



# In Defence of Psychiatric Diagnoses

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Sam Fellowes

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## In Defence of Psychiatric Diagnoses

“*In Defence of Psychiatric Diagnoses* has the great virtues of being really clear and really interesting. Sam Fellowes lucidly sets out some fundamental issues in the philosophy of science and uses them to illuminate contested issues in psychiatric nosology. Philosophers, clinicians and mental health researchers can all learn a lot from this, and find new ways to talk to each other.”

—Dominic Murphy, *Professor of Philosophy, University of Sydney, author of Psychiatry in the Scientific Image (MIT)*

“Sam Fellowes is one of the most innovative and sophisticated thinkers in the philosophy of psychiatry today. In *Defence of Psychiatric Diagnoses*, he develops a novel neo-Kantian approach to understanding psychiatric diagnosis and classification. Through focussing on the importance of idealisation in psychiatric science, Fellowes manages to explain how mental health diagnoses can be scientifically legitimate without merely mirroring reality.”

—Rachel Cooper, *Professor of History and Philosophy of Science, Lancaster University. Author of Classifying Madness (Springer, 2005), Psychiatry and the Philosophy of Science (Acumen, 2007), Diagnosing the DSM (Karnac, 2014)*

“In this thought-provoking book, Sam Fellowes attempts to undermine many influential criticisms of contemporary psychiatric diagnoses by undermining the assumptions about the nature of science on which they rest. He defends, instead, a neo-Kantian view of science as a whole, which highlights the role of construction and idealisation rather than a simple mirroring of the natural world. The result is both a detailed scholarly defence of neo-Kantian philosophy of science and a timely intervention in discussions of psychiatric classification.”

—Tim Thornton, *Emeritus Professor of Philosophy and Mental Health, University of Central Lancashire, author of Essential Philosophy of Psychiatry (OUP)*

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*For my brother Simon Fellowes, a schizophrenic individual who died  
tragically early aged forty-seven*

# Preface

The origin of this book can be traced back to me being diagnosed as autistic half way through my part-time Masters in History and Philosophy of Science. After finishing the Masters I spent a lot of time reflecting upon who I am, my past and my future, in light of being diagnosed as autistic. Additionally, I spent a lot of time around autistic people whom I met at support groups, on internet forums for autistic people and sometimes in person outside of those. I was struck by two seemingly opposing notions. On one hand, the diagnosis of autism seemed an immensely powerful tool for understanding myself and other autistic people. I interpreted behaviour in a new way and made links between behaviour which I previously had not. On the other hand, the differences between autistic people often seemed very high. I tried to work out how notions of autism could increase understanding despite those differences.

My thinking about this was influenced by three philosophies of science that were heavily on my mind during and following my Masters. Firstly, that all observations are theory-laden whereby what we observe can be heavily influenced by theory. I wondered if autism could act as a theory which influences what we observe. Secondly, that science often involves models that only imperfectly describe what actually occurs in the world. I wondered if autism might be an idealised and abstract model which only imperfectly describes actual people. Thirdly, structural realism whereby science relates to describing mathematical structures rather than

entities. I wondered if autism could be understood as a mathematical structure rather than an entity. Eventually, part of the way through my PhD I encountered neo-Kantianism and all these different notions merged together into one cohesive framework. Rather than seeing science as being about describing mind-independent entities, science is about applying something that comes from us to produce idealised and abstract models that describe probabilistic and statistical relationships. I hope that through this framework I can help understand how the diagnosis of autism can provide genuine knowledge despite the heterogeneity of autistic people.

This book has been influenced in at least two ways by me being an autistic person. Firstly, much has been written recently about how people with psychiatric diagnoses have unique insight into their diagnosis through lived experience. Whilst I never directly appeal to my lived experience, my thoughts about how autism does or does not relate to the world will have been influenced by the way in which I think parts of myself are or are not instances of autism. However, I think the move from lived experience to knowledge is quite epistemologically complicated whereby lived experience is theory-laden and needs interpreting through concepts. It is certainly possible that my lived experience has led to insights that otherwise would be difficult to reach but I urge readers to retain in mind that I have not shown any interpretations influenced by my lived experience are epistemologically secure. There is a possibility that my lived experience has not improved or has even reduced the quality of this book. Secondly, as an autistic individual I have a preference to focus on detail but this can sometimes come at the cost of seeing the bigger picture. I have actively tried to keep that wider perspective in mind and remember that more detail is not always preferable, but I suspect I have had limited success in this endeavour. My preference for detail may have many positives but I suspect I will not have appreciated any limitations imposed by my difficulties with seeing wider contexts.

I would like to thank multiple people. I would like to thank Rachel Cooper, Peter Zachar, Awais Aftab, Lucy James, Justin Garson, George Turner, Annika Dhalin, Jane Fellowes, Hane Maung, Alison Stone, Gareth Williams, Jacob Barlow and Brian Garvey who either read parts of this book or had helpful conversations with about this book. This book

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*Competing Interests* I declare no competing interests.

Lancaster, UK

Sam Fellowes



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# 1

## Introduction

There is a long history of scepticism over psychiatric diagnoses and these concerns are still very much present today. These concerns have come from many different sources, such as psychiatrists, philosophers, psychotherapists, sociologists, historians and diagnosed individuals. Psychiatric diagnoses have been described as “arbitrarily constructed” (Burrows 2010, p. 252), “constructed” (Gains 1992, p. 4; Summerfield 2001, p. 95), “arbitrary” (Cushing 2013, p. 38; Horwitz 2002, p. 5), “invention” (Read 2004, p. 21; Summerfield 2001, p. 95) and “made-up” (Watson 2019, p. 2). In this book I will argue that such concerns are largely misplaced. They seem to be driven by an explicit or implicit view of how science relates to reality which I will argue is untenable. I will draw upon an alternative way to think of science. That alternative understanding of science will leave psychiatric diagnoses looking much more respectable and legitimate compared to how their critics portray them. In this chapter I will outline how critics view psychiatric diagnoses and suggest that alternative approaches to understanding reality and science can be held. In later chapters I will argue for those alternative approaches and show how they strengthen the status of psychiatric diagnoses.

The type of psychiatric diagnosis I primarily focus upon is categorical polythetic psychiatric diagnoses. These are the main types of psychiatric diagnoses in the main psychiatric diagnostic manuals, the DSM-5-TR and ICD-11. The DSM [Diagnostics and Statistical Manual] is a diagnostic manual published by the APA [American Psychiatric Association]. It provides the diagnostic criteria for 298 psychiatric diagnoses. The ICD [International Classification of Disease] is a diagnostic manual published by the WHO [World Health Organisation]. It largely lists the same psychiatric diagnoses (though, unlike the DSM, it also lists non-psychiatric diagnoses). Later in this book I will discuss alternative types of psychiatric diagnoses but for now it is sufficient to know that I am discussing stereotypical DSM and ICD style psychiatric diagnoses. The vast majority of psychiatric diagnoses in these manuals are categorical polythetic psychiatric diagnoses. Examples would be autism, depression and schizophrenia.

The main reason why psychiatric diagnoses are seen as scientifically illegitimate is that they are considered not to be real. I now outline three motives for thinking this.

Firstly, reality is thought of in terms of causation and entities. Real causes are taken to produce real entities. What makes two things instances of the *same* type of entity (say, two apples) is that they both have the same underlying causes (the biological structure of the apple). What makes two things instances of *different* types of entities (say, an apple and a banana) is that they both have different causes. If scientists posit a type of thing (say, autism) but instances of that entity (people diagnosed with autism) have much causal diversity then autism is not a real entity. In this situation, what groups people together would not be real causes but rather mere opinion. As it happens, the vast majority of DSM and ICD psychiatric diagnoses appear to cover individuals who are causally heterogeneous (Cuthbert and Insel 2013, p. 3; Kozak and Cuthbert 2016, p. 287; Sanislow et al. 2010, p. 632). Some critics take this to mean psychiatric diagnoses are the product of ideology rather than science. For example, the psychiatric diagnosis of autism is highly causally heterogeneous (Devlin and Scherer 2012, p. 233; Weiskopf 2017, p. 179). This causal diversity (Timimi et al. 2011, p. 139) means “the field of autism rests on ideological assumptions, *not* scientific evidence” (Timimi et al. 2011, p. 4, emphasis original; see also Cushing 2013, p. 38). Instead, “the

autism spectrum has become a catch-all metaphor for focusing on a disparate range of behaviours that suggest a lack of the type of social and emotional competences thought to be necessary for the functioning of society dominated by neo-liberal economic and political foundations” (Timimi et al. 2011, p. 7). Similar claims are made against psychiatric diagnoses more generally. Kirk et al. write that “[s]ince the DSM is unable to document scientifically that these diverse behaviors represent any medical or mental disease, its [the DSM’s] endurance may be reasonably attributed to other powerful social purposes” (2015, p. 67). Other critics would not see causally heterogeneous psychiatric diagnoses as the product of ideology. Rather, they claim that such psychiatric diagnoses are scientifically inadequate and need replacing with superior psychiatric diagnoses which are not causally heterogeneous (Cooper 2005, p. 150; Murphy 2006, p. 11; Cuthbert and Insel 2013, p. 4; Poland 2014, p. 34).

Secondly, science is taken to describe actual entities. The world is taken to consist of actual entities and any scientific theory which inadequately describes an actual entity is not scientifically legitimate. The world is there to be discovered and either we discover it or we do not. What we should not do is *decide* what is in the world. Scientists try to *discover* what is in the world, they do not get to decide that, say, atoms exist. However, there is a well-documented process of psychiatrists deciding which psychiatric diagnoses should make up the diagnostic manuals (Kendlar et al. 2011, p. 1149; Kincaid 2014, p. 151; Jablensky 2008, p. 90). Psychiatrists debate which psychiatric diagnoses should be included in the DSM and ICD, what their diagnostic criteria should be, if they have subtypes or are on a spectrum. Psychiatric diagnoses have been described as “unscientific, made-up constructs voted into existence by the ‘opinions’ of psychiatrists, populating the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* committees” (Watson 2019, p. 2, emphasis original; see also Raskin and Lewandowski 2000, p. 16; Cushing 2013, p. 38; Horwitz 2002, p. 5; Read 2004, p. 21). If psychiatric diagnoses cannot be discovered but must instead result from decisions then they are not real or legitimate science.

Thirdly, science is taken as actually describing the world rather than missing out important aspects. Any scientific theory which attempts to describe part of the world but misses out many significant details would

fail to describe reality and would not be scientifically legitimate. However, psychiatric diagnoses typically only provide a very limited description of particular people. Knowing that someone has a psychiatric diagnosis means that you know they have enough symptoms to meet the diagnostic criteria but this does not reveal which specific symptoms of that psychiatric diagnosis they have and does not reveal other aspects of the individual such as their personality, their life history, their life goals or their social and economic situation (Johnstone 2018, p. 33; Kinderman et al. 2013, p. 2; Pietikainen 2015, p. 323). Some critics take this to mean that psychiatric diagnoses are illegitimate. Kinderman et al. writes that

two people with a diagnosis of ‘schizophrenia’ or ‘personality disorder’ may possess no two symptoms in common, [so] it is difficult to see what communicative benefit is served by using these diagnoses. Surely a description of a person’s real problems would suffice? A description of an individual’s actual problems would provide more information and be of greater communicative value than a diagnostic label. (2013, p. 3; see also Johnstone 2018, p. 39; Kinderman et al. 2013, p. 3; Runswick-Cole 2016, p. 27; Hassall 2016, p. 51; Timimi et al. 2011, p. 1; Vanheule 2017, p. 85)

Psychiatric diagnoses should not be considered legitimate science if they fail to accurately describe actual people.

In this book I shall respond to these concerns. I broadly accept some of the premises behind them. The vast majority of psychiatric diagnoses do indeed have a heterogeneous causal basis, decisions do need to be made over which psychiatric diagnoses are employed, and they do not describe significant aspects of particular individuals. Despite this, I shall argue that psychiatric diagnoses can be seen as being scientifically legitimate. Whether this will be the case with any particular psychiatric diagnosis will be case specific. I will argue it is possible for psychiatric diagnoses to be scientifically legitimate and it is likely that some currently employed psychiatric diagnoses are scientifically legitimate.

I will respond to these concerns by outlining an alternative account of how we should think of reality and how we should think of scientific legitimacy. I suggest these critics are employing an untenable account of science. I suggest that critics of psychiatric diagnoses often take a view of



science as being about describing reality *as it is in itself*. In contrast, I will outline a view of science as being about describing reality *as we can experience it*. I outline this alternative account of science by employing neo-Kantianism. We cannot see reality as it is but only instead as it appears to individuals like us. On this understanding we need to reconsider how we think about reality and legitimate science. Science should not be judged upon whether it describes some set of mind-independent entities in the external world. What counts as science depends upon concepts and principles we apply to the world rather than our ideas reflecting the mind-independent external world. I will argue that this alternative view of science means that psychiatric diagnoses can be seen in a much more positive light.

I will use this neo-Kantian position to address the claim that psychiatric diagnoses do not describe real people or biomedical entities. On this neo-Kantian account, the aim of science is not to simply describe or categorise what we see in the world around us. Rather, science “continually go[es] beyond the given” (Cassirer 1953 [1910], p. 127; see also Natortp 2004 [1921], p. 202; Rickert 1986 [1902], p. 217). Science takes what we observe and transforms it into something that does not resemble what we observe. As such, that psychiatric diagnoses do not conform to anything that we observe around us, such as actual people, does not compromise their scientific legitimacy. Additionally, on this neo-Kantian account, the aim of science is not to describe mind-independent entities. It takes such entities to be in some sense inaccessible to us. This is because we cannot know about mind-independent entities except through applying something to them which they do not themselves have. Our knowledge of mind-independent entities is mediated by the concepts and principles we apply to them. As such, we cannot see mind-independent objects as they are but only as they appear to us. Consequently, we should not judge psychiatric diagnoses upon whether they conform to mind-independent entities, be those mind-independent entities understood as actual people or biomedical entities.

Following this, we need an alternative standard for judging the scientific legitimacy of psychiatric diagnoses which is not based upon describing real people or biomedical entities. The philosophy of science I outline is one where we apply concepts and principles to sensation to build

idealised and abstract models that do not conform to what we see around us or to mind-independent entities. As such, we should see psychiatric diagnoses as idealised and abstract models. Our standard for judging the scientific legitimacy of psychiatric diagnoses needs instead to focus upon what concepts and principles we employ when building those idealised and abstract models. Neo-Kantianism provides standards for making this judgement. Neo-Kantianism aims to avoid relativism by providing an alternative basis for thinking about objectivity in science. Different neo-Kantians have supplied different standards for assessing science. I shall largely draw upon the notion that we can derive those concepts and principles from reason. This then gives those concepts and principles a level of objectivity. As such, we can still potentially think of psychiatric diagnoses as anchored in objectivity even if they do not describe real people or mind-independent entities. Not all currently employed psychiatric diagnoses will meet those criteria and so not all currently employed psychiatric diagnoses should be considered scientifically legitimate. Additionally, I will outline how alternative, not currently employed psychiatric diagnoses, could be formulated from those concepts and principles. They do not simply entail one set of psychiatric diagnoses. This gives us a level of choice over which psychiatric diagnoses to employ although not all choices will result in scientifically legitimate psychiatric diagnoses. A neo-Kantian approach will thus provide an important defence of psychiatric diagnoses in principle and of some currently employed psychiatric diagnoses in particular.

There are two alternative approaches to categorical psychiatric diagnoses which might intuitively seem better at describing the reality of people. The first is dimensional approaches. This is where the presence of traits is measured throughout the population rather than just within people who meet the DSM diagnostic criteria. Given that the symptoms and causes associated with a particular DSM diagnosis can occur in people who do not meet diagnostic criteria, it might seem that dimensional approaches are better able to detect how symptoms and causes manifest in reality. The second is person centred approaches. The aim with these is to understand an actual person who is engaging in therapy, to understand them as a unique individual. This contrasts with categorical and dimensional diagnoses where the aim is to group people together despite those people

having unique differences. It might seem that person centred approaches are better able to describe the reality of actual people, describing the symptoms and causes and other attributes present in specific people. In this book I will argue that neither dimensional nor person centred approaches can better access reality than categorical approaches can. Rather, I argue that categorical, dimensional and person centred approaches are ways of making knowledge possible. They are effectively measurement systems which give data form rather than being descriptions of how people actually are. In this sense I incorporate all three under the neo-Kantian philosophy I endorse. My goal in this book is to argue that categorical psychiatric diagnoses can be scientifically legitimate and can make possible useful data but my goal is not to argue against the use of dimensional and person centred approaches. Rather, all three are scientifically legitimate, all three can make possible different knowledge and all three should be used.

There are four aims to this book. Firstly, in response to the above concerns, I show why DSM style psychiatric diagnoses can be scientifically legitimate. This is not to suggest they are good science, merely that they are the sort of things that scientists can legitimately posit. Secondly, I give an indication of what a good DSM style psychiatric diagnosis would look like, giving the example of autism as a relatively good diagnosis though I suggest it could be improved by adding subtypes. Thirdly, I respond to calls to reform rather than abandon the DSM. Typically, these are calls to make the DSM dimensional. I consider whether such a reformulated DSM should be entirely dimensional or should also still employ categories, and I suggest categorical diagnoses should still be employed. Finally, I consider scientific projects like RDoC and HiTOP that wish to completely dispense with the DSM. Whilst it is difficult to know what psychiatric diagnoses they will eventually suggest or be used to construct, I suggest their aim of finding relatively homogeneous dimensional groupings can plausibly be supplemented by adding categories on to those dimensional groupings.

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# 2

## Psychiatry and the Philosophy of Psychiatry

### 2.1 Introduction

This chapter outlines psychiatry and philosophy of psychiatry to provide a basis for my later analysis. The first half of this chapter outlines important issues in psychiatry relating to psychiatric diagnoses and the second half outlines important issues in philosophy of psychiatry relating to psychiatric diagnoses. The purpose is to give an overview of where we are and how we got here. In Chap. 3 I will outline neo-Kantianism to provide an alternative philosophical position. This will then cast a new understanding on many of the issues discussed in this chapter when I apply a neo-Kantian approach to psychiatry in later chapters.

In this chapter I primarily outline how psychiatrists and philosophers have differed over whether psychiatry should be understood to involve disease entities. A disease entity is typically understood to be a naturally forming part of the world. A disease entity is where real causes produce a real entity with real characteristics. Which causes and characteristics the entity actually has is determined by the world rather than by psychiatrists. Consequently, disease entities are usually understood as real and scientifically legitimate.

In this chapter I will outline how psychiatry has oscillated between disease entity and non-disease entity approaches in the twentieth century and into the twenty-first century. Disease entity approaches are currently recognised to face major challenges and this has led to a crisis of confidence in current psychiatry and has led to the development of new approaches which seem to reject disease entities. However, it is to date unclear what psychiatric diagnoses would look like in a future psychiatry which rejected disease entities. Similarly, philosophers of psychiatry have oscillated in how strongly they adhere to a disease entity approach. The most common way in which philosophers of psychiatry have understood psychiatric diagnoses is as natural kinds. Paradigmatic examples of natural kinds are biological species, like tigers, and chemical elements, like oxygen. In its full-blooded form, natural kinds are understood as naturally forming parts of the world, which have associated characteristics which arise due to underlying causes. This understanding of natural kinds seems highly compatible with notions of disease entities. However, philosophers of psychiatry typically appeal to weaker notions of natural kinds which less resemble disease entities. This raises questions about whether they would be real or scientifically legitimate.

In this book I will draw upon neo-Kantianism to address many of these issues. I will outline an alternative approach which does not involve disease entities but which means psychiatric diagnoses can be considered scientifically legitimate. I will partly do this by rejecting a notion of science as describing *how things are* and instead appeal to neo-Kantianism to see science as describing *how things appear to us and are structured by us*. I suggest that notions of disease entities are untenable because they are based on notions of science as describing *how things are*.

I start this chapter by describing the history of psychiatry. Then I outline alternative approaches to psychiatry, outlining categorical, dimensional and person centred approaches. Finally, I outline philosophy of psychiatry.



## 2.2 The History of Psychiatry

I start this chapter by giving a selective overview of the history of thinking about psychiatric diagnoses in the twentieth and twenty-first century. I describe influential trends which held opposing views on the status of psychiatric diagnoses, presenting them as forerunners of choices which psychiatry currently faces. I aim to draw out two opposing views of psychiatric diagnoses, namely, a disease entity and a non-disease entity understanding of psychiatric diagnoses.

This history will be selective, describing and contrasting significant approaches which have strong parallels to today but without aiming to give a complete history. This history will have limited geographical focus. It will start in Europe and then move to the United States. Additionally, the content relating to Europe will mainly be selected because it is relevant for understanding the history of the United States. The motive for this is twofold. Firstly, my aim is to give the context behind the development of the modern DSM. As such, I selected the history prior to the DSM-III to give context to what the authors of the DSM-III were responding to. Secondly, my work as a historian has focused primarily on the United States, having extensively studied notions of autism and childhood schizophrenia employed between the 1930s to 1970s in the United States (see Fellowes [2024](#)).

### 2.2.1 Kraepelin

Emil Kraepelin is often considered an early forerunner for the modern style of psychiatric diagnoses. He wrote an influential textbook named *Psychiatrie*. Across eight editions of this textbook (1st edition 1883, 8th edition 1927) he developed a new system of psychiatric diagnoses. Kraepelin was dissatisfied with the imprecision of how most of his contemporaries approached diagnosing patients (Decker [2007](#), p. 338). He believed the clinical picture (the symptoms exhibited) and the course of the illness (how the symptoms changed over time) of patients diagnosed as psychotic varied significantly. Kraepelin separated some of those patients diagnosed as psychotic into a dementia praecox group (a

diagnosis with significant similarities to the modern diagnosis of schizophrenia) and separated other patients into a manic-depressive group.

The diagnoses Kraepelin formulated were influenced by three beliefs. Firstly, he believed in the importance of using careful observations of patient behaviour as a basis for formulating psychiatric diagnoses. He valued careful observations more than his contemporary psychiatrists did (Berrios and Hauser 1988, p. 815; Decker 2007, p. 338; Jaspers 1997, p. 571). Secondly, he believed psychiatrists should observe rather than interpret the behaviour of patients and should not speculate about the causal origins of behaviour. This contrasts with some of his contemporaries who employed explicit theorising when observing patients and formulating diagnosis (Decker 2007, p. 340). Thirdly, he believed there was a clear distinction between mental illness and mental health. Correctly diagnosed individuals were ill, whereas most people were mentally healthy, and no one was only partly ill (Decker 2007, p. 340).

Kraepelin's approach is commonly understood as being driven by the underlying belief that mental disorder existed in the form of disease entities (Ghaemi 2009, p. 7; Heckers et al. 2021, p. 328; van Praag 2008, p. 32).<sup>1</sup> A disease entity is typically understood as a specific clinical picture with a specific underlying cause. Jaspers described Kraepelin's account of disease entities as follows:

*Clinical pictures of diseases that have similar causes, a similar basic psychological form, similar development and course, similar outcome and a similar cerebral pathology and which therefore all present the same over-all picture, are genuine, natural disease entities. (1997, p. 566 emphasis original)*

Similarly, Boorse writes that “the strictest definition of a disease entity would be a constellation of signs, symptoms, and pathology with specific etiology and prognosis” (1977, p. 552). Kraepelin followed this general idea when he believed that sufficiently nuanced clinical observations would result in groupings of people with the same underlying disease. Kraepelin hoped his group of dementia praecox patients exhibited a particular set of symptoms due to a specific underlying cause, whilst

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<sup>1</sup> Berrios and Hauser (1988) question the adequacy of this popular account.