

Review of Kendler & Parnas (eds.) *Philosophical Issues in Psychiatry II: Nosology*

Jacob Stegenga

March 20, 2013

Controversy about psychiatric disease categories is ubiquitous. Do fidgety young boys have a disease that goes by the name ‘attention deficit hyperactivity disorder’? Should a person who grieves the death of a spouse be excluded from a diagnosis of depression? Are psychiatric disease categories coextensive with specific abnormalities of brain physiology? This book—a collection of fifteen chapters written by prominent figures in psychiatry and philosophy of psychiatry—addresses such questions of psychiatric nosology: the logic of psychiatric diseases.

The book seems to have arisen out of a conference dedicated to psychiatric nosology (I infer this based on several comments of the authors throughout the book). This lends a colloquial and accessible language to the chapters, and affords conversation between some of the authors. The structure of the book itself fosters such engagement: each chapter has three parts written by separate authors—an introduction, the main text, and a commentary—and the introduction and commentary engage directly with the main text of each chapter. The fact that the book arose out of a conference perhaps explains some of its repetitiveness—many of the authors address the same core themes, in similar ways, using similar tropes. These themes include the question of nosological realism (do psychiatric categories represent real diseases?), the historical shifts in thinking about the basis of classifying psychiatric illnesses (from an etiological approach in the early twentieth century, to an ‘atheoretical’ approach with the development of the DSM-III in the 1970s, to an ‘axiological’ approach in the DSM-IV, and now to a ‘dimensional’ approach with the advent of the DSM-V), and the criteria of adequacy that ought to be employed when evaluating psychiatric nosology (for example, diagnostic reliability versus some form of validity). Given the structure of this book, with its many contributors and several themes about an enormously complex subject, what follows is at best a cursory review.

One of the most interesting aspects of the book is the diversity of views expressed regarding diagnostic criteria. For instance, Kendler seems to favor operationalized criteria (125), Ghaemi argues that diagnosis should be based on causal etiology (47), and Krueger favors dimensional models of psychopathological impairment (300). In contrast to all of these views, Bolton argues that psychiatry is too concerned with classification, and should focus more on prediction, including predictions of patient outcomes based on medical interventions (7). As First notes, the non-specific nature of most psychiatric treatments renders predictions of patient outcomes little more reliable given one diagnosis compared with another (12).

Another interesting aspect of the book is the discussion of the historical shifts in psychiatric thinking and how such shifts became codified into the various revisions of the DSM. For instance, Berrios boldly asserts that since the nineteenth century little has changed in the epistemological basis of the classificatory models of psychiatry (101). Writing about more recent psychiatry, a chapter by Pincus, provides some detail to the development of the DSM-IV (154). One must look past some intellectual chest-thumping. For example, Pincus, who was a central contributor to the development of the DSM-IV, is careful to note that the development of the DSM-IV was “evidence-based” and depended on a “hierarchy of evidence”. In several places Pincus takes parting shots at the DSM-V—he claims that “the continued revision of a descriptive classification has little utility ... changes in future descriptive classifications should be infrequent and guided by a highly conservative process” (157-8). We got it right (the fourth time)—such thinking goes—and so there is no need to change it.

Parnas has a lovely phrase in his chapter which captures a central concern of this book: “the ontology of the psychiatric object” (230). What *is* the ontology of the psychiatric object? Here too the diversity of views expressed throughout the book is fascinating. Parnas says: the patient’s experience. Ghaemi says: microphysiological entities or processes that cause disease (44). Contemporary diagnostic manuals say: syndromes, or sets of symptoms. McHugh says: the localization and pathogenesis of problems of consciousness (271). That this fundamental question remains unresolved is both intriguing and worrying. Worrying, of course, because the stakes are so high. Regier, one of the central contributors to the forthcoming new edition of the DSM, writes that one of his motivations in his career has been a concern about “false positives and the medicalization of normal human experiences.” Several contributors to the book note the expansive momentum of psychiatry which increases the number of subjects within its pharmacological jurisdiction.

Kendler’s previous books in this series have displayed more appreciation for rigorous philosophy—past contributors include many of today’s leading philosophers of science. Despite its title, the present volume is, on the whole, philosophically lightweight. There are few contributions from professional philosophers (I count three of sixteen authors). More salient, only several of the contributions engage with serious contemporary philosophical work on the subject, and many of the contributions smack of philosophical amateurism.

For instance, in the third chapter Ghaemi argues that “we don’t need a general definition of mental illness to identify specific psychiatric diseases” (43)—not only does this neglect the rich philosophical literature on disease and illness (none of which is cited), it ignores the foundational motive for such literature, namely, that identifying a condition *as a disease* requires at least some sort of theory of disease. Ghaemi writes that specific diseases are identifiable simply as abnormalities of the body, and that this

condition (bodily abnormality) is sufficient for disease attribution (44). However, there is near-consensus among scholars who have thought deeply about this question that this condition is in fact insufficient. I am sympathetic, though, with Ghaemi's view that it is a *necessary* condition: he argues with good motivation for resuscitating an etiological approach to psychiatric nosology, on the grounds that knowing the causes of diseases will contribute to developing more effective treatments. A corollary to this, says Ghaemi, is therapeutic conservatism, which he associates historically with Osler, and suggests that we ought to have more of in present-day psychiatry. To use a phrase from McHugh's chapter (270), such therapeutic conservatism might be better than present therapeutic regimes, which have "haphazard outcomes."

We also witness philosophical breeze in a few passing remarks from several of the contributors regarding the question of whether or not our psychiatric categories represent *real* diseases in nature. Kendler invokes a staple argument for scientific realism, usually referred to as the 'no-miracles argument': although psychiatry is in its infancy and its categories are only "highly flawed first approximations", he claims that psychiatry has made plenty of advances, and asks "would these advances have been possible if all of our attempts at psychiatric classification were, at a fundamental level, deeply flawed?" (100). His desired answer, I suppose, is "no". But are they flawed or aren't they? (He says both, after all.) The no-miracles argument is convincing when applied to those areas of science which are, well, seemingly miraculous, such as Jean Perrin's measurement of Avogadro's number, to take a famous example from the history of science. Perrin was able to measure Avogadro's number using thirteen distinct methods, and these methods all closely agreed in their measurements. It would be a miracle if these measurements all agreed so closely and yet molecules were not real, and since science does not accept miracles as explanations (hence the argument's name), molecules *must* be real. I risk stating the obvious for the sake of being thorough: the science and practice of psychiatry is hardly miraculous.

Kendler calls his invocation of the no-miracles argument 'positivistic', a cute foible the irony of which will not be lost on the philosophically initiated. A better attempt at defending his optimism is found in his full chapter, in which he borrows the idea of 'epistemic iteration' from the historian of science Hasok Chang (305). Kendler seems to understand the notion of iteration as something like gradual progress toward a true description of reality. However, as Schaffner notes in his commentary, Chang's original use of epistemic iteration was quite different—Chang held that "truth is a destination that is only created by the approach itself" (325). Kendler maintains the modest view that epistemic iteration does not necessarily warrant thinking that psychiatric categories represent real diseases in nature; one might be optimistic that some of our disease categories are iteratively becoming better descriptions of real diseases, while be pessimistic about other disease categories (317, 320).

The converse of the no-miracles argument is usually referred to as the ‘pessimistic induction’: since many or all of our past theories have turned out to be false, our present theories also will likely turn out to be false. Cooper invokes this argument in a rather confusing manner: “getting a version of the pessimistic induction to work for psychiatry is hard—there isn’t much history, and there’s even less past success” (38). This is odd for several reasons. Psychiatry has a history at least as long as, say, modern physics (arguably psychiatry is older than even classical physics!). It’s just that, as Cooper says, this history has so few successes. That fact, though, provides *warrant* to a version of the pessimistic induction for psychiatry, contrary to Cooper’s claim. A long history of nosological and therapeutic failures in psychiatry ought to make us at least a little suspicious of present psychiatric categories and treatments.

In the end, should we be optimists or pessimists about our psychiatric categories? The beauty of this book is the range of reasoned answers to this question. On the whole, though, it appears that our best research psychiatrists hold humble views regarding psychiatric nosology. Krueger expresses pessimism when he writes “most mental disorders are probably not categories in nature” (298). Kendler, one of the most cited psychiatrists today, calls his own discipline an “immature science” (318). McHugh puts the point politely: psychiatry has yet to come of age (269).

The dearth of careful philosophical analysis in this book should not turn many readers away. It is, as I hope to have indicated, a rich read. Professional psychiatrists and students will find it interesting, as will cultural commentators who discuss and debate the developments of the DSM, and similarly, perhaps, will the growing number of unfortunate people who are diagnosed with psychiatric diseases. These authors give us an insider’s view of psychiatric nosology, and the sight seen is unsettling. This book is promising, though, precisely because it is the result of continued concern among professional psychiatrists regarding the philosophical foundations of their discipline. Such concern might—someday, one hopes—help psychiatry to come of age.