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From the Editor

As this issue was on its way out the door, we learned of the death of our friend, colleague, and AAPP collaborator, Ned Wallace. We haven't seen a lot of Ned in recent years, but his recently published History of Psychiatry and Medical Psychology gives ample testimony that he has not been idle. We will all miss him.

This issue of the Bulletin is devoted to commentaries on Zachar and Kendler's "Psychiatric Disorders: A Conceptual Taxonomy," with a response by the authors. The exchange provides a rich opportunity to reflect on many of the conceptual issues that beleaguer the construction of the new diagnostic manual. I want to express my appreciation to Pete and Ken for their efforts in producing a thoughtful, detailed response to these commentaries.

JP

In Memoriam

Edwin R. "Ned" Wallace IV, M.D.

All members of AAPP should mourn the unexpected death of Ned Wallace this past November 29, 2008 from cardiovascular causes. Dr. Wallace was one of the four cofounders of AAPP in 1989, when he, Osborne Wiggins, Michael A. Schwartz, and John Sadler decided to put on their own philosophy of psychiatry meeting after the American Psychiatric Association turned down their symposium submission.

Dr. Wallace hosted formative meetings of AAPP while chairman of psychiatry at the Medical College of Georgia in the mid-1980's. No one will forget his genteel hospitality, sandpaper drawl, and vigorous, unrelenting intellect. He was a natural for developing the Group for the Advancement of Philosophy and Psychiatry, later AAPP, as he was trained in psychiatry and psychoanalysis at Yale, history of science and medicine from Hopkins, and an additional degree in European history from the University of South Carolina. Ned's encyclopedic knowledge of the history of psychiatry, psychoanalysis, and philosophy led to the publication of his newly-released magnum opus, *History of Psychiatry and Medical Psychology* (Springer, 2008) with his longtime colleague and friend John Gach as co-editor. The author of over a hundred articles and influential books on dynamic psychiatry (*Historiography and Causation in Psychoanalysis: An Essay on Psychoanalytic and Historical Epistemology*; *Freud and Anthropology: A History and Reappraisal*; *Dynamic Psychiatry in Theory and Practice in several editions*), Ned was a member of the American College of Psychiatrists and the AAPP Executive Council. Afflicted with the late onset of bipolar disorder in the mid-1990's, Ned retired from clinical practice and academic psychiatry to serve on the history faculty at USC. He managed his illness and continued to produce academic work, including peer reviews for *Philosophy, Psychiatry, & Psychology*, commentaries in PPP, and additional articles in a variety of bioethics and history journals as a USC Research Professor of Bioethics and Medical Humanities.

Dr. Wallace's commitment, energy, and enthusiasm for the philosophy of psychiatry were never equaled, and those of us who knew him will miss him greatly.

John Sadler

The Travails of DSM-V

With "Psychiatric Disorders: A Conceptual Taxonomy" (Zachar and Kendler 2007) Zachar and Kendler add their voices to a developing chorus of commentators who point to the difficulties facing the author's of DSM-V in attempting to produce a coherent diagnostic manual. They introduce their article by citing the 'white papers' written for DSM-V and published as *A Research Agenda for DSM-V* (Kupfer, First et al. 2002). That document is interesting for the way in which it exposes the contradiction at the heart of the DSM-V project. On the one hand, the general editors write in the "Introduction" that their goal with the white papers is to promote "...the eventual development of an etiologically based, scientifically sound classification system" (Kupfer, First et al. 2002, xv). They also write, rather optimistically, "Those of us who have worked for several decades to improve the reliability of our diagnostic criteria are now searching for new approaches to an understanding of etiological and pathophysiological mechanisms - an understanding that can improve the validity of our diagnoses and the consequent power of our preventive and treatment interventions" (xv). But then, these same editors give us a glimpse of this mountain they are trying to scale: : "In the more than 30 years since the introduction of the Feighner criteria by Robins and Guze, which eventually led to DSM-III, the goal of validating these syndromes and discovering common etiologies has remained elusive. Despite many proposed candidates, not one laboratory marker has been found to be specific in identifying any of the DSM-defined syndromes. Epidemiologic and clinical studies have shown extremely high rates of comorbidities among the disorders, undermining the hypothesis that the syndromes represent distinct etiologies. Furthermore, epidemiologic studies have shown a high degree of short-term diagnostic instability for many disorders. With regard to treatment, lack of treatment specificity is the rule rather than the exception" (Ibid.).

There we have it: on the one hand the dream of a coherent, "...etiologically based, scientifically sound classification system"; on the other hand the incredibly messy state of contemporary psychiatric nosology - the inability to define discrete disorders with non-overlapping boundaries, the enormous comorbidities, the complex, multifactorial etiologies, the failure to isolate specific genotypes or pathophysiologies, the increasing non-specificity of pharmacologic treatments. Oddly, the more we know about psychiatric illnesses and treatments, the more confusing they seem, and the farther we appear from the dream goal of a "scientifically sound classification system."

In the framework of *A Research Agenda*, the authors of the chapter entitled "Basic Nomenclature Issues " (Rounsaville, Alarcón et al. 2002) pick up the pessimistic thread of the general editors' remarks on the Feighner criteria, underlining the multiple failures of those criteria to achieve validity in psychiatric diagnoses. Referring to that chapter at the

(Continued on page 12)

Symposium
"Psychiatric Disorders: A Conceptual Taxonomy"

Peter Zachar, Ph.D. and
Kenneth Kendler, M.D.

In 2007 Professors Zachar and Kendler published the above article in the American Journal of Psychiatry (164: 557-565). This issue of the Bulletin is devoted to a symposium on this important article, which addresses problems inherent in contemporary psychiatric nosology - problems that confront the authors of the next editions of the DSM & ICD diagnostic manuals. The authors have graciously agreed to participate in the symposium with a response to the following commentaries, and for that we thank them.

JP

The Naturalist-Normativist Debate and Psychiatric Taxonomy

Michael A. Cerullo and Kyle E. Karches

Introduction

Zachar and Kendler should be commended for raising a topic crucial to psychiatry in their paper (Zachar and Kendler 2007). They provided an excellent summary and discussion of the many difficult issues related to psychiatric taxonomy. Too little attention was paid to the philosophical foundation of psychiatric taxonomy in the last two editions of the Diagnostic and Statistical Manuel of Mental Disorders (DSM) (American Psychiatric Association 1980; American Psychiatric Association 1994), with a negative impact to the field. There continues to be a strong naïve skepticism towards psychiatric diagnoses (Arun and Chaven 2004; Cerullo 2006; Rissmiller and Rissmiller 2006) and we need to take the opportunity provided by the DSM-V to defend our taxonomy against antipsychiatry arguments. While Zachar and Kendler focused on discussing several important issues of taxonomy, they failed to explore the pragmatic issues crucial to this debate. In addition, they overcomplicated the philosophical debate on disease and taxonomy by adding unnecessary layers of distinction. In this commentary we will discuss these concerns and provide further guidance to approaching the problem of taxonomy in the DSM-V.

What is disease?

The crucial philosophical debate on taxonomy has focused on how to define disease (Nordenfelt 1995; Boorse 1997; Nordenfelt 2007). The debate has centered on two opposing camps, naturalists and normativists (Nordenfelt 2007). The naturalists, exemplified by Christopher Boorse, believe disease can be defined as a breakdown in the normal biology of the organism (Boorse 1997). For Boorse, disease is an objective, factual concept drawn from the sciences of physiology and pathology. By contrast, the normativists, such as Lennart Nordenfelt, believe that our subjective values are crucial in defining disease and are skeptical of any purely objective definitions of disease (Nordenfelt 1995; Nordenfelt 2007). Normativists contend that disease is an aesthetic concept, tied to culturally relative judgments about the good for human life.

The naturalist-normativist question supersedes the six axes Zachar and Kendler propose because the naturalist-normativist distinction entails opposite positions on each of their axes. According to Boorse's naturalist theory, diseases stem from an underlying deficiency in the function of a body part, and disease classifications are factual because they rely not on the practical science of medicine but on the theoretical sciences of physiology and pathology (Boorse 1997). Hence, Boorse's theory requires that "Causalism," "Essentialism," "Objectivism," and "Internalism" – all distinct categories, according to Zachar and Kendler – be true. Furthermore, because Boorse defines disease as subnormal functional efficiency, as determined by a statistical bell graph compiled using data from persons of similar age and gender, his version of naturalism also considers diseases "Continuous" but nevertheless "Entities," since they are not subjective. Similarly, normativists believe that disease is a descriptive, practical, value-laden, and culturally-driven concept and that disease classifications are constructed; therefore, normativism implies that "Descriptivism," "Nominalism," "Evaluativism," and "Externalism" be true and that diseases be "Categorical" and tied to "Agents" (Nordenfelt 1995; Nordenfelt 2007). The naturalist-normativist dichotomy, then, splits all six other axes down the center, preserving all of the important disagreements Zachar and Kendler identified while avoiding unnecessary complexity. Thus the naturalist-normativist distinction captures the most relevant distinctions in taxonomy and suggests the debate about psychiatric taxonomy can and should be carried out along naturalist-normativist lines. Adopting the naturalist-normativist distinction in psychiatry allows consistency with and use of the vast philosophical literature on taxonomy.

The Pragmatics of Medicine

Zachar and Kendler suggest that psychiatrists will resolve many of the concerns regarding taxonomy in the future with further empirical data. Yet we believe this to be in error. Psychiatrists are unlikely to resolve many of the issues in taxonomy discussed by Zachar and Kendler as they ultimately depend on long standing philosophical controversies. Indeed, we believe that many of the issues falling under the naturalist-normativist debate will always remain philosophical questions and thus remain outside the realm of empirical science. Therefore we cannot look to the future to resolve the naturalist-normativist debate, especially as we need immediate guidance as we reconsider the foundations of our current taxonomy. Yet we do not believe these philosophical issues should hinder psychiatrists from improving our taxonomy. Nor do we need to wait until we can link psychiatric disorders with specific biological etiologies to resolve these taxonomical issues. Instead, we feel that the scientific and philosophical foundations of psychiatry are currently sound enough for us to reform our taxonomy and resolve many of the problems that have hounded our field. To do this, we need to step back and look at the bigger picture.

Medicine has always been a pragmatic profession, and psychiatry is no exception. Philosophical uncertainty in the naturalist-normativist debate need not impede the pragmatics of psychiatry. One important pragmatic goal in refining psychiatric taxonomy should be to rectify the current situation, in which our taxonomy is used to hinder the treatment of patients. The DSM-III and IV have fueled the antipsychiatry movement by giving the perception of using only normative models of disease and of voting psychiatric illnesses into existence arbitrarily by committee (Shelton 1993; Rissmiller and Rissmiller 2006). While such perceptions are clearly false, they nevertheless encourage skepticism towards psychiatric diagnoses. Improvements in the DSM-V could remove these stumbling blocks. In what follows, we will justify the use of the "flexible medical model" to address these concerns.

The Flexible Medical Model

The version of the medical model used in psychiatry today is the biopsychosocial model adapted from Engels, which allows the incorporation of psychological and social along with biological contributions to disease (Engel 1977). The current DSM-IV-TR is rooted in the biopsychosocial model, which is flexible enough to incorporate normativist and naturalist definitions of disease. There is likely truth to be found in both naturalism and normativism, and until bioethicists resolve this debate more definitively, we need to incorporate

both models when they are useful. We therefore agree with Zachar and Kendler that more than one definition must be used when classifying mental illness.

Some psychiatric diseases can be defined primarily through naturalist models; examples would include bipolar type I disorder and schizophrenia. Yet clearly some disease definitions seem to intersect with value judgments and thus require normativist language to define them; the most obvious examples would include the diagnoses classified under sexual and gender identity disorders. Of course, these normativist diseases still require empirical evidence to distinguish them from health and careful philosophical arguments to determine why they are undesirable. This is necessary to avoid the repeat of prior mistakes in taxonomy, such as classifying homosexuality as an illness. In fact, we believe the heart of any version of the medical model is the use of empirical evidence when defining disease rather than the linking of illnesses to specific pathologies.

Transparency and Empirical Justification

The key to preventing the abuse of our taxonomy by the antipsychiatry movement is to be as transparent as possible. Essential to this transparency will be acknowledging when we are using naturalist versus normativist models of disease. Also critical for this transparency is including the evidence and rationale for each diagnosis, or at least a good summary, within the one volume DSM-V rather than burying them in a five-volume appendix as in the DSM-IV (American Psychiatric Association 1994). Different empirical evidence needs to be provided for diseases defined according to naturalist or normativist models. Some preliminary criteria necessary for a disease defined using a naturalist definition could include: data on consistent cross-cultural epidemiology (i.e. similar incidence and prevalence); data suggesting heritability of the disease (the strongest evidence would be twin studies ruling out environmental effects via twin adoption studies); data on successful treatment and biological effects of the disorder; and of course data linking the disorder to specific pathology when this becomes available. Criteria for a disease defined primarily using a normativist definition could include: data on consistent epidemiology (i.e. similar incidence and prevalence) within a single culture or subculture; evidence of psychological suffering; proof that the disease is uniquely, if not solely, suitable for medical manipulation; and evidence that the disease is not merely the result of prejudice. These are by no means the final criteria but are offered to suggest how diseases defined by different models would need different justification. Cleary the types of evidence for each model need to be further refined, especially in regards to normativist diseases.

At present, many, if not most, psychiatric diseases will have an element of both definitions. Without biological etiologies, all psychiatric disorders are defined as symptom clusters. Thus this usually introduces some normative elements in the definition related to number and severity of symptoms required. Our medical colleagues, however, face similar problems with deciding where to place the cutoff values for hypertension, high cholesterol, and diabetes, for example. These normative elements are consistent with the medical model as long as we are transparent about our cutoff values and provide empirical evidence to support these cutoffs (i.e. risk benefit data and preventative medicine data). Finally, any taxonomic system needs to be flexible enough to incorporate the rapid advances in science, and specifically the rampant advances in neuroscience. The prior DSM did not allow this, so all diagnoses are linked together and thus vulnerable at their weakest link. The DSM-V should allow for changes in individual diagnoses without revising the entire DSM.

Conclusion

Zachar and Kendler (2007) discussed six conceptual dimensions of taxonomy to consider in the DSM-V. However, these six dimensions can be reduced to the distinction between naturalist and normativist models of disease. Although philosophers remain divided between naturalism and normativism, both definitions currently have enough merit to justify their use in the pragmatic field of medicine, in which the goal is to promote patients' health. When thinking about how to update the foundations of our taxonomy, we need to be cognizant of the fact that the biggest gains are to be made in preventing our taxonomy from being used against us. For the most part, clinicians and patients have little problem recognizing illness. By adhering to a flexible medical model incorporating both naturalistic and normative definitions of disease and providing transparent justification of each disorder, we can answer our critics' long standing doubts about the validity of psychiatric taxonomy. This would be a most welcome gain in revising our taxonomy.

References

American Psychiatric Association 1980. *Diagnostic and Statistical Manual of Mental Disorders, Third Edition.*

AAPP 21st Annual Meeting 2009

Philosophical Issues in Child and Adolescent Psychiatry

May 16 & 17, 2009
San Francisco, CA
(in conjunction with the American Psychiatric Association Annual Meeting)

Invited Panel
Bipolar and Associated Controversies
Moderator
Nassir Ghaemi, M.D.
Panelists
Bhanukrapresh Kolla, M.D.
Solay Unal, M.D.
Anna Yurchenko, M.D.

The Annual Meeting of the Association for the Advancement of Philosophy and Psychiatry will take place in conjunction with the Annual Meeting of the American Psychiatric Association on May 16 & 17, 2009 in San Francisco, CA. This meeting will be devoted to the theme: Philosophical Issues in Child and Adolescent Psychiatry.

Child and adolescent psychiatry has had relatively little philosophical attention, yet it is rich with theoretical, conceptual, ethical, and social issues. Children and adolescents are still undergoing significant psychological development and they occupy very different social roles from adults, so their experience of emotional and cognitive problems is very different from that of adults. A central issue is whether we should conceive of childhood mental disorder in the same way as adult mental disorder. Other related issues include the ethics of diagnosis and treatment of disturbed children, the controversy over the use of antidepressants, and the question of assessing competence, both for decision making and for responsibility, in this population. Philosophical discussion has the potential to illuminate and help to resolve some of these theoretical disputes.

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Washington DC: American Psychiatric Association.

American Psychiatric Association 1994. *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition*. Washington DC: American Psychiatric Association.

Arun, P. and B. Chaven 2004. Antipsychiatry movement and non-compliance with therapy. *Hong Kong J Psychiatry* 14, no. 2: 21-22.

Boorse, C. 1997. A Rebuttal on Health. In *What is Disease?* eds. J. Humber and R. Almeder, 1-134. Totowa, New Jersey: Humana Press.

Cerullo, M. 2006. Cosmetic Psychopharmacology and The President's Council on Bioethics. *Perspectives in Biology and Medicine* 49 no. 4: 515-523.

Engel, G. 1977. The need for a new medical model: A challenge for biomedicine. *Science* 196 no. 4286:129-196.

Nordenfelt, L. 1995. *On the Nature of Health (2nd ed.).* Amsterdam: Rodopi Publishers.

Nordenfelt, L. 2007. The concepts of health and illness revisited. *Medicine, Health Care and Philosophy* 10:5-10.

Rissmiller, D. and J. Rissmiller 2006. Evolution of the antipsychiatry movement into mental health consumerism. *Psychiatric Services* 57 no. 6:863-866.

Shelton, R. 1993. Book Review: The Selling of DSM: The Rhetoric of Science in Psychiatry. *NEJM* 328 no. 15:1132-1133.

Zachar, P. and K. Kendler 2007. Psychiatric disorders: A conceptual taxonomy. *The American Journal of Psychiatry* 164:557-565.

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Practical and Moral Factors Go Beyond the Practical Kinds Model

Christian Perring

Zachar & Kendler present an even-handed summary of different positions on psychiatric nosology in a few pages, leaving plenty of room for comment. There's no point in quibbling over small details concerning their description of different models, since the authors are aiming to steer a whole conversation about how to think about categorizing mental disorders, with the hope of improving the philosophical foundation of DSM-V. So I will try to keep my comments at a more general level.

It is helpful to make a distinction between the model of categorization of mental disorders that DSM-V should use and the model that psychiatry should use ideally in the long term future, because these may not be the same. It is also important to keep in mind the distinction between what function DSM-V is meant to serve, and what function it will actually serve. Let me expand on these two related points.

The editors of DSM-IV-TR describe its purpose as to "provide a helpful guide to clinical practice" and secondarily to "facilitate research and improve communication among clinicians and researchers" (DSM-IV-TR p. xxiii). Yet the manual has been used for many other purposes, and indeed, maybe even primarily for other purposes. Most obviously, it is used by health insurance companies and other businesses that reimburse clinicians for their services as a guide to which conditions should be covered. It is also used by individuals as a guide to which of their expenses are medical, and thus can be claimed as tax-deductable. In legal settings, it is used as a guide to which psychiatric conditions may count as reducing a person's criminal culpability for their actions. To be sure, it is not the only guide used by businesses, tax accountants, or courts, and sometimes the categorizations of DSM are overruled or ignored in the decisions of these other groups. Nevertheless, the decisions of the editors of the DSM can have significant social effects in a number of non-clinical and non-research settings. Let me refer to this as the *social use* of DSM.

The attitude of the editors of DSM-IV-TR to the social use of DSM has been to say it is out of their purview. It is easy to construct arguments to justify this attitude. It would be asking a great deal of the editors of DSM to be responsible for the decisions of health insurers, tax accountants and courts. They can create their own book of criteria for mental disorders, for their own purposes, and it is not their fault if the manual is used for other purposes. They have no expertise in these other areas of the social realm, and so it would be unreasonable for them to produce a manual that is designed to help in those non-clinical, non-research areas.

Nevertheless, it makes a difference which model of categorization we employ when we consider the social use of DSM. With the medical models, the question of which conditions get classified as disorders and what the social effects of such classifications will be are largely independent. (I say "largely" because it is possible that on Wakefield's harmful dysfunction model, at least on some interpretations, one would have to take into account the social effects of the categorization in deciding whether or not the condition is "harmful." However, on such an interpretation of Wakefield's model, it would become more like a "practical kinds" model than a medical model.) On the medical model, the aim of categorization is simply to carve nature at its joints, so to speak, or to mirror reality. Those who are not in the realm of psychiatry are then able to make use of the discoveries made by psychiatric experts about which conditions are mental disorders.

The two "Alternative Models" of categorization that Zachar and Kendler describe are very different from each other. The Dimensional approach does not in itself say anything about how much of a certain trait a person needs to have before he or she is described as having a mental disorder. Furthermore, with the brief description we are given, there's no indication as to which traits or properties should be chosen in the first place. So it is silent on the relevance of the social uses of the DSM.

The "Practical Kinds" model does take into account non-clinical and non-research factors when deciding how to categorize mental disorders. "The practical kinds model claims that although choosing DSM categories requires an evaluation that considers a multitude of priorities, we can still choose them on rational grounds. These grounds will include both scientific and practical values, such as predicting treatment, maximizing true positives and minimizing false negatives, being clinically informative, and reducing stigmatization." (page 562). Note that here the only blatantly non-clinical, non-research ground mentioned is the last one, reducing stigmatization. However, the description of the model leaves open the possibility of other practical values playing a role in the categorization.

Moving onto the models advocated by critics of the Medical Model, i.e., the "Interpersonal Model" and the "Narrative Approach," it is again very unclear to what extent they take into account the social uses of categorization when deciding how to categorize mental disorder. It seems reasonably clear that they do not emphasize these non-clinical, non-research factors. They may allow them to play some role in some versions.

Now I can make my main point. We need to distinguish between the ultimate model of psychiatric categorization that we will end up using when we know all there is to know about the brain (in the unlikely event that this should ever happen) and our place right now in creating DSM-V. Even if we believe it will be possible to divide up psychiatric illnesses neatly into different mutually exclusive kinds, akin to the periodic table, we are clearly not able to do this now in any exhaustive fashion, although it may be possible in a few rare cases. We may aim to be as objective and scientific as possible, and be committed to a medical

model. Nevertheless, even with such commitments, there may be a role for bringing in the social uses of categorization as a consideration of which conditions to count as mental disorders and how to group different conditions together in different categories. The current scientific evidence underdetermines the decisions of where to draw the line between normal and pathological, giving the editors plenty of leeway in how to draw the distinctions. Furthermore, drawing this distinction between the normal and pathological arguably depends on conceptual questions and a variety of values that will not be settled by any amount of scientific evidence collecting. Therefore, no matter which model of psychiatric categorization one adopts, some method that includes factors going beyond neutral-neutral scientific considerations is required for coming up with a set of diagnostic criteria for DSM-V.

To illustrate my point here, I will use the case of relationship disorders. As Zachar and Kendler point out, some contributors to the recent book *Advancing DSM: Dilemmas in Psychiatric Diagnosis* (APP, 2003) have made a case for including relationship disorders in DSM, including cases where two people in a couple are both psychologically normal but their relationship is abnormally dysfunctional. Some would argue conceptually that a relationship disorder cannot be a mental disorder since mental disorders must belong to an individual. However, some have argued that relationship disorders could be included in DSM, notably Wakefield (2006). This might mean expanding DSM to include non-mental disorders, or one might conceivably argue that the concept of mental disorder can be legitimately extended to a couple.

It would undoubtedly be controversial to include relationship disorders in DSM (see Vedantam, 2002). There is certainly a case to be made for including the diagnosis, but many psychiatrists are suspicious of the idea, and worry about how this will play with the public image of DSM as medicalizing every part of human life. Given the lack of decisive scientific evidence and the mixed views about the nature of our concept of disorder, even strict defenders of the medical model might legitimately appeal to such non-scientific, non-clinical considerations here in deciding whether to include these conditions in DSM-V.

One could make similar arguments regarding other controversial diagnoses such as Pre-Menstrual Dysphoric Disorder, and the condition sometimes known as Chronic Fatigue Syndrome.

One of the central difficulties facing the editors of DSM, once they acknowledge that the social uses and social reputation of DSM is relevant to its construction, is to decide *which* non-clinical, non-scientific considerations to take into account. The aim of reducing the stigma of mental illness is relatively non-controversial, although it can be problematic when applied to serial killers and sex offenders. The earlier arguments considered above, that the editors cannot be expected to bring in considerations such as the tax-exempt status of certain procedures, because they have no expertise on such matters, still have plenty of force. On the other hand, the issue of which treatments should be covered by third-party payers is very close to clinical practice, and the argument that such considerations are beyond the expertise of psychiatric experts is far weaker. Given the difficulty of these decisions, it is hard to come up with general rules about them, and they probably need to be basically decided on a case by case basis.

In conclusion, the main point I want to drive home in response to Zachar and Kendler's paper is that they somewhat underplay the role that non-scientific values can legitimately play in deciding how to structure the DSM. Practical and moral considerations can be relevant for all models of psychiatric diagnosis, not just the practical kinds model.

References

Pincus, H.A., First M.B., Phillips, K.A. (Eds). *Advancing DSM: Dilemmas in Psychiatric Diagnosis*. American Psychiatric Press, 2002.

Wakefield, J. Can Relational Problems be Genuine Medical Disorders? A Harmful Dysfunction Perspective. *Family Psychologist*. Fall 2006 Vol , No. 4.

Shankar, V. Doctors Consider Diagnosis for 'Ill' Relationships. Washington Post Sunday, September 1, 2002; Page A01. Accessed online: http://www.washingtonpost.com/ac2/wp-dyn/A21469-2002 Aug31

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The Problem with "-isms"

Claire Pouncey

Twenty years ago, Theodore Millon wrote that "philosophical analysis will not in itself reveal clear resolutions to all nosological quandaries. More likely will be its role in "unsettling" prevailing habits, forcing us thereby to progress, if for no other reason than having had our cherished beliefs and assumptions challenged."[1] In "Psychiatric Disorders: A

Conceptual Taxonomy", Zachar and Kendler classify and challenge some of these conceptual habits. In keeping with the *Research Agenda for DSM-V*[2], and the recent American Journal of Psychiatry editorial[3] (both of which Dr. Kendler co-authored) calling for explicit attention to conceptual issues in crafting DSM-V, Zachar and Kendler argue here that "struggling with conceptual and philosophical issues is a legitimate and . . . necessary part of the nosologic process" [564]. The authors engage in this struggle, and their provocative conclusions suggest that philosophy and psychiatry can together develop and improve psychiatric nosology.

While I like the project's aims and many of its conclusions, the methodology and its implications for future work trouble me. Although Zachar and Kendler set out to unsettle some of our most refractory, cherished, conceptual assumptions about psychiatric nosology, they do not use philosophical analysis to do so. This creates two problems, which I will discuss in turn. First, the conceptual project of parts 1 and 2 is unclear and sometimes misleading. Second, the argumentative strategy provides a poor demonstration of interdisciplinary methodology.

In part 1 the authors explore conceptual issues that ground psychiatric classification by identifying pairs of contrasting conceptual approaches to psychiatric classification [identifying and summarizing "dimensions" of psychiatric classification]. In part 2, they compare these dimensions to various "models" of what mental disorders are, and they show how these rival psychiatric models endorse the dimensions in different combinations and to different degrees. In doing so they provide an interesting nomogram for understanding some of the concepts that have been used to debate psychiatric nosology. In part 3, Zachar and Kendler draw on the concepts identified in the first two sections to try to change expectations of what a legitimate scientific nosology should be.

Despite their promise to explicate and explore nosologic concepts, Zachar and Kendler obfuscate more than they explicate. They introduce a number of "-isms", which they call these "dimensions". This suggests that concepts are analogous to psychological traits, features that may or may not be definitive, and that may be studied to a greater or lesser degree according to the interests of the investigator. The authors do not explore the conceptual "-isms" they name. Rather, they define them briefly, and pair them in questionably sound ways. The authors then use these superficial pairings to make sense of how other authors have described the nosological enterprise.

In doing so, Zachar and Kendler suggest that nosological concepts can be chosen from a menu and applied to a particular problem, rather than recognizing that some "-isms" are central to psychiatry's underlying empiricist epistemology as pre-scientific commitments that precede any particular research program. They fail to recognize, or at least acknowledge, that scientific theories are *always* underdetermined by evidence: induction from scientific observations *necessarily* is logically inconclusive. Although Zachar and Kendler acknowledge that "categorization requires decision as well as discovery" [558], they demonstrate psychiatry's general discomfort with the idea that we make decisions about legitimate, empirical, nosologic content. As a result, Zachar and Kendler misconstrue what choices we make, and at what point in the empirical process we make them.

For one instance, we do not *choose* "inference to the best explanation": it is built into the conceptually prior commitment to empiricist epistemology. For another, "objectivism versus evaluativism" is a false dichotomy. For empiricists, values and objectivity are neither antitheses nor polar extremes of a continuum, and objectivity is never "a simple factual matter" [558]. These two examples are part of a single misunderstanding. Given that inference to the best explanation is always logically inconclusive, fascinating philosophical work has been done on the question of what *non*empirical, evaluative considerations provide scientific reasons for favoring one rival hypothesis or theory over another. One provocative answer is that scientific values (a.k.a., empirical virtues) direct our scientific beliefs toward one "best explanation" and away from others. In other words, evaluative commitments fill the epistemic gap between mere data, and what we accept as *evidence* for or against a particular conclusion. These evaluative conventions are not arbitrary; most are well established throughout science, and in biomedicine form the basis for "evidence-based" medicine and peer review. Thus, values *constitute* rather than undermine what we take to be objective scientific knowledge. It is misleading to suggest that we choose whether or not to allow values to influence nosology, when actual and usually tacit decision involves which and whose values to promulgate. Inference to the best explanation and the influence of values on nosology are not explicit choices, though which values influence which inferences may be.

Some of Zachar and Kendler's other "dimensions" suggest that we need to make pre-scientific decisions when we do not. First, the authors' "internalism versus externalism" dichotomy captures psychiatry's ambivalence about whether psychopathology should be characterized solely as intrapersonal, or whether we should also (or exclusively) characterize it as interpersonal processes, or processes based in interactions between individuals and the environment. Second, their discussion of psychiatric symptoms forming "categories versus continua" suggests another pre-scientific choice, rather than an *a posteriori* decision about how to generalize from a finite number of observations. Third, the "causalism versus descriptivism" dimension suggests that we choose explicitly how to characterize individual mental disorders, and the concept of 'mental disorder' generally, based on metaphysical commitments rather than scientific observation. But we need not decide *a priori* on what grounds we legitimately characterize 'mental disorder' generally, or individual disorders particularly. Readers unfamiliar with the concepts may not recognize that whether disorders are "internal" or "external" to persons likely has an empirical answer, depending on how we frame a research program. They may not recognize that the "categories versus continua", or "causalism versus descriptivism" questions can be answered heuristically, but never definitively or empirically; and that we may want to characterize some disorders as categories, and others as continua, according to our clinical and research purposes. In short, the authors seem to assume a homogeneity about mental disorders, as well as about the concepts we have used to describe them, that could itself be challenged.

This brings me to my second concern, which is that this paper sets a poor example of how inter- or multidisciplinary conceptual work on psychiatric nosology should proceed. There has been little public discussion of interdisciplinary methodology. The authors seem to believe that conceptual analysis has a role in their project, since they describe it as "explication and exploration" [557] of nosologic concepts. But they seem to be using something like an empirical, nosologic method: we observe what is "out there"; we interpret those observations; we compare them with other observations, theories, and hypotheses within our own science; and we compare them with broader scientific theory.[4] This seems to be what Zachar and Kendler are doing, not with respect to nosologic entities, but with respect to philosophical concepts that have been used to describe nosology. They identify concepts that have been used to debate nosology; they characterize the concepts and their "traits"; and they order them in a way that makes sense for their larger pro-

ject. This is an empirical, not philosophical, method. It is not the conceptual analysis the authors claim to provide.

Again, the authors' undefended method shapes their conclusions. This strategy ignores conceptual work that already has been done on some of the "-isms" they describe. If readers who want to take up the challenge of the *Research Agenda* view this paper as an illustration of real explication and exploration (i.e., conceptual analysis), their efforts will not proceed far. Although Zachar and Kendler talk about concepts *and* evidence, they do not explore how concepts *shape* evidence. This omission invites the question of what the methodology of conceptual work in psychiatric nosology should be.

To conclude, I do not mean to be a nay-sayer. I think Zachar and Kendler have done a great service in stimulating important public discussion of the philosophy behind our nosology, and I endorse many of their conclusions. But I think this endeavor is unsound. The authors do not challenge their own conceptual assumptions, they misdescribe those of others, and they mislead about their method of conceptual investigation. As a result, I fear they confuse more than they clarify, both in terms of conceptual content and analytic method.

References

1. Millon T: On the Nature of Taxonomy in Psychopathology, in *Issues in Diagnostic Research.* Edited by Last CG and Hersen M. New York, Plenum Press, 1987, 14.

2. Rounsaville BJ, Alarcon RD, Andrews G, Jackson JS, Kendell RE, Kendler K: Basic Nomenclature Issues for DSM-V, in *A Research Agenda for DSM-V*. Edited by Kupfer DJ, First MB, and Regier DA. Washington, DC, American Psychiatric Press, 2001, 1-29.

3. Kendler KS, Appelbaum PS, Bell CC, et. al.: Issues for DSM-V: DSM-V Should Include a Conceptual Issues Work Group. *American Journal of Psychiatry* 2008; 165 (2):174-5.

4. Meehl PE, Golden RR: Taxometric methods, in *Handbook of Research Methods in Clinical Psychology*. Edited by Kendall PC and Butcher HN. New York, John Wiley & Sons, 1982, pp 127-81.

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A Process-Theoretic Approach To Psychiatric Classification

Abraham Rudnick

Introduction: On Demarcation

The problem of psychiatric classification has been central to modern psychiatry since its inception, e.g., as manifest in the pervasive impact on contemporary psychiatry of Kraeplin's 19th century system of psychiatric classification (Bentall 2004). Simply put, this is the problem of sound distinctions between psychiatric phenomena, and between mental health and mental ill-health. These distinctions can be viewed as internal demarcation and external demarcation, respectively. Hence, insights about problems of demarcation, both in medicine and more generally, may shed light on the problem of psychiatric classification.

It is first important to recognize that attempts at demarcation are common, resulting in successes as well as failures. For instance, the famous (external) demarcation problem of philosophy of science, i.e., the problem of what distinguishes science from non-science, has run into serious problems, e.g., Popper's famous characterization of science as a methodology of refutation (Popper 1959) has been challenged, particularly as refutation is not conclusive, as demonstrated by the Duhem-Quine theorem (Harding 1976). This has led some to forego the demarcation of science (Feyerabend 1975). The (external) demarcation problem of philosophy of medicine, i.e., the problem of what distinguishes general health from general ill-health, has also run into serious problems, e.g., the claim that diseases are natural kinds has been strongly challenged (Reznek 1987). Internal demarcations may fare better in science and medicine, e.g., in the biological distinction between species, although that has been challenged (Mayr 2004). Still, demarcation in general, and classification in particular, may be helpful on a practical level, and as such should be understood and used as best possible.

Overview and Critique of Zachar and Kendler

Zachar and Kendler, in their recent paper (Zachar and Kendler 2007), attempt such an understanding of psychiatric classification. They seem to attempt to understand mainly four medical (psychiatric) demarcation approaches (the organic disease model, the altered function model, the biopsychosocial model, and the harmful dysfunction model) in light of six dimensions of categorization as applied to psychiatry (causalism vs. descriptivism, essentialism vs. nominalism, objectivism vs. evaluativism, internalism vs. externalism, entities vs. agents, and categories vs. continua). I find their attempt instructive, but to my mind they do not sufficiently clarify the conceptual relation between the four models and the six dimensions, other than that "These models are likely to be familiar to readers and illustrate the conceptual dimensions in applied form" (Ibid, p. 559).

Their most important conclusion from this exercise appears to be that nominalism is missing from all four models, i.e., that psychiatric disorders are discovered and not decided on according to these models. Following this they present models that are arguably nominalist, i.e., dimensional models as well as the practical kinds model. The latter in particular suggests a plurality of classifications, where a classification is deemed sound according to its goal (or use). This instrumentalist or pragmatist approach of the practical kinds model is deemed particularly helpful by the authors (Ibid, p. 563); I concur, as psychiatry - and medicine in general - is applied science and humanistic technology, hence primarily driven by differing human goals. They conclude the paper by stating the importance of conceptual analysis in relation to psychiatric classification (Ibid, p. 564). I agree with this statement, hence my commentary.

My critique of their paper is not so much of specific arguments included in it, although I think it has some minor flaws in that respect, such as construing essential hypertension and other risk factors as "diseases" (Ibid, p. 560), and construing Engel's biopsychosocial model as a causal model (Ibid, p. 560) rather than as a mixed causal-communication model (Munitz and Rudnick 2000). My main critique is that Zachar and Kendler (2007) do not state their methodology explicitly, particularly their criteria for selecting the dimensions and models they discuss, other than to state that the six dimensions are critical (Ibid, p. 557) and that the four models are leading ones (Ibid, p. 557), implying that these dimensions are important and that these models are widely endorsed, respectively. A serious related problem is that their conceptualization may not be exhaustive, i.e., they may be missing dimensions and models that may shed further light on psychiatric classification (and demarcation).

In the rest of this commentary I address a model they appear to ignore, that of (mental) health as a process of self-organization, hence of (mental) ill-health as disrupted self-organization. I recognize

that there may be partial overlap of this model with the models they describe, but I argue that this model is still distinct from others (Rudnick 2000).

The Model of (Mental) Health as a Process of Self-organization

Health as a process of self-organization is a veteran notion, systematically established in pioneering notions of modern medicine such as Claude Bernard's internal environment (Bernard 1865) and, following that, Walter Cannon's homeostasis (Cannon 1939). The general idea of this model is that living (and growing) organisms are characterized, at least in part, by bounded (and hence self-related) processes that generate and maintain them (Capra 1996). These two types of processes, i.e., self-creation and self-repair, can be viewed as the two most general processes of self-organization (Rudnick 2002). A prime example of self-creation is ontogenesis, i.e., embryonic development. A prime example of self-repair is wound healing. Self-organization can be disrupted, leading to ill-health. Prime examples of disrupted self-repair are auto-immune disorders, and more commonly infectious diseases (recognizing that an external microbial agent is necessary for an infectious disease, in addition to an immune system that does not adequately address that agent) and cancer (assuming cancer is a result of the failure of the immune system to nip in the bud micro-tumours and pre-malignant growth, as is widely suggested and as is demonstrated in AIDS).

In relation to mental health, a prime example of disrupted self-repair may be delusions of persecution in schizophrenia, where the delusions are argued to be attempts to explain away or normalize hallucinatory experiences by rationalizing them (Maher 1988). More generally, many psychiatric symptoms may be argued to be a result of disrupted self-repair, at least according to some views of Freudian psychoanalysis, where neuroses (and even psychoses) are argued to be the result of applying pathological defense mechanisms, i.e., disrupted self-repair processes, to unconscious conflicts (Fried and Agassi 1976). Note that this is a positive model of health – similarly to the World Health Organization definition of health as physical, psychological and social well-being and it derivatives, such as health as the ability to realize aspirations and satisfy needs and to change or cope with the environment (Kickbusch 1986) – as according to this model, health is conceptually primary to ill-health (although, practically, health is commonly experienced and recognized as the absence of ill-health).

The model of health as a process of self-organization may be based on process philosophy (Rescher 2000), where processes rather than objects are deemed as fundamental (ontologically) to reality and/or (epistemologically) to our knowledge of reality - physical and biological as well as psychological and social. A process can be defined as "a coordinated group of changes in the complexion of reality, an organized family of occurrences that are systematically linked to one another either causally or functionally. It is emphatically not necessarily a change in or of an individual thing, but can simply relate to some aspect of the general 'condition of things.' A process consists in an integrated series of connected developments unfolding in conjoint coordination in line with a definite program." (Rescher 1996, p. 38). According to such a process-theoretic approach, processes are ongoing, hence health as self-organization is ongoing rather than an endpoint. If so, physical and mental health is in flux, with processes of self-organization continuously generating and maintaining health (if they are intact) or ill-health (if they are disrupted). Of course, at the end, all processes of self-organization break down; the ultimate breakdown of self-organization of organisms is death.

The Relation Between the Process-theoretic Approach and Zachar and Kendler's Dimensions of Categorization

What is the relation between the model of (mental) health as a process of self-organization (and its process-theoretic approach) and the six dimension of categorization presented by Zachar and Kendler? First, to clarify the unclear conceptual relation between models and such dimensions, I suggest that the minimal relation is of incompatibility (or alternatively of compatibility) of a model with a dimension. That is, at a minimum, substantive assumptions of a model and of a dimension logically contradict each other (or not). For the purpose of this commentary, I think that this conceptual clarification will suffice.

Regarding causalism vs. descriptivism, it seems that the model of (mental) health as a process of self-organization is more causalist than descriptivist, as it postulates processes that lead to (mental) ill-health. Regarding essentialism vs. nominalism, prima facie it seems that the model is more essentialist than nominalist, as it postulates processes of self-organization to be discovered; yet I claim that any of the models - including the process-theoretic model - can be nominalist, or rather can include the practical kinds model, depending on the philosophical framework - pragmatist or other - adopted. Regarding objecitivism vs. evaluativism, it seems that the model is compatible with both, as the proccesses of self-organization are matters of fact, yet what constitutes sufficient self-organization is value-laden. Regarding internalism vs. externalism, it seems that the model is more internalist than externalist, as self-organization is by definition internal, even though many of the materials for self-creation and self-repair, such as some amino acids and other molecules, are supplied from the environment; admittedly, an ecological approach may view any living (or growing) organism as necessarily interacting with other systems that constrain and even partly design it (as in evolutionary processes), hence the model may be compatibel with externalism. Regarding entities vs. agents, it seems that the model is compatible with both, as the processes of self-organization can be isolated and generalized and thus separated from the individual, but self-organization as a whole is much more individualized, particularly in relation to mental self-organization. Regarding categories vs. continua, it seems that the model is compatible with both, as processes are measured on continua, yet they can be patterned into categories, most generally the categories of self-creation and of self-repair.

Conclusion: A Nosological Turn

The implications of this model for psychiatric classification are important. The model suggests that disagnostic categories (or continua) in psychiatry should address types and particulars of disruptions of various mental self-organization processes. This may require a psychiatric classification quite different from contemporary classifications such as DSM (American Psychiatric Association 2000) and ICD (World Health Organization 1992). At the very least, it may require these classifications to add an additional axis, where the relevant processes of self-organization and their disruptions are listed, when known. More fundamentally, it requires a different psychiatric nosology (theory of disease), so that neurobiological and psychosocial processes of self-organization and their disruptions, rather than endpoints, constitute the general framework. Such a nosology may be necessary - although perhaps not sufficient (Schlenger 1976) - for a scientific understanding of recovery, which can be argued to consist of restorative and compensatory self-organization processes of people with mental health problems (Rudnick In press); recovery processes

will probably be poorly understood and poorly facilitated without sound knowledge of disrupted self-organization processes. This nosological turn may be crucial for psychiatry, considering the growing endorsement of recovery as an ultimate goal of mental health care (Peebles, Mabe, Davidson, Fricks et al. 2007). Be that as it may, further analysis and study of a process-theoretic approach to psychiatric classification may be fruitful.

References

American Psychiatric Association. 2000. *Diagnostic and Statistical Manual of Mental Disorders, 4th ed, Text-Revised (DSM-IV-TR)*. Washington, DC: American Psychiatric Association.

Bentall, R.P. 2004. *Madness explained: Psychosis and human nature*. London: Penguin.

Bernard, C. [1865] 1957. *An introduction to the study of experimental medicine*. Trans. H.C. Greene. New York: Dover.

Cannon, W.B. 1939. *The wisdom of the body*. New York: Norton.

Capra, F. 1996. *The web of life: A new understanding of living systems*. New York: Anchor Books.

Harding, S.G., ed. 1976. *Can theories be refuted? Essays on the Duhem-Quine thesis*. Dordrecht: Reidel.

Feyerabend, P. 1978. *Against method: Outline of an Anarchistic Theory of Knowledge*. London: Verso.

Fried, Y., and J. Agassi. 1976. *Paranoia: A study in diagnosis*. Dordrecht: Reidel.

Kickbusch, I. 1986. Health promotion: A global perspective. *Canadian Journal of Public Health* 77:321-6.

Maher, B.A. 1988. Anomalous experience and delusional thinking: The logic of explanations. In *Delusional beliefs*, eds. T.F. Oltmanss, and B.A. Maher, 15-33. New York: Wiley.

Mayr, E. 2004. *What makes biology unique? Considerations on the Autonomy of a Sientific Discipline*. Cambridge, UK: Cambridge University Press.

Munitz, H., and A. Rudnick. 2000. The biopsychosocial model of medicine revisited: a meta-theoretical excursion. *Israel Journal of Psychiatry* 37:266-70.

Peebles, S.A., P.A. Mabe, L. Davidson, L. Fricks, P.F. Buckley, and G. Fenley. 2007. Recovery and systems transformation for schizophrenia. *Psychiatric Clinics of North America* 30:567-83.

Popper, K.R. 1959. *The logic of scientific discovery*. London: Hutchinson.

Rescher, N. 1996. *Process metaphysics: An introduction to process philosophy*. Albany, NY: State University of New York Press.

Rescher, N. 2000. *Process philosophy: A survey of basic issues*. Pittsburgh: University of Pittsburgh Press.

Reznek, L. 1987. *The nature of disease*. London: Routledge & Kegan Paul.

Rudnick, A. 2000. The ends of medical intervention and the demarcation of the normal from the pathological. *Journal of Medicine and Philosophy* 25:569-80.

Rudnick, A. 2002. The notion of health: A conceptual analysis. *Israel Medical Association Journal* 4:83-5.

Rudnick, A. In press. Recovery from schizophrenia: A philosophical framework.
American Journal of Psychiatric Rehabilitation.

Schlenger, W.E. 1976. A new framework for health. *Inquiry* 13:207-14.

World Health Organization. 1992. *International Classification of Diseases, 10th ed (ICD-10)*. Geneva: World Health Organization.

Zachar, P., and K.S. Kendler. 2007. Psychiatric disorders: A conceptual taxonomy. *American Journal of Psychiatry* 164:557-65.

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Constitutive Evaluativist Externalism

Tim Thornton

At a recent meeting organised by the World Psychiatric Association on their Institutional Program for Psychiatry for the Person, my colleague Pat Bracken suggested that there was one particular thorny question to be addressed in any rethinking of the relation of diagnosis and taxonomy. How should psychiatry respond to those who argue that their experiences, such as hearing internal voices, whilst fitting a psychiatric diagnostic category, are not really pathological?

I will consider what makes that a particularly difficult problem in the light of two dimensions of Peter Zachar and Kenneth Kendler's suggested conceptual framework to assess psychiatric taxonomy. My aim is simultaneously to use their framework to shed light on what I will call 'Bracken's question' and use that question to further clarify aspects of their framework.

The two dimensions from Zachar and Kendler's framework that are most relevant are objectivism versus evaluativism and internalism versus externalism. I will take these in turn.

Evaluativism

The first is defined like this:

> Is deciding whether or not something is a psychiatric disorder a simple factual matter ("something is broken and needs to be fixed") (*objectivism*), or does it inevitably involve a value-laden judgement *(evaluativism)?* [ibid: 558]

The example picked for objectivism may seem surprising. It may not seem to be a *simple* factual matter, a matter to be contrasted with an evaluation, whether something is broken and needs to be fixed. Contrast this idea with a paradigmatic objective taxonomy such as the Periodic Table in chemistry. The Periodic Table classifies on the basis of atomic number (the number of protons in the atomic nucleus). To model the example on that would require thinking of 'needing to be fixed' as an objective property of the layout of the world which is there anyway, like atomic number, irrespective of the values of a judging subject. It would be a property the detection of which would be enough, without complementary desires, to motivate a subject to bring about its repair. Against a stark contrast of facts and values, such an objective and yet at the same time essentially motivating property seems, using John Mackie's term, rather queer [Mackie 1977: 38-42].

In fact, even the first element of their example is not such a simple descriptive idea. Being broken is not a simple physical property. Nor need it even supervene on (simple) physical properties since, for example, a device which is broken with respect to one function might successfully possess a different function.

These considerations would motivate an inversion of the role of the example in the definition to give, instead, this:

> Is deciding whether or not something is a psychiatric disorder a simple factual matter (*objectivism*), or does it inevitably involve a value-laden judgement (*evaluativism*) ("something is broken and needs to be fixed")?

Two things, however, make the choice of example less surprising. Firstly, outside the explicit contrast with an evaluation there is something obviously right in saying that whether something is broken and needs to be fixed is a factual matter which can be of a simple and everyday kind. Unprejudiced by neo-Humean philosophy, one would naturally say that this is the kind of thing that can be the content of a descriptive judgement. A small child viewing a freshly dropped cup might take in both that it is broken and the corresponding urgent need at a glance.

Secondly, whilst it may not have the conceptual simplicity of atomic number it more closely reflects the kind of taxonomic kinds found in psychiatry. Objecti-

vists – as contrasted with evaluativists – will have be able to analyse such claims – broken and needs to be fixed – in value-free and objective terms. The task is fundamentally harder for objectivists than for evaluativists as the former are committed to a purely factual analysis whereas the latter allow both facts and values; they are not committed to a values-only analysis of disorder. In picking this example, Zachar and Kendler are helpfully reminding us of the challenge for objectivists.

Constitutive Externalism

The second dimension is summarised thus:

> Should psychiatric disorders be defined solely by processes that occur inside the body (*internalism*), or can events outside the skin also play an important (or exclusive) defining role (*externalism*)? [ibid: 558]

Zachar and Kendler further characterise the distinction with the following hints. Modern psychiatry has been largely internalist and holds that events within the body are 'critical for understanding and defining' mental disorders. Externalists are either moderate and hold that 'what goes on inside the head cannot be isolated from an organism's interaction with the world' or radical, in taking external events to be definitional, as exemplified in syndromes which are considered to be 'reactions to harsh societal demands'.

It is helpful to draw attention to a further distinction which Zachar and Kendler do not make but which can shed light on their distinction. One can think of externalism as characterising a claim about causation or constitution. If one, plausibly, thinks that environmental factors sometimes cause mental illness then one is a causal externalist. But one may think that they cause mental illness by affecting states – perhaps neurological – within the body. If so, whilst a causal externalist, one is also a constitutive internalist. (Constitution is not quite the same thing as what defines a mental illness. Even a constitutional internalist may find it helpful to label illnesses by their causes.)

This clarification can be applied to an example of externalism that they give, the Interpersonal Model:

> Contrary to any of the medical models, an interpersonal systems model is staunchly externalistic. Most fundamentally, this model views disturbed behaviour as arising from disturbed relationships. Rather than deriving from psychopathology in individuals, psychiatric disorders are seen to develop dynamically from pathology in interpersonal contexts. The notion of patients being containers of internal psychological states is minimised, whereas the view of them as persons trying to adapt to their social worlds is maximised. The context or the interpersonal system is both locus of pathology and the cause of pathological behaviour. [ibid: 562]

Most of the characterisation in this passage would fit a causal externalist but constitutive internalist view of disorder. That disturbed behaviour *arises* from disturbed relationships is consistent with the causation being mediated by states of the brain. Similarly, dynamic changes in response to interpersonal contexts may be dynamic changes of the brain. And there is no reason to rule out a central role for brain-mediated responses for persons *adapting to* social worlds. The 'context as cause', in the final sentence, again exemplifies merely causal externalism.

To get a radical externalism one needs to think of the Interpersonal Model in constitutive externalist terms (and thus play up two so far neglected hints of that in the quotation). On such an account, disturbed behaviour is constituted in or by disturbed relationships. Interpersonal contexts are themselves literally pathological. (Thus, for example, family relationships do not cause pathology in a disturbed child; the relationships, rather than the child, *are* pathological.) The context or the interpersonal system is the *locus* of pathology (and thus not the cause of pathological behaviour since the interpersonal system includes the behaviour).

Constitutive externalism in the philosophy of mental health is a radical view (whilst causal externalism is not). Combined with an evaluativist view from the other distinction it produces a way of approaching Bracken's question.

Constitutive Evaluativist Externalism

Evaluativism is a particular kind of constitutive externalism. According to it, the reason why deciding whether something is a psychiatric disorder involves a value judgement as that psychiatric disorder is constituted in part by values. (Only 'in part' because the values either inhere in or apply to – a distinction to which I will return – other, perhaps physical, properties.)

So, for example, according to a Szaszian view, the problems that are misleadingly labelled mental illnesses are deviations from psycho-social and ethical norms: they are constituted by that deviation [Szasz 1972]. According to the 'lost tribe' view influenced by Laing and Foucault, madness is just another way of going on [Foucault 1989; Laing 1960]. To be mad is just to be evaluatively out of step with the rest of the community. On Bill Fulford's more moderate picture, mental illness has to be bad for its sufferer and more specifically is bad for his or her 'ordinary doing' [Fulford 1989]. For Jerome Wakefield, though illness involves a supposedly factual biological dysfunction, it has also to be harmful where harm is construed as essential value-involving [Wakefield 1999]. On all of these views, the status of a condition as a mental illness is determined in part by the values in play.

Consider again the claim of some people that the experiences they have such as hearing internal voices, whilst fitting a psychiatric diagnostic category, are not pathological. On a non-evaluativist or objectivist view, this is a simple factual claim. It is true or false and, further, its truth or falsity is independent of the value judgements of the subjects of the experiences (or anyone else). But on an evaluative view, how people value experiences is a constitutive element of whether they are pathological. This raises the question of how to respond to differences of opinion about such values and the consequence of such divergence for psychiatric taxonomy.

Zachar and Kendler offer the following brief discussion of one sort of difference of value judgement.

> How do we respond to historical claims that slaves who had a compulsion to run away and advocates for change in the former Soviet Union were mentally ill? An objectivist would claim that those classifications contained bad values and progress was made when those values were eliminated. Their opponents would claim that the elimination of bad values is not the same as becoming value-free, and progress has been made by adopting better values. [ibid: 558]

For an objectivist, however, the fact that a classification reflected *any* values (aside from the epistemic values that shaped its constructions) would be an error. Values, whether good or bad, feature merely as distortions in a classificatory scheme which should reflect the underlying facts. This mirrors the way that, in Lakatosian rational reconstructions of the history of science, social factors enter only to explain *deviations* from rational sensitivity to the facts. When all goes well, there is no need for sociological explanation. So, equally, an appeal to the presence of distorting values in the pathological construction of drapetomania is significant, for an objectivist, in pointing out the presence of values at all rather than specifically bad values.

The characterisation of the contrasting evaluativist's response raises a further question. Talk of eliminating the bad values implicit in drapetomania suggests (though it does not strictly imply) the idea of moral or more broadly evaluative progress. It sug-

gests that value judgements are *disciplined* by the attempt to reflect real values. This contrasts with a view in which nothing disciplines such judgements. What appear to be value *judgements* are really merely expressions of subjective preference and answer to nothing external to them. Their being right is no more than their seeming right. (This is not to downplay their seriousness or importance merely to highlight a view of their logic.) The contrast between disciplined and undisciplined evaluativism is significant in responding to Bracken's question.

Disciplined and Undisciplined Constitutive Evaluativist Externalism

On a disciplined account, psychiatric taxonomy can aim to get right the mixture or, better, the compound of simple facts and values that make up the complex realm of psychopathological phenomenology. Such judgements need not merely reflect motivationally inert features of the world, as the objectivist, assumes. Nor need concepts of disorder (akin to the earlier example of what is broken) be analysed into simple factual terms in order to be accommodated in the taxonomy. But aside from these relaxations, a psychiatric taxonomy based on a disciplined evaluative account would resemble an objectivist approach in one important respect. It would aim to underpin literally true judgements. It would aim, in other words, at validity.

But an undisciplined evaluativist approach is more radical. Mental illnesses are constituted, at least in part, by matters external to the body. In addition, these matters are not features of the world, broadly construed, but rather expressions of subjectivity. If this were the correct approach to the nature of mental illness, however, it fits uneasily with the very idea of a psychiatric taxonomy. Whilst one the aims of taxonomy is validity – to cut nature at the joints – so as to enable the framing of true judgements, on an undisciplined evaluativist approach, that idea of correctness is missing.

Returning to the example of subjects who argue against the pathologising of what are conventionally taken to be pathological symptoms, this distinction is important. For disciplined evaluativists, like objectivists, their claim is a judgement that might be right or wrong and thus would inform, and be informed by, the development of a valid taxonomy. (Unlike objectivists, it is not a *simple*, that is value-free, factual matter.) But for an undisciplined evaluativist, this is not the case. The claim is an expression of subjectivity. This is not to downplay its importance and seriousness. But it is to suggest that its assessment is more a matter for liberal politics than empirical and more broadly academic inquiry. It is more a matter for decision (of how to act) than judgement (as to what is the case). This is what makes Bracken's question such a fundamental one for psychiatry. Under one construal, at least, of the phenomenology in play, responding to the claim he flags does not call for a modification of psychiatric taxonomy but the recognition that it is fundamentally the wrong tool for the job.

So far I have merely flagged two subsidiary, but still important, distinctions within Zachar and Kendler's framework without offering a judgement as to how they might actually apply to psychiatric taxonomy. I have merely argued that *if* mental illness is best thought of according to undisciplined constitutive evaluativist externalism then it will not fit well within taxonomic thinking at all. I will end with two final thoughts which will, hopefully, shed light on such a judgement.

Firstly, might there not still be a role for taxonomy even given the antecedent of that conditional? There are two immediate possibilities. An undisciplined evaluativist is committed to a fundamental ontological difference between facts and values. One might thus attempt to factor out the values from the underlying facts and develop a taxonomy of merely factual elements. On this account – and by contrast with an objectivist view – what would be left would not amount to a taxonomy of illnesses but rather the factual conditions that motivate competing expressions of illness status. There are two reasons to be sceptical of such a possibility. Philosophically, the prospects for a successful analysis of value judgements into simple facts and the evaluative reactions that they prompt looks poor [see Thornton 2007: 66-67]. Practically speaking, past attempts to purge psychiatric taxonomy of evaluative elements have been unsuccessful.

The other taxonomic possibility would be to attempt to encode expressions of subjectivity without any commitment to their underlying validity: a subjective 'hit parade' of mental illness. The problem at root with this thought is that, in the face of disagreements about how to think about diverse experiences and with no metaphysical account of why there might ever be convergence of opinion, there seems to be no rational way to agree any single taxonomy. Pluralism would seem a politically more satisfactory response than framing a taxonomy.

The point above concerning the philosophical implausibility of factoring facts and values is a point that counts against undisciplined evaluativism. Suppose however, as a significant strain of neo-Humean moral philosophers hope, that an analysis into facts and values were possible, would that establish the truth of undisciplined constitutive evaluativist externalism about mental illness? Here a distinction between philosophical debate about moral and psychiatric values is relevant. Whilst there is disagreement about particular ethical judgements in difficult cases, there is to be sufficient agreement about the broad outline of the practices of making moral judgements to make descriptive accuracy a rational aim of meta-ethical moral philosophical debate. It seems plausible to say that Kantian deontology, utilitarianism or neo-Aristotelian moral particularism may simply be the correct description of the moral realm. But that may not be true of the debate about mental illness.

Imagine, for example, that objectivists succeeded in developing a consistent and intuitively plausible account of mental illness, reducing concepts of mental disorder to simple facts. Suppose that on this account, hearing voices turned out to be pathological. Suppose also that undisciplined evaluativists succeeded in developing a rival account on which hearing voices was not in itself pathological. How should the two accounts be assessed. One problem, of course, is that whilst the status of hearing voices is evidence one way or the other, it is contested. If one somehow knew, antecendently, its pathological status that would be a crucial test for the two accounts. But, as Neil Pickering argues, no such pretheoretical knowledge is possible [Pickering 2006]. In fact, however, the problem goes deeper.

Setting out the debate as I have suggests that whether or not mental illness is simply factual or whether it is irreducibly evaluative – and if so of what sort – is itself a deeper level factual matter. But it is open to an undisciplined evaluativist to argue that that deeper level matter is not factual but rather, also, evaluative. (It is a case of 'values all the way down'.) They can argue that we should, for reasons expressive of better subjective value, choose their model of mental illness not because it is true but because it is (evaluatively) right. And that is why assessing Bracken's question runs so deep.

References

Foucault, M. (1989).*Madness and Civilisation*. London: Routledge

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

Laing, R.D. (1960). *The Divided Self*. London: Tavistock

Mackie, J.L. (1977) *Ethics: inventing right and wrong*, Harmondsworth: Penguin

Pickering, N. (2006) *The Metaphor of Mental Illness,* Oxford: Oxford University Press

Szasz, T. (1972) *The Myth of Mental Illness*, London: Paladin

Thornton, T. (2007) *Essential Philosophy of Psychiatry*, Oxford: Oxford University Press

Wakefield, J.C. (1999) Mental disorder as a black box essentialist concept. *Journal of Abnormal Psychology* 108: 465-472

Zachar, P. and Kendler, K. (2007) 'Psychiatric Disorders: A Conceptual Taxonomy' *American Journal of Psychiatry* 164: 557-565

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(Editor, continued from page 1)

beginning of their article, Zachar and Kendler write that "This article extends the work begun in the agenda by offering both a broader and a more detailed analysis, focusing specifically on issues that underlie the idea of a medical-psychiatric nomenclature itself" (2007, 557). Zachar and Kendler do indeed offer a brilliant analysis of the underlying - conflicting, contradictory - assumptions in our understanding of psychiatric classification. These core disagreements are behind many of the difficulties in achieving validity in psychiatric nosology. They identify six dimensions of psychiatric classification (causalism vs descriptivism, essentialism vs nominalism, objectivism vs evaluativism, internalism vs externalism, and entities vs agents) and then map these dimensions onto several prevalent models of psychiatric disorder - that is, they show how each dimension falls out in each of the models.

What is striking about their analysis - which they don't highlight - is the way in which, in the six dimensions, the opposite ends of each dimension tend to cluster together. That is, there is a causalist-essentialist-objectivist-internalist-entity-category cluster and a descriptivist-nominalist-evaluativist-externalist-agent-continuum cluster. (I would like to call the first the right wng cluster and the second the left wing cluster, except that the authors place my right wing to the left and my left wing to the right.) This clustering becomes apparent in the visual representation, with the four medical models predictably clinging to the left side of each dimension. May we argue, then, that what the authors have in fact demonstrated is one dimension or spectrum with several manifestations, i.e., a dimension with hard-core biology at one end (my right wing), and the non-biological-social on the other end (my left wing). It is predictable that the medical models of psychiatric illness fall to the biological end of the spectrum.

In the end Zachar and Kendler come down, with some qualifications, on the side of the descriptivist-continuum cluster. At least implicitly they veer toward the conclusion that psychiatry is not close to the goal of "... an etiologically based, scientifically sound classification system," nor to the simple biological, medical models that such a goal requires. This is indeed a radical conclusion, contravening the prevailing shibboleths of contemporary psychiatry. Zachar and Kendler are modest in addressing the radicalism of this conclusion, as are, similarly, the authors of "Basic Nomenclature Issues for DSM-V," as well as Kendell and Jablensky in their "Distinguishing Between the Validity and Utility of Psychiatric Diagnoses" (Kendell and Jablensky 2003), among others (of note: Kendler and Kendell are co-authors of the "Basic Nomenclature" chapter).

Facing the realization that we can't have a medical model based in biologic etiologies, Zachar and Kendler opt for a pragmatic approach of using a combination of empirical evidence, conceptual resources, and expert judgment to develop the best possible nosologic constructs. They frame this process in the language of "inference to the best explanation." They don't comment on where this leaves them with the issue of validity in diagnosis. In general, one could take one of two positions regarding validity. The authors of "Basic Nomenclaature Issues for DSM-V" argue for varying degrees of validity - strong and weak validators, hierarchies of validators, grading different diagnoses according to their degree of validity. Kendell and Jablensky, on the other hand, draw a sharp distinction between validity and utility, reserving the term 'valid' for conditions of incontestable validity like Down's Syndrome, and rating the vast majority of psychiatric diagnoses on the basis of their practical utility for psychiatric practice. At some level this difference between the two attitudes toward validity seems mainly semantic. My guess is that Zachar and Kendler would somehow agree with both positions, as would I.

The question I would like to raise now takes us in a somewhat different direction. If we grant that psychiatric diagnoses are useful, syndromal constructs without any claim of representing fully validated, etiologically based disease entities, where does this leave us with regard to the question of operational definitions and diagnostic criteria? The use of diagnostic criteria since DSM-III has clearly resulted in an unthinking reification of the diagnostic categories. The authors of DSM-IV write that "The specific diagnostic criteria included in DSM-IV are meant to serve as guidelines to be informed by clinical judgment and are not meant to be used in cookbook fashion" (Association 1994, xxiii). But no matter how much the authors of DSM-IV and others warn against what Zachar and Kendler appropriately term essentialism, the psychiatric world seems incapable of heeding this warning. The distinction between "the patient meets criteria for *x*" and "the patient has *x*" is simply lost. The notion that diagnostic categories represent useful, heuristic groupings - the most productive way to classify psychiatric illness at this time - seems just too subtle for the majority of users of the DSMs.

Granting that this essentialism is a bane in psychiatric nosology to be avoided at all costs, I would make the following argument. The statement from the DSM-IV Introduction - "DSM-IV is a classification of mental disorders that was developed for use in clinical, educational, and research settings" (Association 1994, xxiii) - has proven to be misguided. That is, this statement assumes that what is good for psychiatric research is also good for clinical use. In fact, the use of diagnostic criteria has been of enormous benefit to psychiatric research but has done more harm than good in clinical practice. The benefit for research seems obvious: researchers working on a diagnostic category in different settings need to be clear that they are working with the same population of patients. In clinical work, however, the gain in reliability through use of diagnostic criteria is far outweighed by the crude essentialism produced by the latter.

Let's imagine a DSM-IV written in a different way: under each diagnostic category, diagnostic criteria for research purposes, and careful, descriptive definitions for clinical use. With such a reformulation the researchers would lose nothing, and the clinicians would be authorized to do what they already do: ignore the cookbook criteria and use the definitions to do what the DSM-IV says they should be doing, viz., exercise their clinical judgment to make the best fit between patient and diagnostic category. They would thereby be one measure less tempted to treat the diagnoses as if inscribed on a stone tablet brought down from Mount Sinai. If more pressure is needed to break the addiction to reification, the diagnostic definitions could contain statements to the effect that these are *working definitions*, not final statements. (Let me grant that there is a small case to be made for the opposite of what I am proposing. At times psychiatric research needs to break free of strict adherence to the diagnostic criteria, and at times clinicians do benefit from the guidance of the criteria.)

Would this reformulation, with elimination of diagnostic criteria for clinical use, represent a regression to DSM-II? I don't think so. Let's recall that there were two

problems with the DSM-II categories: they were not operationalized, and they were infected arbitrarily with psychoanalytic concepts. The latter have already been eliminated from DSM-III and DSM-IV. Little would be lost and much gained if, for clinical use, we took the diagnostic criteria for the various diagnoses and embedded them into rich, descriptive presentations - always with the caution that these are working, syndromal categories, subject to clinical judgment, and not fixed essences.

James Phillips

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Response

Philosophical Dimensions, -isms, and the Attribution of Psychopathology

Peter Zachar and Kenneth S. Kendler

We are grateful to Jim Phillips for devoting this issue of the Bulletin to our 2007 article on Models of Classification. We would also like to thank each of the contributors for taking the time to write a commentary. Without exception, each commentary helped us gain a better understanding of what we were trying to say in this article.

James Phillips

We fully intended that our dimensions of categorization would line up on the poles and wish we had been clever enough to align them so that the right wing and left wing of each dimension were appropriately placed. We didn't extensively discuss this ordering for reasons of space, but also because we were concerned about constructing second-order dimensional straw men. It is clearly consistent for someone to adhere to all the left poles or all the right poles on the dimensions, but someone could also coherently combine the endpoints in alternative ways. For example, there are plenty of essentialist "left wingers" out there.

In addition to the issues explored by Claire Pouncey, another problem with '–isms' is that they take what in reality may be variety of views on a topic and reduce them to a single name. Those who accept the name can become somewhat partisan about it – leading to more conformity within the -ism than may have existed before those thinkers were grouped together. As will become apparent when we address the Cerullo and Karches commentary, we prefer a splitting strategy rather a lumping strategy when discussing philosophical aspects of classification. We are inclined to not minimize variation, or be tempted by the allure of reducing the many to the one.

Jim Phillips is absolutely correct to highlight the importance of validity issues in nosology. We have also investigated validity in two pieces written subsequent to this article (Kendler & Zachar, 2008, Zachar and Kendler, in press). Phillips would likely agree with us that the 'validity' question in psychiatric classification has usually been framed in terms of disease realism, i. e., is this a valid disease entity? It is the validity of Robins and Guze, Andreasen, Winokur, and Kendell and Jablensky. Replace 'disease' with 'disorder' and it is also the validity of Wakefield. Disease realism is a historically important approach, reflected in our own use of the term 'nosology' to refer to classification in psychiatry.

An exploration of validity as it exists outside the bounds of disease realism, however, reveals several kinds of validity – a position we have called validity pluralism. From the perspective of validity pluralism, alternative approaches to validity exist. One example is the validity of inferences approach that is used in psychological testing. In testing, validity refers to the validity of inferences made about people using test scores. Diagnostic validity could be conceptualized in the same way.

Phillips also introduces the topic of reification, which has been a major concern of ours under the auspices of what we term diagnostic literalism. Diagnostic literalism is a cousin of essentialism and objectivism. It is associated with a tendency to defend current classifications as correct partly because the authority they are attributed and on the flip side with a tendency to complain that current classifications fail to carve nature at the joints and are therefore primitive and arbitrary. We agree with Phillips that reification has been harmful and that addressing the problem of diagnostic literalism is one of the roles that philosophical analysis should play in psychiatric classification.

Phillips' proposals regarding research versus clinical representations of disorder constructs bears some similarity to the prototype matching approach of Westen and Shedler (2000). Given that the narrative descriptions of the disorders would be more evidence-based than were the DSM-II descriptions, he is likely correct that a more descriptive approach would not constitute a return to a pre-DSM-III model. However, the last edition of the ICD also implemented a more clinician-friendly descriptive approach, but it has not affected the problem of reification. Our worry is that the DSM can provide still richer descriptions of disorders for clinical use, but people will continue to take those descriptions literally. Reducing the prominence of operational definitions won't solve the problem because operationalism is not the main problem. One could say that the problem is sorting individuals into categories of any kind, but making scientific and philosophical generalizations requires dividing the world up in some way. We think that more progress can be made by identifying the problem as literalism - a philosophical and psychological outlook that has roots far deeper and applications a far wider than psychiatry.

Michael Cerullo and Kyle Karches

There is much in the commentary by Michael Cerullo and Kyle Karches with which we agree. We stated in our article that we considered the dimensions to be overlapping, however, we remain unconvinced that all our dimensions should be lumped into a single dimension, primarily because we are concerned that doing so would entail a loss of information.

Phillips labeled the second-order dimensions hard-core biological versus non-biological-social, while Cerullo and Karches name it naturalist versus normativist. There is probably a psychological aspect to this question that could be addressed empirically. Psychiatrists and psychologists could be surveyed regarding their beliefs about philosophical topics and the data could be analyzed in order to uncover a latent structure. The psychologist Richard Coan (1979) studied theoretical orientations in this manner many years ago and found a second order objectivism versus subjectivism factor that loosely parallels the dimensions of Phillips and Cerullo and Karches. Nick Haslam has done something similar with essentialist beliefs (Haslam, 2000; Haslam & Ernst, 2000). In both cases there is often surprising variability in how people will combine different philosophical beliefs, or alter their beliefs across topics and over time. One of the problems of this kind of research is that participants find it difficult

to fill out self-report inventories that inquire about abstract philosophical topics. For these reasons the relationship between the folk psychological structure of these kinds of beliefs and the logical structure as revealed by careful analysis is not clear. While both structures are important, the logical structure seems to be more relevant here.

Cerullo and Karches' definition of naturalism versus normativism most closely adheres to what we originally intended by objectivism versus subjectivism. It might be a better term than ours because of the negative connotations of the term 'subjective.' That dimension was formulated to cover some of the issues addressed by Boorse and Wakefield in their writings on psychiatric disorders. We are uncomfortable reducing the complex philosophical literature on psychiatric classification to six dimensions, and even more uncomfortable reducing it to one. Each of the dimensions was loosely intended to correspond to coherent topics in the literature. As we noted, those topics overlap, but they are not the same.

One of our dimensions was added because of its current importance in the literature, but it does not fit into the hypothesized latent dimensional structure very well. This would be the categories versus continua dimension. Phillips places categorical on the right, whereas Cerullo and Karches place continuous on the right. There is some legitimate ambiguity here. Our own sense of what goes together can be gleaned from how we aligned them on poles, but even then we knew that the categories versus continua dimension was problematic. We also believe that other dimensions could be combined and rationally defended in ways that do not conform to the hypothesized latent structure.

We are unclear what it was in our article that led Cerullo and Karches to infer that we expect that psychiatrists will resolve many of the concerns regarding taxonomy in the future with further empirical data. We do have some sympathies with Quinean naturalism in that we believe that philosophical inquiry is ideally more integrated with science, but we do not believe philosophy proper should become experimental philosophy. Our point was that, to a considerable extent, the history of science is a history of finding clever ways to test something that previously seemed untestable. Example include Young's test of the wave nature of light or Michelson and Morley's attempt to measure the ether. We are unwilling to make a priori judgments about what hypotheses can and cannot be informed by empirical tests, including philosophical hypotheses, but that is not the same thing as predicting that the philosophical issues we discussed will admit of empirical resolution. It is hard to imagine how empirical data could resolve a philosophical controversy such as essentialism versus nominalism, but 'hard to imagine' is a pretty weak argument. Equally important is our claim that many crucial aspects of classification are fundamentally non-empirical.

We agree that some disorders will be more objective. Bipolar I disorder and schizophrenia are good examples. As we have argued elsewhere (Zachar & Kendler, in press), part of their objectivity lies in the fact that the relevant norm violations (psychotic behaviors) that define these disorders tend to be a matter of high consensus. There may be unambiguous evidence of objective dysfunctions waiting to be discovered, but it may turn out that an underlying objective mechanism will be identified as pathological rather than a low base rate variation primarily because of norm violations at the symptom level. We concur that normative considerations will play greater role with personality disorders, sexual dysfunctions and substance use disorders.

We found Cerullo and Karches' thoughts on modifying the DSM so that the classification cannot be used against psychiatry to be interesting. They make a good point that normative considerations are unavoidable, and rather than trying to deemphasize them in the name of scientific respectability in response to the critiques of anti-psychiatry, normative rationales could be made more explicit. If these rationales are also evidence-based, they suggest it would then be harder for anti-psychiatrists and their followers to claim that the various categories of disorder lack justification and primarily serve guild interests. As indicated by the current debate about the status of subthreshold conditions such as minor depressive disorder (Horwitz & Wakefield, 2007), we are not sure that there is as much agreement on what counts as a disorder as Cerullo and Karches claim. The transparency suggested by the flexible medical model would be an admirable goal – but the results will not eliminate controversy.

A small final point. Cerullo and Karches' suggest that "heritability of the disease" would be a good way of discriminating diseases from non-disease entities from a naturalist perspective. Although this claimed by Robins and Guze, we disagree. Many non-disease traits (height and extraversion come to mind) are quite clearly heritable. What counts as an adequate 'naturalism' in psychiatry is itself an important problem.

Abraham Rudnick

We infer that Rudnick would side with us regarding the age-old problem of the one and the many with respect to our dimensions of categorization. We agree that demarcations or 'distinctions" can be informative. With respect to our own distinctions within psychiatric classification, we would not claim that they are anything more than heuristic, and clearly not exhaustive. We could not tell from Rudnick's comments, however, if he was suggesting the addition of another dimension (an internal demarcation) or if he was talking about an independent model of health (self-organization) versus disorder (disorganization) -an external demarcation.

We concur with Rudnick that there is still more to be said. Interestingly, Rudnick's thoughts about self-organization and a process approach were loosely reflected in our original, aborted attempt to elucidate the dimension we eventually named entities versus agents. In the early drafts of this article, this dimension was called entities versus processes, but we couldn't make it coherent, despite repeated attempts.

The root idea was a distinction between a "static entity-something you get-a general kind" versus "a dynamic process-something you do-an individual coping strategy." Entities were defined as what you have whereas processes were defined as how you got there and why you are stuck there. This dimension is not exactly what Rudnick is talking about. His is better grounded in biology. However, it shares a common emphasis on process.

Our article was written over a period of one year. Near the end of the writing, John Sadler suggested our articulation of the entities versus processes dimension was not clearly drawn, or even workable. Based on his comments and further reflection we decided that an entities versus agents dimensions would be clearer.

Entities versus processes overlapped with another aborted dimension called pathological versus developmental. This dimension attempted to elucidate the historical difference between clinical and counseling psychology's

foci on, respectively, mental illness and normal development. It is the difference between conceptualizing depression as analogous to cancer (a disease) and conceptualizing depression as a problem-in-living related to developmental difficulties such as coping with the break-up of a long-term love relationship. While clinical psychologists (and psychiatrists) traditionally focus on curing depression, counseling psychologists would more typically focus on resolving identity and security issues with the assumption that the depression will then dissipate. This dimension, however, didn't make it past the second draft, in part because it is a little ambiguous as to whether it attempts what Rudnick calls an internal demarcation or an external demarcation.

It was difficult for us to write the section applying the dimensions to the medical models because so much inference and speculation was required, and we might not defend everything we wrote there too strongly. Rudnick also applied our dimensions to his self-organized versus disorganized model – not an easy task. We likely would have coded it the same way as he did.

Christian Perring

Christian Perring makes a unique choice to address the second half of our article where we discussed various versions of the medical model and outlined some alternatives. Although we devoted some space to these alternatives, there is more heterogeneity between the models than between the dimensions because they are not all models of the same thing. The various medical models are more directly about the nature of psychiatric disorders. The dimensional model is primarily an empirical claim about the phenotypic structure of psychiatric disorders and their interrelationships. The practical kinds model is a theory about the classification of disorders from a nominalist perspective. The interpersonal model was included to exemplify externalism. The narrative model addresses some issues not reflected in the dimensions, being primarily a theory about how disorder concepts are best represented.

Perring's critical focus is directed at the practical kinds model. Christian has long been under-impressed by the articulation of the practical kinds model for both reaching too far (What isn't a practical kind?) and also for not going deep enough.

There is some ambiguity about practical kinds. On the one hand 'practical kind' is used to refer to categories that have been carved out of continua, such as essential hypertension and mental retardation. On the other hand, the practical kinds model' can represent a pragmatic, nominalistic approach to classification. Perring focuses on the second.

He quite accurately identifies something the practical kinds model is not, i.e., the view that all legitimate psychiatric disorders are 'natural kinds' waiting out there to be discovered by science. According to the natural kind view, the job of the scientist is to learn what these entities are.

Scientific psychiatrists can even worry about social consequences of disorders, but those consequences are not relevant to their discovery or their underlying nature. Whatever legitimacy the natural classification perspective has, claims Perring, it primarily refers to a future psychiatry. In the current state of affairs, practical factors have to be considered, and he notes that the richness of the non-clinical and non-scientific factors that are important in classification have never been captured in the lists that have been offered when describing 'practical kinds.'

Perring's choice of relational disorders to illustrate his point is an excellent example. How are psychiatrists to justify the inclusion of relational disorders in their diagnostic manual, or alternatively justify excluding them? Either way the empirical evidence is inadequate to the task. Because the evidence by itself does not justify either inclusion or exclusion, no participant in the discussion can avoid extra-empirical considerations.

Furthermore, notes Perring, although some practical considerations regarding use of the DSM are not in the purview of psychiatry, others are. In some cases, no one is as qualified as psychiatrists and psychologists to address practical issues, therefore they cannot simply be ignored as some DSM authors would prefer. The point is well-taken. Indeed, although not widely advertised, the possible social harm caused by psychiatric disorders played an important role in the deliberations about the inclusion of a small number disorders in DSM-IV, in particular Premenstrual dysphoric disorder and paraphilic rapism.

If considerations of practical factors are endemic to classification, asks Perring, then what is distinct about the practical kinds model? This is an excellent question. Our best answer is that essentialisitic thinking accords better with common sense, and a non-essentialist, nominalist approach is often counter-intuitive. It has to be learned and practiced. Scientists often learn to think non-essentially in their area of expertise, but not in other domains. In various ways, Zachar, Ghaemi and Brendel all share this view. The practical kinds model is a paradigm for a non-essentialist approach to classification, or it is meant to be.

Claire Pouncey

An important challenge of interdisciplinary scholarship is establishing consensus on what counts as quality work. Throughout the middle and latter part of the 20th century many analytic thinkers considered continental philosophy to be an embarrassment, while continental thinkers considered the detailed dissections of analytic philosophers to be trivial. Until relevantly recently, one of the few things that both groups agreed on was that pragmatism is not worthy of serious attention. This view was similar to Pierce's own opinion of William James' pragmatism. It was frustrating for Peirce to have his more careful and scientifically-inspired work take a back seat to James 'popular' philosophy. Disagreements about standards of quality are potentially magnified when multiple disciplines are involved, and nowhere does this appear to be more true than in the philosophy of psychiatry.

One of the ideal outcomes of interdisciplinary writing is to produce work that is valued by a majority of the disciplines involved. Claire Pouncey takes us to task for failing to achieve this ideal with respect to the discipline of philosophy. It is helpful for her to do so and we take her criticism seriously. We did not presume that our article would be appropriate for Philosophical Review or Philosophy of Science – the target audience was the readers of AJP – but we acknowledge that our hope was also to offer a philosophically relevant argument to psychiatrists that would have some value for philosophers.

Did we suggest that there is a menu of items such as essentialism, nominalism and objectivism served up by Chef Philosophy? It was not our intent to offer a choice selection of -isms for the intellectual palates of our readers. Philosophical positions shouldn't be chosen from a menu like the evening dinner, but they are still chosen, often times chosen based on limited arguments. People subsequently learn to see the world according to their philosophical choices

and they sometimes change their minds. Just as we categorize disorders for certain purposes, we categorize philosophical positions, and it can be useful to survey some of the positions that have been articulated. The only dimension we intended to explore in a more than cursory fashion in this article was essentialism versus nominalism.

One of Pouncey's explicit complaints is that we were asking psychiatrists to be open-minded and accept a role for values in the nosological process, but in even putting it that way it appears that a) we believe that it is natural to separate facts and values and b) we are proposing that it would better if psychiatrists decided to proceed differently. A more penetrating analysis, observes Pouncey, would show that the fact-value dichotomy is not sustainable and, she claims, we underestimated how deep prior value commitments go and how fully they penetrate empirical decisions. Rather than asking people to admit evaluations into their thinking as we did, she notes it is impossible to eliminate evaluations. Don't ask them to choose a values-based view when they have no choice in the matter. It would be better to use philosophical analysis to reveal the values that are already there. We concur that this would require the kind of careful analysis that we have not offered, but it was not our intention to write that article.

To clarify a bit, from our perspective the philosophical distinction between facts and values is made, not discovered, and like other philosophical distinctions, it may be useful for certain purposes. Part of what is important about the scientific perspective is its claim that we should try to classify the world as it is, not as we want it to be. This is one area where we believe that a fact versus value distinction can do some good work. Cultures are also very skilled at making their values seem natural, and a fact-value distinction helps in questioning some of these assumptions. Furthermore, to the extent that psychiatrists and psychologists accept what Lakoff (1978) calls the myth of objectivism, there is some value in asking them to consider the possibility that the facts alone cannot justify all the inferences needed to develop a classification system.

The issue regarding inference to the best explanation is a bit more complicated. We introduced inference to the best explanation to suggest that there is going to be an intuitive, practical aspect to categorization which should not be labeled anti-scientific. By introducing inference to the best explanation we were also trying to suggest that our thinking was running along the lines of scientific realism rather than the instrumentalism of the empiricists, i.e., to clarify in what our nominalism consists.

It is not true that we consider causalism, descriptivism or categorical versus dimensional approaches to be pre-scientific distinctions. Just the opposite is the case – hence our claim that it is unwise to prejudge what can and what cannot be formulated as an empirical question. Our primary concern was that some thinkers in psychiatry and psychology afford those positions more ontological certainty than is warranted. Here and elsewhere we have singled out causalism and the dimensional model as carrying more ontological heft than they have earned.

Pouncey's closing remarks amount to a suggestion we named some concepts and organized them in a (perhaps) different way, but did not extend the conversation, especially as it occurs in philosophy. This might be true and has occurred to us as well. We did not strive for deep creativity – our main goal was to organize prior disparate perspectives and in so-doing help elevate the discourse in the psychiatric community and raise consciousness about the importance of these issues. Reactions we have received have indicated to us that we have succeeded at our humble goals.

Tim Thornton

Tim Thornton's commentary exemplifies careful, detailed philosophical analysis. He is correct that our definition of objectivism versus subjectivism could have been more precise. Even if "broken" can be defined as a factual matter, "needs to be fixed" represents a value judgment. Our concept of broken was meant to refer to the Boorse and Wakefield notion of natural function. If, for example, hearts evolved because pumping blood conferred an adaptive advantage, then pumping blood counts as a heart's natural function. According to this view, value judgments such as "a heart should be able to pump blood" can be translated into factual statements about evolutionary history. But, as Thornton points out, it is not true that everything failing to function as designed "needs to be fixed." A tire used as a swing may not be able to function as designed but it does not need to be fixed, and it might not be so good were a human to be treated so that his canine teeth function as they were originally designed in all respects.

We don't dispute that natural functions may exist, but those historical 'facts' are not very accessible to modern science. Regarding the place of values in defining mental disorder, we argue that some value judgments are of such a high degree of consensus (hearts should pump blood as designed) that they appear as facts. They are evaluative but the evaluation component is quite minimal.

On the issue of constitutive externalism, again Thornton's analysis is informative. Externalism is not a unity, it can be split into causal and constitutive versions. The causal version of externalism (the environmental risk factors alter risk for psychiatric disorders by impacting on internal states which could be understood from either a biological or a psychological perspective) is consistent with a large body of empirical literature and reflects a far less radical position than the constituative version. In introducing the interpersonal perspective we sought to articulate the view that relationships could be understood to be the locus of pathology. There is some vagueness and/or debate in the interpersonal psychiatry literature between the idea that psychopathology is manifest in relationships and the notion that it is constituted by relationships. In our example of the interpersonal perspective, we wanted to illustrate the concept of constituative externalism and could have distinguished the two externalisms better.

On the issue of drapetomania, the key point we make is that objectivists view progress as occurring when the bad values were eliminated, but we did not intend eliminated and replaced with good values. We primarily intended to say that objectivists consider the elimination of values to be progress. As we also noted, the evaluativist would have to add –and replaced with better values. Was there evaluative progress in thinking about drapetomania? Not going too deeply into this question, our answer would be "yes." How can this be? "All men are created equal" and "Do onto others" were part of a social contract at the time, and that contract implicitly expressed some political and moral norms/ principles that were contradicted by the construct of drapetomania. We would not, however, refer to these norms as 'real values' in an objectivist sense – that is a bit strong, but they are more 'regimented' by rationality than are Humean sentiments.

Ian Hacking (2002a, 2002b). writes about styles of scientific reasoning that are developed and improved upon over time. Two examples relevant to psychiatry are ordering diversity by taxonomy and statistically analyzing regularities using prob-

ability. Perhaps styles of moral reasoning, which includes the appropriate affective reactions, are also introduced and then developed over time. The same is true with political styles of reasoning. Within a style, there can be "progress."

Our own view here and elsewhere better fits Thornton's "disciplined" category than it does his "undisciplined" category, although we might question the subtle shift in meaning from "constituative externalism refers to the locus of pathology lying outside an individual organism" to claiming that it also applies to the necessity of making value judgments in attributing disorder status. A casual externalist- constituative internalist could also advocate the necessity of values in attributing disorder status.

There is a mix of facts and values that may legitimatize the attribution of a disorder. Facts about either the brain or cognitive-affective-perceptual processes offer a role for internal variables. The relevant values are subject to varying degrees of consensus. There are also multiple scientific, moral and political norms of rationality at play, and they can be integrated in multiple ways. We believe that putting all this information together is a species of practical reasoning guided at times by inference to the best explanation. We do not believe that our characterization coheres with Thornton's suggestion that a right mixture of facts and values is out there waiting to be discovered analogous to chemical compounds.

We were surprised to find Thornton introducing a term such as validity without clearly defining what he means, and whatever he means, we would not tie validity to the tradition of literalism and/or essentialism, or to the metaphor of carving nature at the joints. Why wed a concept as important as validity to such a disputable and narrow framework?

The primary purpose of the commentary is to explore what Thornton calls Bracken's question. It is a good question. What if someone says that I am pretty much as described in your diagnostic category. My emotions and thoughts and perceptions are as described. I do hear voices, and this trait runs in my family, but I do not agree that I am disordered. How should psychiatry respond?

Obviously, as a practitioner you do whatever you can to help the patient live as normal and fulfilling a life as possible according to the ethical mores of your discipline, your political traditions and your culture. We do not doubt that the psychiatric toolkit has become too narrow and some of the motives for this narrowing are less than honorable. Our focus, however, will be on how to respond to this question as taxonomists, and our target will be those who provide systematic reasons for rejecting attributions of psychopathology.

A case study that is sometimes discussed in terms of problems with lifetime appointments to the U. S. Supreme Court may have some relevance for Bracken's question. As relayed by Damasio (1994), after having a stroke Justice William O. Douglas was afflicted with significant left side paralysis. Although confined to a wheelchair, he claimed this charge of paralysis was a myth. One of his responses to being confronted by reporters with the fact of his paralysis was to invite them to join him on a hike. These kinds of denial of deficit problems are commonly seen with damage to the right hemisphere.

One potential problem with using examples of psychosis to address Bracken's question is that psychotic episodes are typically associated with a lack of insight that is comparable to denial of deficit in a traumatic brain injury. Indeed, the standard definition of a delusion requires that the deluded individual not have insight into the pathological nature of their belief. This, however, does not doom Bracken's question because it also applies to members of the pro-ana movement who claim that anorexia is a life style choice and not a psychiatric disorder. Anasognosia is not relevant for understanding the pro-ana movement. As stated, asking how psychiatry should respond to denials that one or more of its diagnostic constructs does not represent psychopathology is a very good question.

What are our options according to Thornton? Constituative internal objectivism? According to this viewpoint the denials are just wrong, analogous to denying that the earth is round. One response to the patient would be mandatory treatment, but such an authoritarian response is unattractive as a general principle.

Undisciplined constituative evaluativist externalism (i.e., radical normativism)? This is a kind of psychiatric emotivism: "The DSM say's voices in the head – bad!" Such a viewpoint would likely be classified in the anti-psychiatrist camp and it is not surprising to find out that its proponents don't see a need for a psychiatric taxonomy. Would there even be any patients? We imagine that there still would be – with the radical normativists claiming that big pharma, elitist guilds, and enlightenment values are to blame.

We had not thought of where an anti-psychiatry proponent could be classified in terms of the dimensions, but Thornton's notions make sense, as does his claim that it is pretty hard to justify proposing any kind of psychiatric taxonomy once constituative evaluativist externalism has been adopted.

Interestingly, in addition to there being an impasse between the objectivist and the radical normativist, there is also likely one between the fact+value view and the radical normativist because the radical normativist could make her claim about ANY illness. As long as she finds a value judgment, then she can say it is really a not disease-disorder-illness. We do not have to point out to this audience that desiring to prevent or fix death blindness and mental retardation also requires making value judgments. To claim that it would have been better if Justice Douglas did not have left side paralysis is a value judgment as well. These are also examples of the minimally evaluative. Claims that schizophrenia, mania, depression and substance abuse ought not to be are evaluative, but each represents different orders of value.

Some ideas discussed by Zachar and Potter (in press) may be relevant here. Psychiatric disorders could be considered to be a family of conditions with various degrees of overlap, but no shared essence. Exemplary disorders include schizophrenia and bipolar disorder, which are also likely candidate members of a disease family that includes general medical conditions. Disorders about which there is more debate include things like substance abuse or dependence and personality disorders. In some cases a condition such as borderline personality disorder (BPD) is considered to be part of the psychiatric disorder family because it represents a systematic vulnerability to the development of symptoms that are seen in less controversial disorders – meaning disorders where the value judgments are more minimal. These symptoms include depression, panic attacks and transient psychotic experiences. The high degree of comorbidity between BPD and other disorders is also a relevant factor in considering it to be a candidate for the family of psychiatric disorders (although BPDs overlap with normal personality and normal coping should also be considered in its assessment). One re-

sponse to Bracken's question is that hearing voices is a symptom that tends to be associated with exemplary psychiatric disorders. Furthermore, that symptom alone may not justify an attribution of psychopathology. In most cases psychopathology refers to a comprehensive pattern of behavior – or syndrome –as a whole.

What evidence and/or arguments would the radical normativists accept that would lead them to alter their views? Thornton hypothesizes that they could maintain their views in light of any possible evidence. If this is so, then psychiatric taxonomists would be mistaken to try to respond to Bracken's question as either professional diagnosticians or scientists. If Thornton is correct, the other party is unwilling to engage in Bracken's question as taxonomists might interpret it.

The family resemblance approach begins with the supposition that some conditions can legitimately be called psychopathology. It further makes a claim such as, if anything is an example of psychopathology, then bipolar I disorder is. If the other discussant denies the existence of psychopathology tout court, then a different kind of conversation has begun. The DSM and ICD are also social documents, and political and moral issues are important considerations in their overall evaluation. Who is qualified to systematically examine the important political and moral issues? It seems we have identified yet another important role for philosophers to play in our thinking about a psychiatric taxonomy.

References

Coan, R. W. (1979). *Psychologists: Personal and theoretical pathway*. New York: Irvington.

Damasio, A. (1994*). Descartes' error: Emotion reason and the human brain*. New York: Avon.

Hacking, I. (2002a). Inaugural lecture: Chair of Philosophy and History of Scientific Concepts at the Collège de France, 16 January 2001. *Economy and Society,* 31, 1-14.

Hacking, I. (2002b). *Historical ontology*. Cambridge, MA: Harvard University Press.

Haslam, N. (2000). Psychiatric categories as natural kinds: Essentialist thinking about mental disorder. *Social Research*, 67, 1032-1058.

Haslam, N., & Ernst, D. (2000). Essentialist beliefs about mental disorders. *Journal of Social and Clinical Psychology*, 21, 628-644.

Horwitz, A. V. and Wakefield, J. C. (2007*). The loss of sadness: How psychiatry transformed normal sadness into depressive disorder*. New York: Oxford University Press.

Kendler, K. S., & Zachar, P. (in press). The incredible insecurity of psychiatric nosology. In K. S. Kendler & J. Parnas (Eds*.), Philosophical Issues in Psychiatry: Explanation, Phenomenology and Nosology*. Baltimore: Johns Hopkins University Press.

Lakoff, G. (1987). *Women, fire, and dangerous things.* Chicago: The University of Chicago Press.

Westen, D. & Shedler, J. (2000). A prototype matching approach to diagnosing personality disorders: Toward the DSM-V. *Journal of Personality Disorders*, 14, 109-126.

Zachar, P. & Potter, N. N. (in press). Personality disorders. Mad, bad – or both? *Philosophy, Psychiatry, and Psychology*.

Zachar, P. & Kendler, K. S. (in press). Philosophical issues in the classification of psychopathology. In. T. H. Millon, R. Krueger, E. Simonson. (Eds.). *Contemporary directions in psychopathology: Toward the DSM-V and ICD-1*. New York: Guilford Press.

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