With the publication of this handbook in 2013, the centenary of Jaspers' *General Psychopathology*, it is natural to ask: "What comes next?" Projecting forward from the timeline shown on our website (www.oup.co.uk/companion/fulford) suggests a future of continued expansion of the field as a research-led international discipline with increasingly close connections with policy, research, and practice across all areas of mental health. Such a future is anticipated in this handbook, covering as it does a wide range of both theoretical and practical issues and with contributions from different philosophical traditions and many different parts of the world. But the timeline also contains a warning. Aside from ongoing work in phenomenology and psychoanalysis, *General Psychopathology* was followed by fifty years of silence (Fulford et al., 2003).

There are differences, of course, between Jaspers’ period and our own. Notably, whereas psychiatry at the start of the twentieth century was mainly doctor-led, mental health services today are increasingly multidisciplinary, and, with the growing importance of the service user voice (Williamson 2004), patient- as well as professional-led. These shifts in the model of service delivery in the early twenty-first century are reflected in this book. Like other volumes in the Oxford Handbooks in Philosophy series, *The Oxford Handbook of Philosophy and Psychiatry* is written mainly by philosophers for philosophers. But our website includes a rich and (so far as we are aware) unique collection of diverse service user narratives drawn together by the service user/survivor researchers Jayasree Kalathil, Jasna Russo and Debra Shulkes, together with the support of David Crepaz-Keay, Toby Williamson and others at the Mental Health Foundation, London; several of our contributors draw in part on personal experience of mental health difficulties; and Owen Flanagan's philosophical account of addictive disorders (Chapter 51) draws explicitly on his perspective as an “expert by experience.”

There are also important similarities, however, between our two periods. Jaspers, as the first philosopher-psychiatrist, was writing at a time of rapid advances in the neurosciences so like our own that it has come to be known as psychiatry’s “first biological phase.” It is surely no coincidence therefore that, as the timeline indicates, cross-disciplinary work between philosophy and psychiatry should have finally taken off in a big way in the 1990s,
the so-called “decade of the brain.” The contemporary rise in importance of the service user voice, moreover, gives Jaspers’ *General Psychopathology*, with its call for meaningful understanding as well as causal explanations in psychopathology (Stanghellini and Fuchs, in press), perhaps even greater resonance today, in psychiatry’s second biological phase, than it had in its first. We return toward the end of this introduction to the significance of the service user voice for the future of psychiatric science. Our view as we will indicate is that, taken together, the twin pressures of the new neurosciences and of the service user voice make the twenty-first century potentially the best of scientific times for psychiatry. We have sought to reflect these best of scientific times in this volume with a range of topic areas covering different aspects of the sciences of the mind and brain and through the work of a number of contributors (such as Broome and Fuchs) whose research expertise straddles philosophy and key areas of contemporary neuroscience such as brain imaging.

So what can we learn from a century of philosophy and psychiatry? And where might the subject be a century hence? Clearly the details (who will do what, when, and where) remain below the horizon. There will also be much that is outside our control. The Australian psychiatrist and poet Russell Meares (2003) has pointed out that the publication of *General Psychopathology* in 1913 coincided more or less to the year with the tipping point of the “move to mechanism” which was to become the dominant European and North American zeitgeist for most of the first half of the twentieth century. Small wonder therefore that Jaspers’ call for meanings as well as causes in psychopathology should have gone largely unheard for so many decades. Nonetheless the past century we believe does suggest a number of conditions for flourishing that may prove helpful in guiding the future development of the field. We will look briefly at some of these, as they relate respectively to problems, products, partnership, and process, and at how we have tried to incorporate them in this book.

**Problems**

Of one thing at least we can be confident: by the end of the century the problems of philosophy, the “big questions” of mind and brain, of freedom and determinism, of what is and of what ought to be will remain unresolved. In an earlier model of philosophy it would have been assumed that the role of philosophers in psychiatry is to solve problems of just this kind and thereby provide foundations on which empirical research and practice might securely build. The search for foundations is natural enough. Consistently with the philosophy of Jaspers’ time, there is something of this Philosophy-as-the-Queen-of-the-Sciences model in *General Psychopathology*; and latter day claims to having established a new philosophical foundation for psychiatry will no doubt continue to be made in years to come. But if there is a lesson from twentieth-century philosophy for psychiatry today, it is that (post-Gödel, Wittgenstein, Quine, and others) foundations are not to be had (Fulford, in press).

This is an important lesson for psychiatric science. The German historian and psychiatrist Paul Hoff (2005) has neatly summarized the history of psychiatric science as a history of repeated collapses into “single message mythologies” reflecting this or that influential school’s or individual’s view of the “true” nature of psychiatry. But it is an important lesson also for psychiatric practice: in psychiatry it has been the misguided conviction that this or
that model provided “foundations” that has been the basis of some of the worst abuses of psychiatric care (Fulford et al. 2003).

Far from providing foundations, therefore, an important role of philosophy is to forestall premature closure on the philosophical problems by which the science and practice of psychiatry are alike characterized. In psychiatry, the lesson of history runs, big theories mean big trouble. This book, correspondingly, although including chapters by philosophers working across the full spectrum of philosophical disciplines, from ancient philosophy through value theory, phenomenology, and philosophy of mind, to core issues in the philosophy of science, offers no “foundations.” Our contributors, severally and together, reflecting the lively dynamic between theory and practice that is a key characteristic of the field, offer to varying degrees new slants on their respective philosophical topics, while at the same time illuminating the particular issues in contemporary mental health with which they are concerned. But there are no attempts at big theories, no claims to explaining consciousness or dissolving the problem of free will, still less to having (finally) defined mental illness.

**Products**

If, then, research at the interface of philosophy with psychiatry is to flourish in coming decades, it will be characterized by disciplined attention to particular well-defined problems rather than indulging in grand theory building. All of which is not to say that we should be chary of progress. To the contrary, for the field to prosper it must remain responsibly product-oriented. Our handbook indeed illustrates a number of philosophy-into-practice successes: phenomenology (Fuchs, Sass, and Pienkos; Gallagher; Grünbaum and Zahavi; Ratcliffe; Stanghellini) continues to deliver insights for both research and practice; agency (Pickard) and value theory (Fulford and van Staden) have found new applications in mental health care; and the new kid on the block, neuroethics (Foddy, Kahane, and Savulescu), is already well established as a fast growing field in its own right (Iles and Sahakian 2011).

There is though a lot packed into that word “responsibly” when it comes to being “responsibly product-oriented.” For practitioners—whether patients, carers, clinicians, scientists, or indeed managers and policymakers—being responsibly product-oriented means being prepared to engage with the conceptual as well as empirical issues by which the day-to-day problems of mental health research and practice are characterized. This book as we have indicated is mainly by philosophers (some of whom are of course also practitioners) for philosophers. For those new to philosophy, there are other books in the IPPPP (International Perspectives in Philosophy and Psychiatry) series, such as the *Oxford Textbook of Philosophy and Psychiatry* (Fulford et al. 2006), and the companion volume to this book, *The Oxford Handbook of Psychiatric Ethics* (Sadler et al., forthcoming), that are more practitioner-oriented. Our hope nonetheless is that, co-branded as this handbook is between the Oxford Handbooks in Philosophy and the IPPPP series, it will prove a resource not only for philosophers but also for those practitioners willing and able to go deep philosophically.

For philosophers on the other hand, being responsibly product-oriented means going deep practically. On first inspection it may seem that philosophers should need little encouragement to go deep practically given the richness of the philosophical resources offered by
clinical work and research in psychiatry. We have reflected this richness of resource in this 
book by structuring its contents around the stages of the clinical encounter rather than 
within conventional philosophical subject areas. The danger though is that the very richness 
of these philosophical resources makes psychiatry an easy prey for what might be called the 
“quick buck” philosopher, spinning academic publications from a superficial and often par-
tial and unrealistic reading of their practice-based sources.

Quick buck-ism is irresponsible academically: in philosophy as in any other field we have a 
responsibility to put in the work necessary to get things right. When it comes to philo-
sophical work in psychiatry though, quick buck-ism is also irresponsible clinically. This is 
because in psychiatry, philosophers really can make, and as we have indicated are already 
making, a difference. Philosophical work in psychiatry we should add hastily is not justi-
fied as such by making a difference practically. To the contrary, for the field to prosper it is 
we believe important that as in other areas of philosophy, its justifications remain primarily 
intellectual rather than (directly) practical. All the same, the fact that mental health is an 
area in which what philosophers say really can make a difference practically, has the una-
voidable consequence that going deep is a clinical as well as academic responsibility.

PARTNERSHIP

The “responsible” in being “responsibly product-oriented” in philosophy of psychiatry thus 
means, equally for philosophers and for practitioners, going deep in each other’s disciplines. What this in turn implies, we believe, as a further condition for flourishing, is the need for partnership. This is essentially because so much of what either has to learn from going deep with the other is tacit and hence acquired only by working side-by-side in a shared learning experience. Expertise in health care as in other practical disciplines is defined (in part but essentially) by the skilled application of tacit knowledge: and philosophy as a whole is as much an activity based on implicit (though learnable) skills of reasoning as it is a body of explicit knowledge.

While therefore there is much that we can learn from each other working separately, 
going deep means working in one way or another in partnership. The qualifier in that last phrase, however, “in one way or another,” is important. Exactly what form a given partner-
ship takes will and should vary widely with the contingencies of personal and professional 
circumstances and according to the varying constraints of different areas of philosophy and practice.

We signaled the importance of a diversity of partnerships between philosophers and 
practitioners in calling this book the “The Oxford Handbook of Philosophy and Psychiatry.” If the field is to continue to develop successfully it will need a number of philosophers of 
psychiatry, philosophers (or indeed practitioners) who self-identify as specialists in the 
field in the sense that most of their scholarly output is focused on the conceptual issues 
of research and practice at the interface between philosophy and mental health. Equally 
important, though, will be the perhaps much larger number of philosophers (and indeed practitioners) who as specialists in their respective scholarly fields work in part but only in part on philosophical topics in mental health. In either case, partnership, again of one kind or another will be essential. The contributors to this book illustrate some of the range of
as conditions for flourishing, problems, products, and partnership at and across the interface of philosophy with psychiatry are each underpinned by the need for good process. That good process presents particular challenges in a cross-disciplinary field need hardly be said. In a single-discipline field the challenges are hard enough: evidence-based medicine, for example, with a few tweaks surely the acme of good empirical process, has generated a veritable industry of practical, ethical, and indeed philosophical debate (Howick 2011). But imagine philosophy proceeding by meta-analyses of its research outputs, or, conversely, clinical trials being judged by their internal logical consistency! Clearly, good process however defined within either discipline, and although no doubt including a number of generic features (acknowledgment of sources, for example), fails to translate fully one into the other.

The twentieth-century development of philosophy of psychiatry has sought to meet the challenge of good process by adopting what amounts to an HCF (highest common factor) rather than LCD (lowest common denominator) approach: new research to the extent that it covers both fields must pass muster with the best of both. But aiming for the “best of both” of course begs the question “What is best?” The test adopted thus far has been that of twin-track but independent peer review. And peer review must surely form part of any future test of best. But peer review itself must be used in a self-reflective way if it is to avoid a degree of self-validation inimical to innovation.

Peer review and a self-reflective process have both been important in the development of this book. The original proposal for the volume went through Oxford University Press’s normal processes of both independent peer and delegate committee review and we are grateful to the reviewers and delegates for the many helpful suggestions made at that stage. But we also carried out an extensive post-contract process of research and development. This process, which was strongly supported by both the Philosophy Faculty in Oxford and Oxford University Press, included a wide-ranging review of the literature (carried out mainly by Will Davies, at the time a Laces DPhil Scholar) and a workshop to which every member of our International Advisory Board generously contributed either in person or by telephone conference. The importance of partnership was particularly evident at this developmental stage of the book and became so again, as our list of contributors indicates, in the production of our supporting website.

None of which is to claim that for all our focus on process, we got all “the best”: even with the generous word length of an Oxford Philosophy Handbook there were many significant contributors to the field that we were unable to include. Our aim was rather
the more modest aim of examining through an open and reflective process the question of what the best might look like rather than relying (solely) on our own (albeit no doubt reasonably well-informed) views. And to the extent that the process we adopted produced much of the content and many of the distinctive features of the book (including its structuring around the stages of the clinical encounter) it proved to be nothing if not creative.

**WATCHING OUR PS . . .**

The importance of “watching our Ps” in coming decades if we are to avoid another fifty years of silence is well illustrated by what happened at the meeting of senior European and North American psychiatrists convened by the World Health Organization (WHO) in New York in 1959, from which, as the timeline on our website indicates, our current systems of descriptive (i.e., symptom-based) psychiatric classifications, the WHO’s ICD (*International Classification of Diseases*) and the American Psychiatric Association’s DSM (*Diagnostic and Statistical Manual of Mental Disorders*), are ultimately derived.

In his introduction to the mental disorders chapter of ICD-9 (the ninth edition of the ICD), Norman Sartorius, who went on to become Head of the Mental Health Section of the WHO, described a classification as providing a kind of photographic snapshot of the state of a given science at a point in time (Sartorius 1992). Two of our chapters (Poland and Von Eckhart, Chapter 44 and Sadler, Chapter 45) explore particular aspects of what by extension might be called the family photograph album of snapshots provided by successive editions of ICD and DSM. The lessons, though, for the future success of cross-disciplinary work between philosophy and psychiatry, come from understanding the precise role played by the philosopher of science, Carl Hempel, in that original New York meeting.

The received history (e.g., Kendell 1975; Sadler et al. 1994, introduction) has been one of foundations. The WHO, in its early work in the aftermath of World War II, needed reliable comparative statistics on rates of disease in different parts of the world; this in turn depended on an agreed system of classification; but in contrast with most other areas of medicine, it had proved impossible to reach international agreement on the classification of mental disorders. The New York meeting was thus convened in an attempt to reach consensus, and Hempel, as a distinguished philosopher of science, was invited to give the opening address. Drawing on the logical empiricist philosophy of science in vogue at the time, Hempel, so the story has standardly gone, argued that psychiatry was at a descriptive rather than etiological (causal theoretical) stage in its development as a science and hence should seek a common basis for its classification of mental disorders in (descriptively defined) symptoms. Hempel’s analysis, the standard story has continued, was reported back to the WHO; it was adopted as the basis for a new descriptive (symptom only) glossary to ICD-8; ICD-8 with its supporting glossary achieved a high degree of international acceptance; and descriptive (symptom only) criteria went on to become the foundation for all subsequent editions of both ICD and DSM.

Hempel’s role in the development of modern psychiatric classifications is rightly celebrated. Examination, however, of a transcript of the 1959 New York meeting, together
with the recollections of some of those actually involved at the time, shows his role in an entirely different light (Fulford and Sartorius 2009). Hempel did indeed introduce the distinction between descriptive and etiological (causal theoretical) stages in the development of a science. But far from recommending that psychiatry should develop a descriptive classification he argued that it should continue with what he saw as its current good work in developing etiological classifications based on (the then current “big theory” in the USA) psychoanalysis. The suggestion for a descriptive classification, so the transcript of the meeting shows, came in fact not from the philosopher Hempel but from a psychiatrist, Aubrey Lewis. Adopting Hempel’s terminology, Lewis proposed that:

for the purposes of public classification we should eschew categories based on theoretical concepts and restrict ourselves to the operational, descriptive type of classification, whereas, for the purposes of certain groups, the private classification, based on a theory which seems a workable, profitable one, may be very appropriate.

At the time Lewis’ proposal was not taken up. Indeed aside from qualified support from the French delegate, Dr Pichot, he was in a minority of one. A large majority of those present welcomed instead Hempel’s proposal for an etiological classification and it was this (rather than a descriptive classification) that was reported back from the meeting as a recommendation to the WHO. Lewis proved, however, to be a tough minority of one. For in the event it was Lewis, working with Sartorius and others at the WHO, who went on to produce the descriptive symptom-based glossary to ICD-8 from which as noted earlier our current classifications are derived.

All the Ps are evident in this story. It is clear, first, that Lewis had a very particular problem in mind in proposing a symptom-based classification, namely the need to develop a “public” classification that was fit for the specific and well-defined purpose of collecting comparative international statistics on rates of mental disorder. It was the need to find such a classification that as we have described led to the WHO convening the New York meeting in the first place. To this extent therefore, corresponding with our second P, the meeting was by its very terms of reference product-oriented. As to being responsibly product-oriented however, the meeting failed to “go deep” in that (Lewis aside) those present simply ran with Hempel’s ideas as providing (as they saw it) philosophical foundations (and hence justification) for current practice. Our third P, partnership, was the vital ingredient in “going deep” and thus producing the required classification: Hempel the philosopher was essential to the mix; but it took the psychiatrist Lewis to see the potential of Hempel’s philosophy; and without the support of Sartorius as an up-and-coming WHO official, Hempel-plus-Lewis would still have equaled zero. “Good process,” furthermore, our final P, had it been based on a merely mechanical application of peer review, would actually have blocked the key shift to a descriptive classification: the transcript of the New York meeting shows that as we have indicated an overwhelming majority of peers present (and they represented the great and the good of the psychiatry of the day) welcomed Hempel’s support for further development of the then current etiologically-based classifications; and Lewis’ proposal for a symptom-based classification failed to make it even as a minority view, either into the official summary of the meeting or into the subsequent report to the WHO.
All the Ps then will be important if research at the interface of philosophy with psychiatry is to avoid the perils of failure, a brief flourishing followed as General Psychopathology was followed by fifty years of silence. Yet if there are perils of failure for the philosophy of psychiatry in the coming century there are perils too of success, of becoming a new orthodoxy, inward looking and ossified. This is where Q, a measure of group inter-connectedness defined by two American sociologists, Brian Uzzi and Jarrett Spiro (2005), working on the social conditions that support creativity, could be important in years to come. Research on creativity has focused mainly on the psychology of the individual. Uzzi and Spiro’s work suggests that important as creative individuals undoubtedly are to the development of a new field, their creativity is to a degree dependent on the support of a group with the right balance of Q: too open a group fails to provide the necessary checks and balances to drive creativity; too closed a group seizes up for lack of new ideas.

There was Q aplenty in the run-up to the renaissance of philosophy of psychiatry. As indicated in the timeline and supporting materials on our website, many senior psychiatrists active in the 1970s and 1980s (Hill, Kendell, Kroll, Lewis, Roth, and others) wrote still influential conceptual as well as empirical research papers and at a personal level these and others directly supported the nascent field. There was similar cross-disciplinary research and support also from the brightest and best in philosophy. In Oxford alone, Farrell, Glover, Hare, Harré, Newton-Smith, Quinton, Wilkes, and the Warnocks (Geoffrey and Mary) all contributed to the emergence of the new field either directly as authors of seminal publications and as supervisors of cross-disciplinary doctorates or indirectly through their support for the new journals, organizations, and other academic infrastructure underpinning the establishment of the new field.

The philosophy of psychiatry as it has developed in recent years might be thought by some to have become somewhat too open. Certainly, as a discipline it has shown thus far a remarkable degree of collegiality, avoiding the splits into different “schools” that historically have been so much a feature of emerging fields. The HCF rather than LCD approach noted earlier has been in part an attempt to maintain the balance required for Q. Yet it has been relatively easy to remain open and collegial when we have had so little to lose. Come success, therefore, come celebrity, come the power and influence and resources of orthodoxy, and the perils of becoming too inward looking and thereby creatively sterile will be real indeed. Even in this handbook we have for all our efforts ended up being perhaps too closed with little in the way of dissenting voices (Crisp, for example, in his commentary on Fulford and van Staden, Chapter 26, is an exception). There will we hope be more dissent on our website as this is further developed; and future editors of the handbook may feel able to take more risks—a speculative 5% would go a long way to maintaining the balance required for Q.

The perils of success may seem like something of a high-class worry as things currently stand. The philosophy of psychiatry, after all, for all its recent burgeoning, remains a minnow to the neuroscience whale. Yet we need look no further than the family photograph album of psychiatric classification for a clear presentiment of success.

As we go to press new editions of both ICD (ICD-11) and DSM (DSM-5) are about to be launched. The jury is still out on how they will be received. But both have continued the
excellent precedent of their predecessors in aiming for a transparent process. The American Psychiatric Association in particular anticipated the launch of the DSM revision process with a publication setting out its Research Agenda for DSM-V (Kupfer et al. 2002). In their introduction the editors of the Research Agenda, David Kupfer, Michael First, and Daryl Regier, who went on to become leaders of the DSM-5 review, argued that progress in the sciences of psychiatry required “an as yet unknown paradigm shift” (p. xix). True, there is no indication that it was philosophy that Kupfer and his colleagues had in mind here. All the same, the actual research issues outlined in the opening chapter of their book are all conceptual issues. True, also, they avoided using the word “conceptual,” calling their opening chapter instead “Issues of basic nomenclature” (p. 1). But the issues outlined in their opening chapter are conceptual issues nonetheless. The particular conceptual issues they cover, moreover, show a considerable degree of overlap with the issues covered in this handbook. There is an extensive discussion of how the concept of “mental disorder” and related concepts such as “illness” and “disease” should be defined; and in just the first three pages of the chapter problems are raised respectively in the philosophy of science (core concerns include “validity” and “reliability”), in the philosophy of mind (“Cartesian dualism” is explicitly rejected), and in philosophical value theory (values being taken to differ what they call “sociopolitical” from “biomedical” models of disorder).

It would be straying too far into big theory building to speculate on what Kupfer, First, and Regier’s anticipated new paradigm might be. The twin pressures though on contemporary psychiatry noted at the start of this introduction, of a growing service user voice and of the new neurosciences, suggest that something along the lines of Jaspers’ original research agenda in General Psychopathology, his agenda for meanings as well as causes in psychopathology, will have to figure in some way. Philosophy at the start of the twenty-first century is of course not where it was at the start of the twentieth century. In particular, the majority of contemporary philosophers would regard it as a datum that intentional (representational) mental states (e.g., believing, wanting, seeing as) figure in causal explanations. If that is right then there are levels of description and causal explanation in which personal-level concepts figure, including phenomenological and normative concepts. Even at this level there are unresolved issues for psychopathology: Jaspers, anticipating current debates about the role of values in diagnostic concepts (Sadler, Chapter 45, this volume), resisted their inclusion in psychopathology (Stanghellini et al. 2013). But below the personal level of description and explanation, there are multiple subpersonal levels of mechanistic description and explanation, including the levels of physics, chemistry, biology, neuroscience (including computational neuroscience), and psychology (including information-processing psychology), the relationships of which to the personal level of description and explanation remain unresolved. Even leaving aside, therefore, conceptual difficulties within either level, Jaspers’ agenda re-emerges in contemporary debates in philosophy and psychiatry about the relationship between the personal (as in the role of the service user voice) and the various subpersonal (as in the role of the new neurosciences) levels of description and explanation.

For these if for no other reasons, therefore, psychiatry in any new paradigm will find itself working within multiple and in some respects mutually inconsistent theoretical models and thus having to tackle research problems that are as much conceptual as empirical in nature. As such, psychiatry will have to redefine itself as a science, not as in the twentieth century trailing the traditional medical sciences of cardiology, gastroenterology and the like, but rather as a science more like theoretical physics very much at the cutting edge.
For theoretical physics, too, works within multiple and in some respects mutually inconsistent theoretical models and thus has to tackle research problems that are as much conceptual as empirical in nature. Naturally, psychiatry being a science not of particles but of people, the particular theoretical models and the particular conceptual problems with which it is concerned, will be quite different from those of physics. But the prominence afforded conceptual issues in the DSM’s Research Agenda, and the range of philosophical issues evident in its opening chapter, are surely sufficient indications that any genuinely person-centered psychiatry of the future will proceed physics-like, as much by way of conceptual as of empirical research.

We should not expect a person-centered physics-like psychiatry any time soon. No less a creative genius than Max Planck, one of the founders of quantum mechanics, warned in his scientific autobiography that "new sciences aren’t born, old scientists die!" (1948, p. 22, paraphrased). This is why our time frame in this introduction has been the next hundred years. Time enough then for old scientists to die and for new sciences to be born. Time enough, too, for us to face the perils not only of failure but also of success by watching our Ps and Q.

REFERENCES


