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FROM NAMES TO OBJECTS—PHILOSOPHICALLY ABOUT PSYCHIATRIC CLASSIFICATIONS

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ABSTRACT

At each introduction of a new edition of psychiatric classifications, a vivid debate resurfaces and concerns their very validity: should classifications be based on etiology or should they be descriptive, based on observation, and not on some or other theories of etiopathogenesis? I shift the attention to the philosophical aspect of the debate. Psychiatric classifications employ (and have always employed) taxonomic methodology but in fact are not (and never were) based on biological mechanisms leading to mental disorders. Therefore I tried to catch the moment where certain observable features, recognized as symptoms, begins to be perceived as an ontologically independent entities and we start to think that nosological units must have a specific cause (e.g. a neuropathogenesis), which is simply reflected in the diagnostic picture. I tried to catch the moment, when by naming, classifying and diagnosing, we, in a sense, create objects. Then I show how from there we can slide into objectification: we can stop to see a person and start to an illness.

Keywords: psychiatric classifications, DSM, ICD, essentialism, nosography, abstraction.

1. INTRODUCTION

Diagnosis is the most fundamental issue in psychiatry. Most of us are familiar with the names of the various mental disorders, such as major depressive disorder or schizophrenia. Yet, introduction of every new psychiatric classification (or a new edition of it) stirs a vivid debate. Are diagnostic categories based on etiology, that is, mechanisms which lead to the origin of mental disorders and therefore describe discrete entities? Or are diagnostic categories descriptive, based on observation, and not on some or other theories of etiopathogenesis? In deep, the question concerns the very validity of

psychiatric classifications and resurfaces with their every edition, including the latest: the DSM 5 (Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association from 2013) and ICD11 (International Classification of Disease of the World Health Organization from 2019). The question is indeed an endeavour given that we still ignore the etiology of most psychiatric disorders and that our classifications are not based on neuroscience. There are attempts to create such classification. For instance, The Research Domain Criteria, RDoC, is a project led by the US National Institute of Mental Health, which aims to create a classification system for mental disorders based on the biology of the central nervous system and not on symptoms like the DSM and ICD. However, for now, psychopathology and neuroscience do not coexist in psychiatric classifications (Crocq 2018).

For each disorder category, both classifications of ICD and DSM include a set of diagnostic criteria, which is a list of symptoms and guidelines that psychiatrists, psychotherapists, and other health professionals use to determine whether a patient or client meets the criteria for one or more diagnostic categories. Later editions of DSM and ICD contain an increasing number of diagnostic categories (and are increasingly extensive). Thus, the 1952 DSM I classified 106 mental disorders (and has 100 pages). The 1980 DSM III classifies 265 units (and is almost 500 pages long). The latest edition, the 2013 DSM 5, classifies 410 mental disorders (approximately 1,000 pages). The number of nosological units increased by 400% compared to the first edition. However, if this evolution does not result from neurobiological discoveries, to what is it due?

Fundamentally (and philosophically), the question is whether certain characteristics listed as diagnostic criteria *make us recognize* a mental disorder, or whether these characteristics *are responsible for* the disorder? For example, characteristics thanks to which we recognize the major depressive disorder in person A and person B, are they also responsible for the origin of the major depressive disorder? The question is an ontological one (*onto-* in Greek means "that which is"): how exist mental disorders—as subjective categories or as discrete entities? Are mental disorders "in the eye of the beholder" (and then we tend toward an *ideal*ist position in the sense that mental disorders are "*ideas* in mind"), or do they exist also in objective *real*ity (and then we tend toward a *real*ist position).

I will explain it in a literarily illustrative manner, by making an analogy to the Pablo Picasso's famous work entitled *Le Taureau* (The Bull). It is a suite of eleven lithographs created from December 1945 to January 1946, depicting a solitary bull (in profile). The first of the series is highly detailed, naturalistic. It could be a representation of an individual, real bull. Then, in each successive print, Picasso simplifies, substracts, makes more abstract, pares the animal's representation down to some essential elements. The last

representation of the bull is truly spare—as spare as possible to remain evocative. In this abstract form it is not only evocative, but it seems to capture… the bullishness itself! These few lines really render the quintessential taureau. How this is so? We do recognize the bull, yet, the lithograph contains no male reproductive organs, we recognize the bull although there are no muscles on the representation (bulls are much more muscular than cows), no thicker bones, no larger feet. At last, it also has no muscular neck and no large, bony head real bulls have. "In the end, the bull's head was like that of an ant" (Lavin 1987, p. 4). "The taureau was reduced to its essential form, rendered in a few perfectly placed lines which symbolized this poor bull with his pinhead and ridiculous horns like antennae" (Mourlot, 1979). The nosological units from categorical psychiatric classifications are (in a sense) like the last lithograph, an essentialist representation of the bull. The fundamental question now is: these essential characteristics left by Picasso are the one which *make us recognize* the bull, or do they reflect the biological characteristics essential for cattle to become bulls? In this sense, does psychiatry indeed has something from art, as once was already claimed by George Canguilhem: "Medicine is an art at the crossroads of several sciences"[1] (Canguilhem, 1966, p. 7)?

2. OBJECTIVE AND SUBJECTIVE KNOWLEDGE, SCIENCE AND ART

We expect that scientists do not create nosological units (after all, this is science, not art; after all, they are scientists, not artists). We expect that scientific classifications of mental disorders "discover" already existing diseases/disorders/dysfunctions, recognize them, name and group. From ancient Greek philosophy we inherited (and it still works in us) the distinction between, episteme, doxa and techne. Episteme is the Greek word most often translated as knowledge, which is certain, truth, scientific, concerning the essence of things. Doxa is a belief of a particular person or of a group of people, resulting from their individual, particular experience. Doxa has the status of mere conjecture, opinion, subjective experience (Plato, *Timaeus*, 28a1–4, cited in Zeyl, Sattler, 2023). There is also techne, translated as either craft or art, refers to a practical skill. Together with doxa, techne has a lower status than episteme. This distinction works in us whenever we want to know how things are, and not only how some people think that things are. For instance, we tend to think: different theories say different, sometimes contradictory things about mental disorders? Let science decide! In the context of mental disorders by science we often mean "biology" (*bios*, life and

[1] «La médecine est un art au carrefour de plusieurs sciences.»

logos), almost a synonym of objectivity. *Logos* is the opposite of individual knowledge, intimate ("private") and specific to each person ("peculiar to each"). Logos is therefore sometimes translated as: Word, Truth, the principle according to which things function ("the formula of things")[2] (Hülsz, 2013). It is significant that in ancient Greek "logos" means at the same time: word, discourse, truth, science, raison d'être (Curd, 2020). We believe we can discover how things are, because we believe that logos is the language of the real, Hülsz, 2013).

Classifications are supposed to reflect mental disorders as "a real part of the causal structure of the world" (Murphy, 2011, p. 433, cited after Banicki 2015). For instance, the DSM was created precisely to deal with the "vagueness and subjectivity inherent in the traditional diagnostic process" (Blashfield, 1984, p. 85). For instance, the DSM III was explicitly promoted as an atheoretical approach (Demazeux, 2013), purely descriptive, objective, based on observation, and not on some or other theories of etiopathogenesis, thus allowing to go beyond theoretical disputes.

This conviction was shared by the fathers of psychiatry (e.g. Emil Kraeplin, Benjamin Rush, Philipp Pinel and Jean Esquirol, or Henry Maudsley). The first modern medical classifications were based directly on the methodology of biological taxonomy developed by Carl Linnaeus and on the assumption that diseases (including mental illnesses) can be captured as they occur in nature. For example, Boissier de Sauvages maintained correspondence with Linnaeus, and in the preface to the posthumous French edition of his classification of diseases he explained that certain observable features (symptoms) exist only in a given disease and distinguish it from all others. This is the very quintessence of categorical classifications. Someone who has a mental disorder is assumed to be "different" (e.g. his brain) from people who does not have the disorder.

Yet, every psychiatric classification was addressed the question: do diagnostic categories it lists correspond to an objective, biological etiology, or are based on arbitrarily isolated and grouped criteria? The classification of Boissier de Sauvages (Nosologia Methodica, 1771) was criticized by his successor, the famous alienist Philippe Pinel (1745–1826) who created his own classification (Philosophical Nosographie, 1798). Boissier de Sauvages is the founder of nosology, the very basis of classification of diseases. He methodically ordered 2400 diseases (among theses psychiatric illnesses) into classes, orders, genera and species, following the method of botanists and was convinced that each group comprises illnesses that are postulated to be caused by a common mechanism. Yet, Pinel disagreed with the very number of categories, criticized Boissier de Sauvages for making arbitrary choices,

[2] "Logos as objective rationality pertains to the formal aspect of the real, the way things are and happen, the structure in all change. Seen in this light, and without being named, logos is mirrored in the eternal kosmos" (Hulsz 2013:297).

for mistakenly – in his opinion, isolating symptoms and taking them for real illnesses. The same happened in Germany (Meynert's classification versus the later Kraeplin's classification.

Since their beginning, psychiatric classifications employ taxonomic methodology but in fact are not based on biological mechanisms leading to mental disorders. Time has shown that some "disorders" seem indeed purely arbitrary concepts. One of them is "masturbation madness." "Onanism" itself was treated as a disease, but also as a source of mental illness (masturbatory insanity) by the fathers of psychiatry (Benjamin Rush in the United States, Philippe Pinel and Jean Esquirol in France, Henry Maudsley in Gran Brittany, Emil Kraeplin in Germany). The sexual organs of children and people considered mentally ill were protected with plaster, leather or rubber devices. A way of "treating" masturbation madness was to cut penis innervation or to remove clitoris (Jankowski, 1975/94, pp. 50–51). Of course, no causal relationship was demonstrated between masturbation and mental disorders, neither then or later.

Another example in this vein is the one of hysteria. Until the last century hysteria was considered a diagnosable physical illness in women. The term hysteria endured for more than two thousand years and comes from the Greek *hystera* meaning womb, uterus. According to this "gynecological" explanation, for what was considered as mood and behavioral abnormalities would be linked to a dysfunction of uterus. It was considered "treatable" by getting married, pregnant or through an intercourse with a man. One of the "symptoms" of hysteria was woman's decision not to wed or to refuse to have a marital intercourse. Jean-Martin Charcot hypothesised that hysteria results not from the dysfunction of uterus, but of the central nervous system – therefore, according to him, men also could suffer from hysteria and male homosexuality was included to its symptoms (Le Talec, 2008). During one of the famous Tuesday clinical lessons at the Salpêtrière (on October 30, 1888) Charcot claimed to have isolated hysteria as a distinctive and universal pathology, which is one and indivisible[3] (Charcot 1889, cited in Brémaud 2015, trans. A. G.). Needless to say, that Charcot's hypothesis was not based on any prior neurobiological discovery of an organic correlate of hysteria (especially that it was a phenomenon of that times: never seen in this form before and never after (Cachera, 2021). Neverthelless he could identify it through "clinical observation: "Charcot could "see" and observe hysteria in all of its aspects. [...] The hysteria in its entirety was contained in that observation"[4] (Trillat, 1970, cited in Brémaud 2015, p. 489, trans. A. G.). According to Freud, for his students, Charcot was like Cuvier in the Jardin des Plantes, surrounded by different species that he was supposed to describe,

[3] „l'hystérie est une et indivisible".

[4] «Charcot avait «vu» et observé l'hystérique sous toutes les coutures […]. L'hystérie tenait tout entière dans ce regard».

group, classify, or the Adam of Paradise who recognizes and names species (Freud 1893, cited after Szasz 1960). Hysteria is indeed an excellent example of a mental illness "in the eye of the beholder."

3. FROM NAMES TO OBJECTS

Certain observable features are recognized as symptoms—symptoms of a disorder. The disorder begins to be perceived as an ontologically independent entity: nosological units are supposed to have a specific cause, a specific neuropathology, which is expressed in a characteristic clinical picture; we also look for a proper way to treat it (already known or still unknown). We pass from a word (logos) to the object. We pass from a name of a mental disorder to the conviction that there are mechanisms leading to this mental disorder. The moment we pass from names to objects is captured by probably the most commented paintings of the twentieth century *La trahison des images*, in English translated as *The treachery of images*; it can also be translated "deception, illusion of representation"—this is the title of the work of the Belgian painter René Magritte from 1929. If you ask someone who is looking at this painting "What is this?"—the first response would probably be "This is a pipe." And indeed, we do see a pipe. However, at the bottom of the painting there is an inscription: "Ceci n'est pas une pipe" which means "This is not a pipe." And indeed, this is not a pipe … you cannot pick it up, fill it up, light it, clean it, and put it back … this is not a pipe, but a representation of a pipe. By analogy, when we have a description of something, a name for it and it becomes operational, we can indeed end up deluded by the "illusion of representation." While what "science says about how things are" is first of all what "scientists think that things are" and it is different for different people, evolves in time. In this sense, there is no such thing as Spitzer wanted (Demazeux, 2013), i.e. an "atheoretical," purely "descriptive" classification.

In the same vein, when Szasz talks about the myth of mental illness, he does not deny that people face difficulties and suffer. Szasz expresses an ontological thesis, namely that the concept of "mental illness" should not be taken for a thing. *The concept* of mental illness, as Szasz puts it, is "a metaphor that we are accustomed to take for fact." As André Bourguignon writes: "To make a diagnosis, is to create an entity—a disease—by naming and classifying it"[5] (quoted after: Jaccard, 2015, pp. 40–41, trans. by A.G.).

[5] «Poser un diagnostic, c'est créer une entité – la maladie – en la nommant et en la classant».

3. FROM OBJECTS TO OBJECTIFICATION

"Physicians think they help a patient a lot when they give his disease a name." (Kant after Jankowski, 1994, p. 23). Yet, once the name, the diagnosis is given, there is a risk that it shifts the focus from the person to the diagnosed disorder: "Since then, the ill person, who is a carrier and a commentator of symptoms is put in brackets"[6] (Canguilhem, 1988, p. 19). Diagnostic categories are like the last lithograph of the Picasso's bull: pares the patient's description down to elements essential to the disorder, it is abstract, yet captures "the bullishness" itself. The risk is that the health professional will see the illness in the person, not the person with the illness: "[...] once the patient is classified according to a nosography, he stops being a subject to whom we talk, and becomes the object about which we talk and of which we dispose"[7] 2015, p. 45, trans. A.G.). André Bourguignon writes: "to give a diagnosis, he writes, is to create an illness – by naming it and by classifying it. At the same time it dries up the spring of its anxiety [psychiatrist, A.G.], the unknown of the madness and the relation to the mad. Because as soon as it is named, the illness becomes this familiar thing, autonomous, with which we directly enter into relation, without having to through the mad. Do not we say that we healed this or this illness, don't we call the ill person by its diagnosis?"[8] (Jaccard, 2015, pp. 40-41, trans. A.G.) The chapter is meaningfully entitled *Antidiagnosis*.

Thomas Szasz writes about the ontologically and ethically objectifying power of logos in *The Second Sin* (1973): "In the animal kingdom, the rule is, eat or be eaten; in the human kingdom, define or be defined." Szasz continues: "The struggle for definition is veritably the struggle for life itself. In the typical Western two men fight desperately for the possession of a gun that has been thrown to the ground: whoever reaches the weapon first shoots and lives; his adversary is shot and dies. In ordinary life, the struggle is not for guns but for words; whoever first defines the situation is the victor; his adversary, the victim. For example, in the family, husband and wife, mother and child do not get along; who defines whom as troublesome or mentally sick?... [the one] who first seizes the word imposes reality on the other; [the one] who defines thus dominates and lives; and [the one] who is defined is subjugated and may be killed". It is significant how Jaccard translates this passage of Szasz into French: "the struggle for definition" Jaccard

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[6] "Dès lors, le malade, comme porteur et souvent commentateur de symptomes, est mis entre parenthèses."

[7] «[…] dès le moment où le patient se trouve classé dans une nosographie, il quitte la position de sujet à qui l'on parle pour devenir l'objet dont on parle et dont on dispose».

[8] «Poser un diagnostic, écrit-il, c'est créer une entité – la maladie – en la nommant et en la classant. C'est, d'un seul coup, tarir les deux sources de son angoisse, l'inconnu de la folie et la relation au fou. Car, dès qu'elle est nommée, la maladie devient cette chose familière, autonome, avec la quelle on entre directement en relation, sans avoir à passer par le fou. Ne dit-on pas qu'on a soigné ou guéri telle ou telle maladie, ne nomme-t-on pas les "malades" par leur diagnostic?».

translates as “La lutte pour le Verbe” (“the struggle for the Word”). Then Jaccard continues: “Dans la réalité, l’enjeu n’est pas une arme, mais une etiquette,” i.e. “In fact, what is at stake is not the weapon, but the label” (Jaccard, 2015, p. 36), the victim is the defined, labelled person. Elsewhere in this vein: “The person who has the Word has the privilege of defining and classifying; the ascendant one person has oven another through the word is a new form of “civilised” physical constraint.”[9] (Jaccard, 2015, p. 36, trans. A.G.)

5. CONCLUSION

Introduction of every new psychiatric classification (or a new edition of it) stirs a passionate debate. One objection toward categorical classifications of mental disorders is that they are not suited to assess the diversity of people and their individual histories, their uniqueness, are not suited to conduct research on dimensional or trans-diagnostic traits common to clinical reality. I have shown a philosophical aspect of the debate: do diagnostic criteria a kind of characteristics thanks to which *we recognize* mental disorders*,* or are they *responsible for* (the ethology of) mental disorders? Will one day psychopathology and neuroscience coexist in psychiatric classifications? Will we find over 400 distinct biological correlates to more than 400 nosological units the DSM and ICD list? The endeavour is also of this kind: when we try to identify mechanisms of mental disorders underlying their origin, stress appears to be the lowest common denominator “that promotes vulnerability to, or exacerbates the symptoms of, almost all mental illnesses” (Notaras, van den Buuse, 2020, p. 2). And what causes that “stress”? Reasons can be as individual as individuals. What is first: I have such a brain therefore I have such mental disorder? Or I have such a life, therefore I have such a brain and such mental disorder?

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[9] «Le détenteur du Verbe possède le privilège de définir et de classer; l’ascendant qu’il exerce par la parole est une reconduction ‘civilisée’ de la contrainte physique».

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