

**Table 3.1** Recovery rates in long-term follow-up studies of psychosis

Lead researcher	Location	Year	<i>n</i>	Mean length of follow-up (years)	% Recovered or significantly improved
Huber <sup>a</sup>	Bonn	1975	502	22	57
Ciampi <sup>b</sup>	Lausanne	1976	289	37	53
Bleuler <sup>c</sup>	Zurich	1978	208	23	53–68
Tsuang <sup>d</sup>	Iowa	1979	186	35	46
Harding <sup>e</sup>	Vermont	1987	269	32	62–68
Ogawa <sup>f</sup>	Japan	1987	140	23	57
Marneros <sup>g</sup>	Cologne	1989	249	25	58
DeSisto <sup>h</sup>	Maine	1995	269	35	49
Harrison <sup>i</sup>	18-site	2001	776	25	56

Notes:

<sup>a</sup>Huber G, Gross G, Schuttler R. A long-term follow-up study of schizophrenia: psychiatric course and prognosis. *Acta Psychiatrica Scandinavica* 1975; **52**:49–57.

<sup>b</sup>Ciampi L, Muller C. *The Life-course and Aging of Schizophrenics: A long-term follow-up study into old age*. Berlin: Springer; 1976.

<sup>c</sup>Bleuler M. *The Schizophrenic Disorders*. New Haven, CT: Yale University Press; 1978.

<sup>d</sup>Tsuang MT, Woolson RF, Fleming J. Long-term outcome of major psychosis. *Archives of General Psychiatry* 1979; **36**:1295–1301.

<sup>e</sup>Harding CM, Brooks G, Ashikage T, Strauss JS, Brier A. The Vermont longitudinal study of persons with severe mental illness II: long-term outcome of subjects who retrospectively met DSM-III criteria for schizophrenia. *American Journal of Psychiatry* 1987; **144**:727–735.

<sup>f</sup>Ogawa K, Miya M, Watarai A, Nakazawa M, Yuasa S, Utena H. A long-term follow-up study of schizophrenia in Japan, with special reference to the course of social adjustment. *British Journal of Psychiatry* 1987; **151**:758–765.

<sup>g</sup>Marneros A, Deister A, Rohde A, Steinmeyer EM, Junemann H. Long-term outcome of schizoaffective and schizophrenic disorders, a comparative study, I: Definitions, methods, psychopathological and social outcome. *European Archives of Psychiatry and Clinical Neuroscience* 1989; **238**:118–125.

<sup>h</sup>DeSisto MJ, Harding CM, McCormick RV, Ashikage T, Brooks G. The Maine and Vermont three-decades studies of serious mental illness: II. Longitudinal course. *British Journal of Psychiatry* 1995; **167**:338–342.

<sup>i</sup>Harrison G, Hopper K, Craig T, Laska E, Siegel C, Wanderling J et al. Recovery from psychotic illness: a 15- and 25-year international follow-up study. *British Journal of Psychiatry* 2001; **178**:506–517.

- Independent living without supervision by informal carers
- Having friends with whom activities can be shared
- All sustained for a period of two years.

Their conclusion is that ‘it is now realistic to set as a goal the feasibility of recovery from schizophrenia for half or more individuals with first episode’. Does this fit with findings from naturalistic longitudinal studies? Results are difficult to interpret due to differences in participant selection, definition of recovery, use of retrospective versus prospective tracking, frequency of repeated measurement, length of follow-up, location and time period<sup>37</sup>. Perhaps the most meaningful data comes from studies with long follow-up periods. In Table 3.1 we show all 20-year or longer follow-up studies published until 2008.

For example, Courtenay Harding’s study in Vermont involved 32-year follow-up of the most difficult-to-place third of people resident in a psychiatric institution<sup>113</sup>. At follow-up she found markedly higher rates of recovery indicators than would be expected from this institutionalised group, with 81% able to look after themselves, and 68% having moderately close to close friendships. Just over half (54%) were still in touch with mental health services. Overall, 25% were fully recovered and 41% showed significant improvement,

i.e. 68% of the most dependent third had at least partially recovered, implying that only 11% of people with severe and enduring mental health problems remain unrecovered and deep in the system. This is of course much less than the clinical rule of thirds (i.e. a third recover, a third have fluctuating course and a third will never get better) would suggest.

These empirical data challenge the applicability of a chronic disease model to mental illness, with its embedded assumption that conditions like schizophrenia are necessarily life-long and have a deteriorating course. The most recent collation of all long-term follow-up studies included over 1000 patients between 12 and 26 years after initial assessment<sup>114</sup>. Commenting on the results, Richard Warner concludes<sup>115</sup>:

What do we learn of the lives of people with schizophrenia from this fascinating study . . . ? Most importantly, Kraepelin's view that a deteriorating course is a hallmark of the illness just isn't true. Heterogeneity of outcome, both in terms of symptoms and functioning, is the signature feature . . . bad outcome is not a necessary component of the natural history of schizophrenia; it is a consequence of the interaction between the individual and his or her social and economic world.

Consistent with the issues discussed in [Chapter 2](#), we need to acknowledge that sometimes this recovery has been in spite of, rather than because of, mental health services<sup>116</sup>: 'The psychiatric system far from being a sanctuary and a system of healing was . . . a system of fear and continuation of illness for me. Like so many others recovery was a process that I did not encounter within the system, indeed . . . it was not until I left the system that the recovery process really got underway in my life.' Perhaps this problem arises from treating recovery as an outcome. Although this allows prevalence questions to be addressed, it also implicitly involves deep assumptions about normality. As Ruth Ralph and Patrick Corrigan put it<sup>117</sup>: 'This kind of definition begs several questions that need to be addressed to come up with an understanding of recovery as outcome: How many goals must be achieved to be considered recovered? For that matter, how much life success is considered 'normal'? (p. 5). The people who use mental health services have called for a new approach<sup>118</sup>: 'The field of psychiatric disabilities requires an enriched knowledge base and literature to guide innovation in policy and practice under a recovery paradigm. We must reach beyond our storehouse of writings that describe psychiatric disorder as a catastrophic life event.' The second meaning of 'recovery' provides this enriched knowledge base.

## Meaning 2: personal recovery

People personally affected by mental illness have become increasingly vocal in communicating both what their life is like with the mental illness and what helps in moving beyond the role of a patient with mental illness. Early accounts were written by individual pioneers<sup>116;118–122</sup>. These brave, and sometimes oppositional and challenging, voices provide ecologically valid pointers to what recovery looks and feels like from the inside.

Once individual stories were more visible, compilations and syntheses of these accounts began to emerge from around the (especially Anglophone) world, e.g. from Australia<sup>123</sup>, New Zealand<sup>107;124–126</sup>, Scotland<sup>55;127</sup>, the USA<sup>118;128;129</sup> and England<sup>106;108</sup>. The understanding of recovery which has emerged from these accounts has a different focus from clinical recovery, for example in emphasising the centrality of hope, identity, meaning and personal responsibility<sup>123;130;131</sup>. The translation of these ideas into an action plan for mental health services is the primary goal of this book.

We will refer to the consumer-based understanding of recovery as **personal recovery**, to reflect its individually defined and experienced nature. To note, other distinguishing terms

have also been used, including recovery ‘from’ versus recovery ‘in’<sup>132</sup>, clinical recovery versus social recovery<sup>133</sup>, scientific versus consumer models of recovery<sup>134</sup>, and service-based recovery versus user-based recovery<sup>135</sup>.

Opinions in the consumer literature about recovery are wide-ranging, and cannot be uniformly characterised. This multiplicity of perspectives in itself has a lesson for mental health services – no one approach works for, or ‘fits’, everyone. There is no right way for a person to recover.

Nonetheless, some themes emerge. A first clear point of divergence from the clinical perspective is that recovery is seen as a journey into life, not an outcome to be arrived at. As Repper and Perkins put it<sup>4</sup>: ‘Recovery is not about “getting rid” of problems. It is about seeing people beyond their problems – their abilities, possibilities, interests and dreams – and recovering the social roles and relationships that give life value and meaning’ (p. ix). Many definitions of recovery have been proposed by those who are experiencing it:

Recovery refers to the lived or real life experience of people as they accept and overcome the challenge of the disability . . . they experience themselves as recovering a new sense of self and of purpose within and beyond the limits of disability<sup>119</sup>.

For me, recovery means that I’m not in hospital and I’m not sitting in supported accommodation somewhere with someone looking after me. Since I’ve recovered, I’ve found that in spite of my illness I can still contribute and have an input into what goes on in my life, input that is not necessarily tied up with medication, my mental illness or other illnesses<sup>55</sup>.

(p. 61)

This book will use the most widely cited definition, by Bill Anthony<sup>1</sup>:

Recovery is a deeply personal, unique process of changing one’s attitudes, values, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful, and contributing life even within the limitations caused by illness. Recovery involves the development of new meaning and purpose in one’s life as one grows beyond the catastrophic effects of mental illness.

It is consistent with the less widely cited but more succinct definition proposed by Retta Andresen and colleagues, that recovery involves<sup>123</sup>: ‘The establishment of a fulfilling, meaningful life and a positive sense of identity founded on hopefulness and self determination’ (p. 588). For those who value succinctness, the definition we use in our local service is<sup>136</sup>: ‘Recovery involves living as well as possible’.

One implication of these definitions is that personal recovery is an individual process. Just as there is no one right way to do or experience recovery, so also what helps an individual at one time in their life may not help them at another. If mental health services are to be focussed on promoting personal recovery, then this means there cannot be a single recovery model for services. This is a profound point, and challenging to the concepts of clinical guidelines, evidence-based practice and care pathways. The issue will be explored further in relation to the Apollonian versus Dionysian spectrum, in [Chapter 4](#). For now, we note that a recovery-focussed service is an approach, a way of thinking, a set of attitudes and values put into practice by skilled mental health practitioners. Caution should therefore be exercised about being highly prescriptive about the nature of recovery, and what a recovery-focussed service should look like and how it should work.

Key elements of a recovery approach have been identified by Rachel Perkins and Julie Repper<sup>4</sup> in the UK and Ruth Ralph<sup>137</sup> in the USA, and are summarised in [Table 3.2](#).

**Table 3.2** Descriptions of personal recovery

Summary description	Aspect identified by Perkins and Repper	Aspect identified by Ralph
Recovery involves a journey	<i>Recovery is a continuing journey, not an end-product or a result</i>	<i>Recovery is a journey from alienation to a sense of meaning and purpose</i>
from disengagement to engagement,		<i>Recovery is moving from withdrawal to engagement and active participation in life</i>
from surviving to living and growing.	<i>Recovery is about growth</i>	<i>Recovery is active coping rather than passive adjustment</i>
Although awareness of the journey often starts in adversity, such as mental illness,		<i>Recovery is breaking through denial and achieving understanding and acceptance</i>
	<i>A recovery vision is not limited to a particular theory about the nature and causes of mental health problems</i>	
the journey is not about the adversity.	<i>Recovery is not the same as cure</i>	
Although the journey of recovery has many routes,	<i>Recovery can, and does, occur without professional intervention</i>	
and each person's journey is unique,	<i>Everyone's recovery journey is different and deeply personal. There are no rules of recovery, no formula for 'success'</i>	
it often involves finding the courage to hope for a good future and to relate to yourself		<i>Recovery is the reawakening of hope after despair</i>
	<i>Recovery is about taking back control over one's own life</i>	<i>Recovery means no longer viewing oneself as primarily a person with a psychiatric disorder and reclaiming a positive sense of self</i>
and others in beneficial ways.		<i>Recovery is not accomplished alone; the journey involves support and partnership</i>
Setbacks are inevitable, but the challenge is universal	<i>Recovery is not a linear process</i>	<i>Recovery is a complex and nonlinear journey</i>
	<i>Recovery is not specific to people with mental health problems</i>	

Personal recovery has high ecological validity – it emerges from the narratives of people with mental illness who describe themselves as recovered or in recovery. It also removes the unhelpful evaluative element of whether, according to some externally defined criteria, someone has achieved recovery.

A disadvantage of personal recovery is that it makes operationalisation of the concept and empirical investigation problematic. If recovery is an ongoing, idiosyncratic and sometimes cyclical process, how can we get a reliable snapshot or show positive change? This does not mean that empirical quantitative research is impossible. For example, Sandra Resnick and colleagues used principal components analysis and confirmatory factor analysis to identify four domains of a recovery orientation in patients: empowerment, hope and optimism, knowledge, and life satisfaction<sup>138</sup>. This allows the prevalence of a recovery

orientation among service users, and the impact of interventions on this orientation, to be investigated empirically.

We have presented clinical recovery and personal recovery as having fundamentally different meanings. Is this distinction valid?

## Are clinical recovery and personal recovery incompatible?

Two overlapping but nonetheless different understandings of recovery have been proposed. Not all authors identify two meanings of recovery. For example, Ruth Ralph and Patrick Corrigan propose three definitions of recovery<sup>117</sup>:

1. Recovery is a naturally occurring phenomenon.  
Some people who meet diagnostic criteria for a serious mental illness are able to overcome their disabilities and fully enjoy a life in which their life goals are accomplished without any kind of treatment.
2. As with other medical illnesses, people can recover from mental illness with proper treatment.  
Others who do not enjoy spontaneous recovery from mental illness are able to achieve a similar state of goal attainment and life satisfaction as a result of participating in a variety of services.
3. Recovery reintroduces the idea of hope in understanding serious mental illness . . . It means that even though a person is diagnosed with schizophrenia or other serious psychiatric disorder, his or her life need not be limited to institutions.

(pp. 4–5)

They note that mental health professionals gravitate towards the second definition (clinical recovery), whereas consumers typically find more value in the first (spontaneous recovery) and third (personal recovery).

These three definitions are also used in the joint statement on recovery issued by the Care Service Improvement Partnership, the Royal College of Psychiatrists and the Social Care Institute for Excellence in the UK<sup>139</sup>. Each definition is valued: ‘Many concerns about engaging with a recovery approach arise from thinking that these different conceptions are in competition with one another, whereas they are complementary and synergistic . . . Adopting a recovery approach harnesses the value of current treatments but is directed at living with and beyond these continuing limitations’ (p. 2). This book takes a different position. It envisages a future in which the goal of mental health services is more explicitly the promotion and support of personal recovery. Clinical recovery has value, as one approach to supporting personal recovery. However, a primary focus on personal recovery would fundamentally change the values, goals and working practices of mental health services. Clinical recovery is subordinate to personal recovery.

Personal recovery encompasses the three types of recovery listed above. Spontaneous recovery occurs for some people, when the individual’s biological, psychological, social and spiritual self-righting skills and supports combine to manage the mental illness. Personal recovery occurs for some people through receiving evidence-based treatments, so treatment is an important element of mental health services. But, crucially, personal recovery is underpinned for all people by hope, meaning, identity and personal responsibility.

A primary focus on clinical recovery is incompatible with a primary focus on personal recovery. This is a strong statement, so we will illustrate with examples of how the current focus on clinical recovery can hinder personal recovery in three domains: hope, meaning and symptoms.

## Clinical recovery and hope

Hope is central to personal recovery. It leads to action based on approach rather than avoidance motivation<sup>140</sup> – having positive goals, rather than trying to avoid negative outcomes. It also sustains through the inevitable (but otherwise unbearable) setbacks and suffering: ‘Having some hope is crucial to recovery; none of us would strive if we believed it a futile effort’<sup>141</sup> (p. 32); ‘The thing that keeps me going is the knowledge that I’m going to get better. The one thing I do know about my illness, if history tells me anything, is that I bounce back. And when I bounce back the trick is to bounce back and stay well’<sup>55</sup> (p. 60).

Hope is a problem in mental health services. The rhetoric is clear: services should work in ways which foster hope and optimism<sup>142</sup>. However, the reality for many people who use mental health services is quite the opposite<sup>143</sup>: ‘The belief held by hospital staff was that I would be powerless to influence the return of psychotic symptoms that could at any moment strike again. For me to escape this prophecy, it felt like wading through miles and miles of swamp. This was an incredibly lonely journey. I had no guides, no specialist support, no stories of success’ (p. 307). This is not a new problem. In 1959, Menninger commented on mental health professional training that: ‘I perceived vividly how hopelessness breeds hopelessness, how the non-expectant, hope-lacking or “unimaginative” teacher can bequeath to his students a sense of impotence and futility, utterly out of keeping with facts known to both of them’<sup>144</sup>. This leads to a situation where the possibility of a good future is rarely communicated by mental health professionals. It is therefore all too easy for people using services to develop the belief that they will never recover, and the self-fulfilling nature of such a belief is obvious. This is why people exposed to the idea of recovery often express surprise and disbelief<sup>55</sup>: ‘About two years ago I realised that I really could recover. I find that quite an amazing fact, because over the years no one has actually said, “You can recover”. I thought once you had mental health problems you were just going to be stuck with it’ (p. 38).

Some consumers find that interactions with mental health professionals engender feelings of being disrespected, discouraged and hopeless. This phenomenon is labelled as ‘spirit breaking’ by Patricia Deegan<sup>145</sup>:

The experience of spirit breaking occurs as a result of those cumulative experiences in which we are humiliated and made to feel less than human, in which our will to live is deeply shaken or broken, in which our hopes are shattered and in which ‘giving up’, apathy and indifference become a way of surviving and protecting the last vestiges of the wounded self.

(p. 306)

This lack of hope has toxic consequences. The self-fulfilling nature of being told by an expert that you’ll never be able to work, or live independently, or have children or be treatment-free is profoundly damaging. The reason that clinicians should never make these statements (either explicitly or – more commonly – implicitly) is not some vague notion of withholding damaging information. It is because these statements are often wrong. The evidence about recovery rates was reviewed earlier in this chapter. Work is a specifically important contributor to recovery, yet one study found that 44% of people with mental illness who had obtained employment had been previously told by a clinician that they would never work again<sup>146</sup>. A focus on clinical recovery, with its emphasis on engendering realistic (i.e. low) expectations, can destroy hope.

## Clinical recovery and meaning

Finding meaning in life is a central challenge for anyone, with or without mental illness. It involves making sense of experience, and generating a story which fits for the person.

This gives a narrative of how they come to be where they are in life. Often there is a liberating aspect to the narrative, such as a discovery that we don't need to be a prisoner of our auto-biography or a slave to our genes. It also provides a context and purpose for the future – it is the spring-board for hope.

The importance attached to meaning has been downgraded in contemporary mental health services<sup>83</sup>. In [Chapter 2](#) we identified how imposing a biomedical or biopsychosocial model on the person's experience can remove its meaning. For example, depicting delusions as 'empty speech acts, whose informational content refers to neither world nor self'<sup>147</sup> does not support individuals to meet the universal life challenge of finding how to understand and grow from experience.

How do people develop meaning? Alain Topor interviewed 16 people with severe mental illness who both self-defined and met professional criteria for recovery<sup>148</sup>. They identified experimenting with four types of explanatory model:

1. Life history (e.g. a difficult childhood)
2. Medical, often expressed with ambivalence, such as a view of medication as a 'necessary evil' (with recovery as present when medication had ceased to be an 'issue')
3. Spiritual, in line with other studies<sup>107</sup>
4. Social, especially constructing a self-narrative through telling one's story, and negotiating or compromising on the basis of the listener's response.

The implication of this diversity is that imposing any single explanatory model can be damaging. It is more productive to support the person in their quest for meaning through a stance of offering an understanding rather than imposing an explanation.

One response by mental health professionals to a call to emphasise the development of meaning is to invoke issues of insight: people with mental illness *by definition* cannot make sense of their experiences, because it is exactly that capacity for self-awareness which is impaired by the illness. The professional knows what is going on whereas the patient may or may not.

The embedded assumptions, that there is an absolute reality to know and that one party has privileged access to it, are challenged in [Chapter 4](#). However, even within a clinical frame of reference, empirical studies do not support an automatic focus on promoting insight. Pat McGorry cautions against adding 'insight to injury', by ignoring the individual's readiness to accept an illness explanation<sup>149</sup>. Indeed, a shift in the first 6 months from integration to sealing over is associated with symptomatic improvement<sup>150</sup> and increased self-esteem<sup>151</sup>. Or, to put it in the language of lived experience, isolation and withdrawal from life and reality is 'a perpetual suspended animation that is better than never-ending pain' (p. 71). This is not to argue that what clinicians perceive as a lack of insight is desirable, but it may be necessary.

In a service focussed on personal recovery, disagreement with a clinical model simply does not matter – what is important is that the person finds their own meaning, which makes some sense of their experience and provides hope for the future. Why? Because suffering with meaning is bearable – meaningless suffering is what drives you mad. Finding meaning *is* moving on. By contrast, in a mental health service focussed on clinical recovery, lack of insight is always to be avoided, because it is a symptom of illness and symptoms are by definition undesirable. We turn now to symptoms.

## Clinical recovery and symptoms

For clinical recovery, symptom abatement is necessary. For personal recovery, there is no universal stance about symptoms. This issue plays out in the realm of medication. Even



if pharmacotherapy consistently reduced symptoms (which it does not – see [Chapter 6](#)), compliance with prescribed medication limits its effectiveness. If symptom reduction is a predefined goal of mental health services, then increasingly coercive approaches to ensuring medication compliance are justified. If, by contrast, empowerment, autonomy and self-determination are primary goals, then judgements about compulsion are more individualised. The issue does not reduce to a simplistic clinician versus patient power battle. For example, some consumers argue for a tiered approach to decision-making, with transfer of control gradually happening as the individual re-obtains capacity<sup>152</sup>, whereas others argue that it is precisely at times of acute crisis when empowerment is most important<sup>153</sup>.

There are at least two pragmatic reasons not to view symptom reduction as the primary goal of mental health services. First, it leads to this escalating cycle of increasing compulsion. Second, a view of symptoms as always undesirable ignores the potential benefits. This is not intended in any way to romanticise the suffering commonly occurring in mental illness, but rather to note the reality that symptoms of mental illness are not always all bad. In [Chapter 2](#) we described how mental illness can co-exist with high achievement, or contribute to a richness in life. Even more challengingly, some people report that the experience of symptoms can itself be therapeutic or cathartic<sup>55</sup>:

I think sometimes there can be confusion between getting better and being symptom free. It is often during the times when I have had the most PTSD (Post Traumatic Stress Disorder) symptoms that I have achieved greater gains in recovery. For example, when new memories are surfacing my speech may be affected, but once I get through the difficult patches I am better than before.

(p. 30)

Personal recovery is not always about symptoms, although it is almost always about the relationship with the symptoms<sup>127</sup>: ‘I have taken ownership of my illness and I take responsibility for what I do and do not do. I don’t let it control me. And it is an “it”. It’s not the whole of my life; It’s part of my life now.’

## Personal recovery and mental health services

We have argued that clinical recovery and personal recovery are different, and in some respects incompatible as primary goals for a mental health system. Specifically, the values, goals and working practices associated with clinical recovery are one of several approaches to promoting personal recovery. Clinical recovery is a sub-set of personal recovery. Therefore, prioritising clinical recovery is helpful for many people in supporting their personal recovery, but inadequate for others, and toxic for some.

Having made this distinction, we will now argue that mental health services should be focussed on the promotion of personal recovery, and not of clinical recovery. Five justifications for giving primacy to personal recovery over clinical recovery are presented in [Section 2](#).

1. Epistemological – personal recovery places more value than clinical recovery on the knowledge of the individual
2. Ethical – acting in the professionally defined best interests of the patient should not be a primary value of mental health services
3. Effectiveness – the most common treatment (medication) does not cure, so the central promise of a clinical recovery approach is simply not fulfilled.
4. Empowerment – ‘their’ life has not been safe in our hands
5. Policy-based – national policy requires a focus on personal recovery.





# The primacy of personal recovery

## Epistemological rationale

### Summary of the epistemological rationale

Evidence-based medicine is based on Enlightenment principles, and downgrades the importance of subjective experience. Since mental illness is fundamentally subjective, constructivism would provide a better basis for mental health services, as it values both expertise-by-training and expertise-by-experience.

The epistemological basis of clinical research was developed during the Enlightenment. Shortcomings of this approach to knowledge will be outlined, and alternatives identified.

### What is knowledge?

Epistemology is the branch of philosophy which deals with knowledge and belief, including the nature of knowledge itself, how it is obtained, what people know, and how knowledge relates to concepts such as truth and belief. A central assumption in the field of epistemology shifted during the Enlightenment.

Classical understanding of knowledge was influenced by the Greek philosophical world-view. Aristotle defined truth and falsehood: 'To say of something which is that it is not, or to say of something which is not that it is, is false. However, to say of something which is that it is, or of something which is not that it is not, is true'. Drawing on this assumption of objective truth, Plato identified knowledge as a subset of that which is both true and believed.

The existence of absolutes and the centrality of belief dominated thinking until the Age of Enlightenment in the seventeenth and eighteenth centuries. The period is sometimes called the Age of Reason, as it involved a move from belief to reason as the primary basis of authority. The transition is sometimes called *the mechanisation of the world-picture*<sup>154</sup>, and followed from wider cultural assumptions, such as empiricism (basing cognition in experience common to all) and the democratisation of knowledge. The idea of an experiment – 'a question we put to nature' through intervention and observation – was developed by Francis Bacon<sup>155</sup> and others during this period. Crucially, the central goal of science was to establish causal relationships and processes which allow predictions to be made about what will happen in the future. The goal is not understanding meaning or reasons.

Scientific principles emerging from the Enlightenment emphasise a particular type of knowledge, called nomothetic knowledge. The distinction between nomothetic and idiographic knowledge was introduced by Wilhelm Windelband. **Nomothetic knowledge** is based on what Kant described as a tendency to generalise, and involves the effort to derive laws that explain objective phenomena. It is derived from the study of groups which represent populations, normally using quantitative methodologies. **Idiographic knowledge**, by contrast, is based on the tendency to specify, and involves efforts to understand the meaning of contingent, accidental and often subjective phenomena. It is derived from the

study of individuals and the properties which set them apart from other individuals, normally using qualitative methodologies.

Research focussed on the development of nomothetic knowledge seeks to develop generalisable explanations of the world derived from group-level experimentation. This involves **reductionism**: squeezing all the subjectivity or meaning or perspective out of a situation, so that truth can be revealed. Reductionism in the natural sciences is an asset – it indicates a robust theory, and allows reproducibility of a theory to be established through experimentation.

This world-view is the cultural and scientific context in which clinical research has developed, and accounts for why evidence from the randomised controlled trial has become dominant. The evidence-based medicine movement has developed the hierarchy of knowledge (which is in fact a hierarchy of method):

*Highest (i.e. strongest) type of knowledge:*

Systematic review and meta-analysis of randomised controlled trials

*Followed in order by*

Randomised controlled trials with definitive results

Randomised controlled trials with non-definitive results

Cohort studies

Case-control studies

Cross-sectional surveys

*Lowest (i.e. least compelling) type of knowledge*

Case reports

It goes without saying (because it has been said many times<sup>156–158</sup>) that this hierarchy brings benefits. The focus on randomised controlled trials (RCTs) as the gold standard of research methodology means that uncontrolled or poorly controlled studies are given less weight, more importance is attached to methodological issues, and more caution is exercised in evaluating outcome. As Derek Bolton puts it<sup>159</sup>: ‘RCTs are here to stay. They are based on deep philosophical and cultural assumptions about nature and knowledge, assumptions that have well proved their effectiveness elsewhere.’ How applicable to mental illness are scientific methods based on Enlightenment principles?

## The development of a science of mental illness

We argued in [Chapter 2](#) that mental illness is, before all else, a subjective experience. Therefore the object of mental illness research is the inner subjective world of experience. This gives rise to a basic problem: it is not possible to directly access subjective experience. It is only possible to investigate the observable world, either inside the body (e.g. biochemistry, neuroanatomy, self-reported cognitions) or outside (e.g. life events, social context, familial history). Clearly these inside and outside phenomena influence experience, and so research into the relationship between observable phenomena and subjective experience may be informative. But if the essence of mental illness is the inner subjective world, then only the person themselves can access this stratum.

The central challenge for any science of mental illness is to accommodate knowledge from both observation and subjective experience. This integration has been problematic. Two broad (and opposing) philosophies have dominated thinking.

On the one hand, **subjectivism** holds that the existence of every object depends on someone’s subjective awareness of it – that perception is reality and that there is no