to be read accordingly. (cited in Pilgrim, 2005: 435–6)

As Pilgrim (2005) notes, this definition raises a series of irresolvable philosophical problems. He writes that there is a confusion between identifiable neurological disorders and psychiatric problems. There is also a lack of definition of what exactly a dysfunction of 'mind' will be (Pilgrim, 2005: 436).

One proposed solution to these philosophical complexities is to get rid of the whole system of psychiatric classification and diagnosis. Bentall (2006) has proposed a 'complaint-oriented' model of mental illness. Rather than the classification and diagnosis of people according to highly contested diagnostic categories such as schizophrenia, we should simply understand and describe the experiences that people bring when they attend for help such as hallucinations, delusions, mania and disordered communication (Bentall, 2006: 224). Bentall proposes that health care practitioners should help people with their distress but not impose arbitrary medical categories upon their experience. Whilst this appears an attractive proposal and a solution to the problems of defining mental illness, there are two questions for

Bentall's approach. First, it becomes clear that even when attempting to move away from diagnostic categories, Bentall's list of complaints begins to sound stereotypically medical (i.e. he sidesteps the issue of just what is to count as a delusional belief and for whom). Second, is the issue that many people with severe mental distress do not present with complaints in the way that Bentall describes, so how are we to seek out and help these people without a classification system.

Classifications in practice: should the schizophrenia label be abolished?

This debate about the nature of mental illness and the use of classifications is not only of philosophical interest but it enters into day-to-day practice in mental health care. One example of this is the term 'schizophrenia', which has been used for over a century to define a range of experiences including hallucinations, strange beliefs, poor communication and poor ability to be motivated and make decisions. Boyle (1990) has argued that this grouping of symptoms does not necessarily make a coherent category for a disease or a syndrome. She writes that there is no coherent agreement as to onset of such a putative illness or the course of the illness or a prognosis for its outcome. This becomes particularly problematic in practice as many service users do not want the label schizophrenia and the consequences of such a label are highly stigmatising. Thornicroft et al. (2009) reported a study of people diagnosed with schizophrenia who found difficulty in maintaining jobs, friendship and sexual partnerships due to stigma and discrimination. Such was the stigma facing service users with the schizophrenia label in Japan that there was a campaign which eventually led to the renaming of schizophrenia as 'integration disorder' in 2002 (Sato, 2006).

A key issue in clinical practice was the labelling of all people with psychosis as experiencing schizophrenia, when psychotic experiences can exist across a range of mental health problems and in people who do not have contact with psychiatry (Romme and Escher, 1993). This led to the development of early intervention services working with people with psychosis that explicitly did not diagnose using the classifications of schizophrenia or bipolar disorder but viewed psychotic experience as caused by a range of stressors in the environment that could be worked with psychologically as well as medically (Garety, 2003). Thus, we can see how the debate around disorders and classifications has entered the mainstream of clinical practice and everyday mental health care.

Understanding madness

If classifying and labelling people with medical diagnoses is an ethically contested and a clinically problematic enterprise, there are also philosophical issues surrounding the possibility of understanding a person who is experiencing strange beliefs or experiences. If somebody is expressing feelings that they have been taken over by an alien force or that parts of their bodies have been taken away, then these statements are very hard to understand. Karl Jaspers (1997) famously argued that schizophrenia could not be understood. His radical claim was that all understanding relates to empathy, and that when confronted with the profound disturbances in schizophrenia, there is a block to empathic understanding. For Jaspers, we cannot empathise with these strange experiences for two reasons. First, they put an immediate block to any project of attempting to understand because we are confronted with statements that we cannot grasp or attach any meaning to, and we are bewildered in the presence of such bizarre statements as someone claiming that their body has been taken over by alien forces. Second, we can't make any sense of such statements in narrative terms, as the feeling that one is occupied by alien forces cannot be linked to previous life events in any clear manner. Jaspers concluded that such experiences are beyond understanding, and therefore we should only try and explain them as symptoms of underlying biological defects that are yet to be discovered. We can never understand schizophrenia, and therefore it can only be explained through biological causes.

This approach became orthodoxy in psychiatry, and to a large extent the lifeworld and beliefs of people with psychotic experiences were ignored, and in clinical training health care practitioners were encouraged not to engage or 'collude' with the strange beliefs of people who were seeking help (Read et al., 2004). However, there is a branch of philosophy termed phenomenology that is explicitly engaged with understanding the meaning of subjective experience. This branch of philosophy was very influential in the development of French and German psychiatry in the twentieth century, and a number of key psychiatrists attempted to understand the experiences and beliefs of 'madness' from the perspective of the person (Blankenburg, 2001; Minkowski, 1958). The psychiatrist Minkowski famously wrote a case study of a patient who he lived with over a short period of time to try to thoroughly understand his experiences which were centred around the belief that the world was coming to an end (Minkowski, 1958).

Phenomenology literally means the 'science of phenomena' and the phenomena being studied here were the thoughts and experiences of people with hallucinations

and strange beliefs. Minkowski, for example, focused on alterations in how the person with the catastrophic end of the world belief experienced time and day-to-day existence, and identified concepts of meaning, significance and the particular logical structure of the person's beliefs. Understanding begins here with a patient attentiveness and openness to another person's experience however strange that may be, and this phenomenological tradition in psychiatry was briefly influential in the UK context and was highly important in the early work of the radical psychiatrist R.D. Laing, who tried to understand how people might retreat into psychotic experiences due to overwhelming family and societal pressures (Laing, 1975). However, until the last 15 years, Jaspers' view that psychoses should be explained and treated biologically rather than understood psychologically has held sway. Nevertheless, in the past 15 years, a number of approaches have revived an interest in understanding and working with voices and prioritising the service user perspective on their own experiences.

Accepting voices: the work of Romme and Escher

A new approach to working with voices was instituted in the early 1990s by the Dutch psychiatrist Marius Romme and his colleague Sandra Escher. There were two strands to this approach. The first was bringing together people who experienced voices in order to share their experiences. Rather than thinking that voice hearing was a meaningless expression of biological disorder this approach quickly demonstrated the therapeutic benefits in terms of peer support from sharing experiences. The second approach was to try and understand the full extent of voice hearing in the so-called 'normal' population; those people who had no contact with psychiatric services (Romme and Escher, 1993). Romme appeared on Dutch television and asked for people to contact him if they hear voices. Many people who heard voices wrote in and many of them had no contact with psychiatry. Romme and Escher (1993) then began to learn about how people lived with their voices and coped with their distressing and positive effects. They described a new way of working with voices which was about accepting the experience of the person as real and then attempting to understand the frame of reference within which people understood that experience (Romme and Escher, 1993).

In many ways, there was a continuity here with earlier phenomenological approaches in psychiatry, in that understanding the person from their own perspective and the significance and meaning they gave to their experience was central, rather than just dismissing this experience as pathological. In 2000, the

British Psychological Society produced a report recommending the use of more psychological approaches working with psychosis, and the latest National Institute for Health and Clinical Excellence (NICE) guidelines on working with schizophrenia recommend a wide-ranging use of psychological therapies (BPS, 2000; NICE, 2010). This demonstrates how a new framework for conceptualising the understanding of unusual experiences can impact upon improved and more person-centred practice.

James has been referred to a community mental health team by his GP as his parents have become concerned about him isolating himself from his friends and seeming increasingly preoccupied with martial arts. James is an 18-year-old young man. He has dropped out of Further Education College and lost contact with a number of his friends. When the community mental health nurse visits James he discloses that he started hearing voices six months ago. This happened following a very stressful time in his life when his parents separated and he split up from his long-term girlfriend. He had become very interested in martial arts and the first voice he heard represented to him a 'grand master' who was educating and mentoring him. He found this voice gave him strength and helped him. He then started to hear another voice that was criticising him for his martial arts practice and then started making further derogatory and negative comments about his appearance and how he spoke to people in public. He also began to hear an indeterminate voice that would comment on his activities. Sometimes he didn't mind this, but occasionally this voice joined with the negative voice to make negative comments which James found very distressful.

CASE EXAMPLE

Working with James

Of primary importance is trying to understand James's frame of reference for the voices – how does James understand and conceptualise his experience (Romme and Escher, 2000)? James did not accept he had a mental illness and felt the voices represented forces both helpful and harmful to him. He did recognise that at times he became too preoccupied with the voices and might need help in 'tuning out' the voices. It may be helpful at this stage to communicate to James that the startling onset of voices is quite common and is often linked to stressful life events (Romme and Escher, 2000).

The nurse then encouraged James to make a weekly log of his voices (Chadwick et al., 1996). This logged the frequency of the voices, their emotional consequences and how easy James felt he was able to 'tune in' or 'tune out' of the voices.

James reported that the negative voices often occurred when he was in difficult or stressful situations and sometimes became overwhelming so he had to flee from these situations. He was not able to ignore the voices as they were so intrusive. He found that the only way he could get rid of them was by responding to them and speaking directly to them. He was able to 'tune out' the voices that came in a running commentary by distraction techniques such as listening to music or doing some exercise. Occasionally, the 'good' voice would cause him to be too preoccupied with his martial arts activities so the mental health nurse encouraged James to set time aside to 'listen' to the good voice and to undertake his martial arts hobby.

The nurse worked with James's frame of reference and coping strategies, but also assisted James with techniques to manage his anxiety in social situations as this might lessen the onset of his negative voice hearing experiences (Coleman and Smith, 2005).

Implications for practice

- The nurse did not impose a frame of reference on James's experience but understood and accepted his understanding of his experience. This is central to assisting a person who is hearing voices (Romme and Escher, 2000).
- Helping James to understand he is not alone in hearing voices and the sudden onset of his voices is quite common and often linked to stressful experiences can help to make sense of the experience (Coleman and Smith, 2005). This feeling of shared experience could be helped by encouraging James to attend a group for voice hearers where experiences and coping strategies could be shared.
- It is important to work alongside the person and to understand and utilise their own coping strategies as well as attempting to assess how well these coping strategies work and trying alternative approaches (Romme and Escher, 2000).
- Medication may be used as a tool to help someone alongside other coping strategies but it is not necessarily the first or the only option.

Mental health and ethics: coercion and care

The final aspect of philosophy of mental health care is the broad aspect of ethics. Ethical conflicts are acute in mental health care as mental health is the one field in which people can be coerced to accept treatment against their will. In all other

aspects of health care if an adult refuses consent then they cannot be treated against their will, but in mental health care, subject to particular provisions, forced treatment can and does take place.

Ethics in practice: Community Treatment Orders

In 2008 in England and Wales amendments to the Mental Health Act 1983 were put in place to provide for a level of mandatory treatment of people with mental health problems in the community. People who had previously been on Section 3 or Section 37 of the Mental Health Act and who had a history of disengaging from mental health services could be compelled to present themselves for assessment in the community. Additional conditions can be applied by a clinician, usually including a requirement that the person remains compliant with medication (DH, 2008). This extension of coercion into the community was a radical change to the Mental Health Act. Previously, individuals could refuse to consent to treatment in the community and could only be coerced into treatment if they met the criteria for an admission to hospital under the Mental Health Act. After these changes, individuals could be recalled to hospital if they refused to comply with the measures under a Community Treatment Order (CTO).

The arguments put forward for Community Treatment Orders were explicitly consequentialist. Proponents of these measures argued that it would enable people to spend more time out of hospital and to be freer to live their lives even though they were living under an 'umbrella' of coercion (Dale, 2010; Molodynski et al., 2010).

Supervised community treatment was introduced in England and Wales against a background of much controversy and a united opposition amongst health care professionals and service users organised through the Mental Health Alliance (Mental Health Alliance, 2005). The background evidence for the effectiveness of CTOs was extensively reviewed by Churchill et al. (2007) and found to be lacking. The restriction of autonomy here is quite extensive and would normally only be considered if someone had committed a crime, and it demonstrates how far consequentialist arguments, backed up by elements of social control, have come in policing the lives of those labelled with mental illness.

The issue of supervised community treatment is just one recent example of how these complex ethical questions are continually and daily negotiated in modern mental health care and practice.

Summary

This chapter has introduced the reader to the importance of philosophical issues in mental health care. Philosophy has been defined as concerned with issues of existence (ontology), knowledge (epistemology) and what is right and wrong (ethics). Four areas of philosophy and mental health care have been outlined and introduced; mind and brain, classifications and diagnosis, understanding madness and ethical issues in mental health. A contemporary issue within practice and research has been outlined and related to each of these four areas; neuroscience and neuroimaging of the brain, the existence of the schizophrenia label, working with voices and Community Treatment Orders.

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