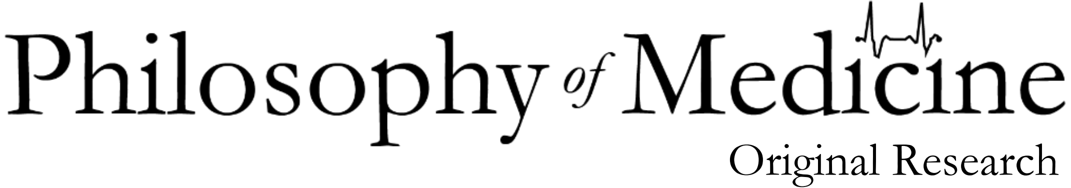
Original Research

Does Schizophrenia Exist? A Deflationary Perspective

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Abstract

This paper develops and defends a deflationary analysis of existence claims involving psychiatric disorders. According to this analysis, a given psychiatric disorder exists if, and only if, there are people who have the disorder. The implications of this analysis are spelled out for our views of nosological decision making, and for the relationship between claims about the existence of psychiatric disorders and claims about their reality. A pragmatic view of psychiatric nosology is defended and it is argued that worries about the "reality" of any given disorder have to be distinguished clearly from questions about its existence.

1. Introduction

Does schizophrenia exist? This is the question raised and addressed by a series of contributions to the *British Medical Journal* (BMJ). According to one prominent psychiatric epidemiologist, schizophrenia does not exist (Van Os 2016). Others disagreed, maintaining that it does, in fact, exist (Abou-Saleh and Millar 2016), while yet another view was that all claims about the existence of any psychiatric disorder are equally meaningless (Lawrie 2016).

What are we to make of this dispute? On the face of it, it may seem puzzling that anyone from within the psychiatric profession would doubt the existence of one of its paradigmatic disorders. And yet, questions about the existence of various psychiatric disorders are not unheard of in the context of nosological decision making. Why? What is going on here?

In this paper I argue for the following tripartite view. First, claims about the existence of particular psychiatric disorders are not meaningless. Second, their meaning is easy to comprehend and their truth is not beyond reach. Contrary to what ongoing or recurring disputes might suggest, questions about the existence of psychiatric disorders can be settled easily. Third, this does *not* mean that these nosological disputes are pointless, however. Drawing on recent work in philosophy of language, I provide an interpretation of these disputes that shows how they are really disagreements about what to *do,* not about what there *is*.

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In order to establish my view, we need: (1) a general account of the meaning of claims about the existence of psychiatric disorders; and (2) an account of the disagreement between the three parties above, assuming that there is any legitimate disagreement at all. Drawing on recent work in metaontology, I develop and defend a deflationary analysis of claims concerning the existence of psychiatric disorders in sections 2 and 3. This type of analysis has the distinct advantage of making ontological questions utterly unmysterious, answerable straightforwardly through empirical inquiry—give or take some prior conceptual work. In section 4, I spell out the implications this analysis has for our understanding of nosological decision making in psychiatry and what, in turn, that understanding means for our interpretation of disputes about the existence of psychiatric disorders.

The deflationary account of existence claims will help us see nosology for what it is—a complicated and fundamentally pragmatic enterprise. But that's not all. As I show in section 5, we can also use it to clarify the relationship between claims about the existence of disorders and claims about their reality. In the philosophical literature, these two types of claim are often treated as if they were equivalent. This is usually *not* justified, however, given that there are different ways to spell out what the (lack of) reality of psychiatric disorders actually consists in.

A more detailed outline of this paper is as follows: To set the scene, in section 2, I introduce the general approach to ontology followed in this paper, and I explain why it should be the default choice for non-metaphysicians. Next, in section 3, I develop this approach in more detail and show how it can help us answer questions about the existence of psychiatric disorders. I also motivate and defend this approach, taking into account current medical practice. The relationship between ontology and nosology is addressed in section 4. In particular, I argue against what I call the existential approach to nosological inclusion, provide an alternative view of nosological decision making, and explain why, in one way or another, the authors in the BMJ debate were all mistaken. Finally, in section 5, I examine the relationship between claims about the existence of psychiatric disorders and worries about their reality, arguing that we are dealing with a variety of distinct issues here.

2. On Methodology

Ontology is concerned with the study of what exists; that is to say, ontologists try to provide answers to questions about the existence of various (kinds of) things. They ask, for instance, whether numbers exist, or deny the existence of ordinary things, like tables and chairs. *Metaontology* is concerned with the study of ontology—its aims, claims, and methodological foundations. Thus, metaontologists debate the meaning, and meaningfulness, of various ontological claims, and ponder how questions about the existence of various (kinds of) things are to be settled.

In this paper I develop a metaontological view that will let us settle ontological disputes about the existence of mental disorders. It is a specialized version of the more general *neo-Carnapian* approach to ontology. In this section, I first outline this general approach and then argue that this kind of approach should be the default choice for anyone interested in ontological questions in psychiatry and medicine.

2.1 Neo-Carnapian Metaontology

The neo-Carnapian approach to ontology is a descendant of the deflationary view proposed by Rudolf Carnap in his seminal "Empiricism, Semantics and Ontology" (1950).[1] According to Carnap, there are four different types of ontological questions: two types of internal questions and two types of external questions. *Internal* questions are questions about the existence of things, asked from *within* a given "linguistic framework" (that is, by using the relevant expressions according to a given set of rules). These internal questions can either be *particular,* concerned with the existence of a specific entity (for example, "Does the Sydney Opera House exist?"), or *general,* concerned with the existence of kinds of entities (for example, "Do material objects exist?"). Either way, the key idea is that most of the existence questions raised by metaphysicians, interpreted as internal questions, can be answered rather straightforwardly, through empirical or formal investigations, without recourse to obscure metaphysical theories. In fact, they often have affirmative answers that strike non-metaphysicians as trivially true.

Internal questions must clearly be distinguished from *external* questions—which are raised and answered "outside" of a given linguistic framework. Although they are framed in exactly the same way as the most general internal questions, external questions, as conceived by the philosophers asking them, are not meant to be answered by proceeding in accordance with the semantic rules provided by the framework. According to Carnap and his disciples, there are two ways to interpret these questions. First, they might simply be *practical* questions, albeit misleadingly phrased, about whether we should adopt a given linguistic framework. These practical questions call for a *decision* about what to do, based on pragmatic considerations (for example, the expediency and goal conduciveness of the linguistic framework). Second, they might be attempts to formulate *theoretical* questions that do have factually correct answers. The problem with this latter strategy is that, once we remove the relevant terms from the rules that customarily guide their use, it is unclear *what* these questions mean, if they mean anything at all. Thus, the neo-Carnapians take theoretical external questions to be unanswerable, given that we cannot, by definition, interpret them in the way we usually would (that is, as general internal questions).

2.2 The Neo-Carnapian Approach as the Default Approach

There are several reasons why the neo-Carnapian approach is attractive and should be adopted as the default approach by philosophers who do not have any prior commitments to doing "deep metaphysics."

Firstly, the approach is epistemically tractable, or "easy" (Thomasson 2014). It lets us evaluate the truth of existential claims straightforwardly. Once we are clear about how to apply the relevant terms we use to make these claims, we are good to go. This is an important advantage, given that epistemic concerns form the basis of many objections to other metaontological approaches (Kriegel 2013; Woodward 2017; Thomasson 2014, 2017b; Saatsi 2017; Stanford 2017; Bradley 2018).

Second, this approach is metaphysically deflationary, or minimalist. It will let you answer ontological questions without having to commit to some grand theory about the

[1] The neo-Carnapian approach has found its most fervent defender in Amie Thomasson (2008, 2009, 2014, 2016). See also Bird (1995), Glock (2002, 2003), and Price (2009). I say more about what my own version of the approach looks like in section 3.

fundamental nature of language, truth, and reality first. Qua being deflationary, the approach only commits you to platitudes—platitudes that should be compatible with deflationary accounts of other philosophically important topics, such as truth and reference, if developed in the right way.

Third, the approach embodies the pragmatic spirit of Carnap's original proposal. Apart from being easily applicable, by eliminating deep metaphysical distractions, it also makes room for the kinds of methodological considerations that many practice-oriented philosophers of science, such as James Woodward (2014), are so eager to put front-and-center.

In light of these considerations, it should be clear that a neo-Carnapian approach to existential questions in psychiatry deserves careful consideration. Moreover, if you are simply interested in what there *is* and what is *real,* as opposed to what there *really* is and what *really* is real (in some metaphysically special way), a deflationary account, like the one provided in this paper, should be your default choice.[2]

3. Deflating Questions about the Existence of Psychiatric Disorders

Let us now return to our initial question: Does schizophrenia exist? What can the neo-Carnapian approach tell us about how we are supposed to understand and go about answering this question, and other questions like it? First, it should be noted that, on the face of it, this is a particular internal question. If we were able to answer it in the affirmative, however, we would also be able to infer that psychiatric disorders, in general, exist. Second, it is an empirical question. In other words, the truth of the claim that schizophrenia exists should, in some way, depend on what the world is like. But what, exactly, do we mean when we say that a particular psychiatric disorder, like schizophrenia, exists? In this section, I provide, motivate, and defend a tripartite analysis of such claims.

3.1 Analysis

In the first step of the analysis, we transform claims about the existence of schizophrenia into claims about cases of schizophrenia, according to the following principle:

> (P_1) A given medical condition exists *if, and only if,* there are people who have the condition.

Thus, schizophrenia exists if, and only if, there are people afflicted by it.

Whether there are people who have schizophrenia is, of course, an empirical question. How can we answer this question? This takes us to the second step of my analysis. The following principle tells us, in general, when it is true that somebody has a given medical condition:

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[2] Let us suppose you want to know whether there is a squirrel in your bedroom. How are you to find out? If you think what you need to do is to go into your room and look out for specimen of the particular type of animal that we call "squirrel," you should adopt a deflationary approach as your default approach. However, if, instead, you think you rather need to go to the library and study the latest issues of the *Review of Metaphysics* to work out a way to solve this "mystery," a deflationary approach might not be your starting point (although you may end up coming back to it later on).

(P_2) Relative to a particular usage of "X": *P* has medical condition *X if, and only if,* it is correct to apply "X" to *P*.[3]

Thus, relative to a given way of using the term "schizophrenia," someone has schizophrenia if, and only if, it is correct to predicate "schizophrenia" of that someone.

But how can we tell whether it is correct to apply "X" to *P*—and, thus, whether it is true that *P* has *X?* We need a non-trivial way of spelling out what the correct application of a diagnostic term consists in, one that makes no recourse to (P_2). The third step of my analysis does just that, via the following principle:

(P_3) Relative to a particular usage of "X": The application of diagnosis "X" to *P* is correct *if, and only if,* the application conditions for "X" are fulfilled.

The application conditions for "X" are those under which the term can be applied truthfully (Thomasson 2009, 4).[4] In the case of a psychiatric diagnosis such as "schizophrenia," the application conditions of the most common, *officially sanctioned* usages are specified, as far as possible, in the relevant *diagnostic criteria* of the current *Diagnostic and Statistical Manual of Mental Disorders* (DSM) (APA 2013a) and the *International Statistical Classification of Diseases and Related Health Problems* (ICD-10) (WHO 1993).[5]

With this analysis in hand, answering questions about the existence of psychiatric disorders becomes a rather trivial exercise. For instance, according to epidemiological studies (Jablensky et al. 2000), there are many people who, relative to ICD-10's use of "schizophrenia" (WHO 1993), meet the relevant diagnostic criteria and thus qualify for a correct diagnosis of schizophrenia. That is to say, there are many people who have schizophrenia. In other words, *schizophrenia exists*. Moreover, given that schizophrenia exists and that schizophrenia is a psychiatric disorder, there is at least one psychiatric disorder. Thus, *psychiatric disorders exist*.

[3] In general, when we identify and distinguish various usages, or ways of using a term, we distinguish the ways *it is to be used*. We do so by pointing to the differing rules, or norms, that govern the application of the term for each usage. Of course, in practice, these semantic rules may sometimes be hard to specify precisely, insofar as we can state them at all. Consequently, it may occasionally not be clear whether to count various applications of a term as belonging to one and the same use, or to two different usages. In cases like these, a *decision* might be called for, based on a consideration of why we wanted to identify and distinguish various usages in the first place.

[4] Importantly, these are not just "assertability conditions" that, if met, would make the ascription epistemically justified. What the relevant application conditions *are* is determined by the *constitutive rules* of use for the term (Thomasson 2008, 67). I say more about these rules below.

[5] The diagnostic criteria proper are typically supplemented by information pertaining to differential diagnoses and more extensive descriptions of the relevant diagnostic features. Of course, there may also be unofficial uses of these terms, uses that determine different application conditions. For evidence that such idiosyncratic, unsanctioned uses might be rather common in clinical psychiatric practice, see First et al. (2014), Garb (2005), Whooley (2010), and Zimmerman (2016). It should be noted, moreover, that in general medicine, unlike in psychiatry, "diagnostic criteria" typically do *not* specify the application conditions of the relevant diagnostic terms, as I understand them here. Instead, they describe *evidential* conditions such that if these are fulfilled, the diagnosis may reasonably be applied (although it might still turn out to be wrong). In general medicine, the application conditions are typically fixed through definitions or explanations of what a given diagnosis is a diagnosis *of*.

3.2 Clarifying the Status of the Three Principles

My analysis makes answering existence questions in psychiatry empirically tractable. It relies, however, on the three principles introduced above. What is the status of (P_1), (P_2), and (P_3), respectively? And how can their use in my analysis be justified?

In my view, (P_1) captures adequately how we actually talk about the existence of medical conditions. We ask, for instance, whether plague still exists, and expect an answer along the following lines:

> Plague still exists in various parts of the world. In 2003, more than 2,100 human cases and 180 deaths were recorded, nearly all of them in Africa. The last reported serious outbreak was in 2006 in the Democratic Republic of the Congo, when at least 50 people died. The United States, China, India, Vietnam, and Mongolia are among the other countries that have confirmed human plague cases in recent years. (National Geographic 2016)

Similarly, we might learn that

> Lassa fever is known to be endemic in Benin (where it was diagnosed for the first time in November 2014), Ghana (diagnosed for the first time in October 2011), Guinea, Liberia, Mali (diagnosed for the first time in February 2009), Sierra Leone, and Nigeria, but probably exists in other West African countries as well. (WHO 2017)

Thus, whether and where a medical condition exists depends on whether and where cases of the condition can be found. Moreover, when we talk about the *eradication* of a medical condition, such as malnourishment or childhood obesity, we usually mean the treatment and prevention of all cases of the condition.

What about (P_2)? I take it to be a platitude. All it does is to state the truth-conditions for a statement about the correct application of an expression, relative to a given way of using the expression. As such, it is no different from generally accepted principles such as the following:

> (P_{alt}) For any *S, x:* if "red" means *red,* it is correct for *S* to apply "red" to *x* if and only if *x* is red. (Whiting 2016, 221; Glüer, Wikforss, and Ganapini 2022)

Qua platitudes, there is not much that can be or needs to be said in order to justify their acceptance.

Things are slightly different in the case of (P_3). Here, we have a principle that presupposes the existence of (non-trivial) "application conditions" for each of our diagnostic terms. Moreover, these are supposed to be determined by the "constitutive rules" of use for the term, given a particular usage. Why should we accept all this? Once we unpack it a little, it becomes clear that we are justified in accepting principle (P_3) based on reflections on actual medical practice.

First, let me clarify what I mean by "constitutive rules" in this context. Following Hans-Johann Glock, we can characterize the relevant "constitutive rules" as those that

> do not prescribe a certain form of behavior, but instead lay down what a thing must be like to satisfy a certain description. Prime examples are the beloved EU norms concerning, for example, what qualifies as chocolate or the rules of games like chess. These norms lay down *what counts as* chocolate or as castling, without requesting anyone to produce or buy chocolate, or to castle. (Glock 2015, 846)

Accordingly, relative to a particular usage, the constitutive rules for a given diagnostic term "X" are those that specify, or determine in some way or other, *what counts as* a case of *X*. Put differently, when we spell out an answer to the question "What counts as a case of *X*?", we provide, or make reference to, the constitutive rules for the use of "X." The constitutive rules thus act as a *standard of correctness* for the application of "X." They are the basis for sorting potential patients into those that do have the relevant condition *X,* and those that do not.

What form do these rules take in modern medicine? What is considered a standard of correctness for the application of diagnoses? Typically, in medicine, the most important rules will be captured in explicit definitions, issued by authoritative institutions in the relevant specialty.[6] Here are just two examples. According to the *2017 American College of Cardiology/American Heart Association Clinical Practice Guideline for High Blood Pressure in Adults:* "Stage 2 hypertension is defined as an average SBP [systolic blood pressure] of at least 140 mm Hg or an average DBP [diastolic blood pressure] of at least 90 mm Hg" (Carey and Whelton 2018, 352). According to the definition provided in the *Global Strategy for the Diagnosis, Management, and Prevention of Chronic Obstructive Pulmonary Disease 2019 Report:* "Chronic Obstructive Pulmonary Disease (COPD) is a common, preventable and treatable disease that is characterized by persistent respiratory symptoms and airflow limitation that is due to airway and/or alveolar abnormalities usually caused by significant exposure to noxious particles or gases" (Global Initiative for Chronic Obstructive Lung Disease 2019, 4).

A given case only counts as a case of stage 2 hypertension or COPD if the conditions outlined in the above definitions are met. These conditions are thus (part of) the "application conditions" for the *2017 American College of Cardiology/American Heart Association Clinical Practice Guideline*'s use of "stage 2 hypertension" and the *Global Initiative for Chronic Obstructive Lung Disease*'s current use of "COPD." In general, the application conditions are simply those that have to be fulfilled for a patient to count as a case of *X*.[7] So, what needs to be the case for a patient to have *X,* and thus for the application

[6] These definitions are usually supplemented by further specifications and explanations of relevant terms occurring in the definition, as well as advice relating to the differential diagnosis of the condition. Moreover, all these definitions and explanations are embedded within a biomedical practice marked by highly regulated ways of measuring and assessing the various characteristics at issue (Cambrosio et al. 2006).

[7] Why do I not identify the application conditions with the characteristics referred to in the relevant definitions? There are two reasons to resist this urge. First, there might still be some uses of diagnostic terms that have not been captured and codified by way of explicit definitions. Second, and more fundamentally, definitions capture linguistic conventions conceived and adopted *within certain background circumstances* (Canfield 1974). These background circumstances are *not* explicitly mentioned in the definition itself, however. Yet, that the relevant background circumstances obtain *is* a requirement for the application conditions to be fulfilled (and, arguably, for the used expressions to mean what they do). Thus, the application conditions are more encompassing than the characteristics referred to in the explicit definitions, and the former cannot simply be identified with the latter.

of "X" to P to be correct? The relevant application conditions have to be fulfilled, as per principle (P_3).

3.3 Possible Objections to the Analysis

There are a few possible objections and concerns that I want to respond to here preemptively. I deal with them rather swiftly, however, for they will lose much of their force in light of considerations presented in the rest of the paper.

The first objection, to principle (P_1), runs as follows. Although I have presented some reminders of how we use existential claims in the context of medicine more generally, one might be skeptical whether we should understand existential claims made in the context of psychiatric nosology in the same way. Maybe they are used here to make a different sort of claim? If so, my analysis would be descriptively inadequate.

I agree. In fact, I do think that claims ostensibly about the existence of a specific psychiatric condition (for example, schizophrenia), made in the context of nosological decision making (broadly construed), are often claims to the effect that the respective diagnostic term (for example, "schizophrenia") should not be used anymore, or is defective in some way. In these cases, however, we should not understand the claims literally, as about the existence of the condition in question. Instead, we should treat them as disguised, or misleadingly phrased, *metalinguistic assertions*. I say more about this below. The point I want to make here is simply that we *should,* in general, understand existential claims in psychiatry in the way I suggest above, following medical practice. For in this way it will always be clear *what* we are saying, when we say that a given disorder does or does not exist.

The second concern comes from a different perspective. There will be a lot of stakeholders who have no particular interest in philosophical methodology but who might be concerned with some of my conclusions. "Whatever your metaontological views and arguments," they might say, "they have to be wrong because disorder *X* does not really exist." To these people I would say that when you make a claim like this, you will have to provide a good reason for it. Most likely, the relevant worry is not really a worry about the existence of the disorder itself, but rather a worry about a specific feature of the disorder or the corresponding diagnosis—as I attempt to show below.

The third response might come from someone who endorses the second objection, but this need not be the case. For them, the worry is that my deflationary analysis trivializes claims and debates about the existence of particular disorders. If my proposal were accepted, all disagreements about the existence of particular disorders could be resolved rather easily—too easily, as it were, given that these disagreements were taken to be a rather weighty matter by all those involved. So why not develop some alternative proposal, one that keeps the weight?

I think this is a legitimate question. In response, I would like to make four points in defense of my approach. First, my proposal has an independent justification, in that it would align talk about the existence of psychiatric disorders with talk about the existence of medical conditions in general. Second, this use of existence claims is not completely vacuous, as it conveys empirical information. To be precise, it can be used to state that there are (still) patients (somewhere) who have the condition in question. For example, here is an excerpt from a review article on adult dissociative identity disorder (DID), doing just that: "Does DID occur across cultures? DID does *exist* in both Western and non-Western

cultures. There are distinct differences in prevalence across cultures, however" (Boysen and VanBergen 2013, 8; emphasis added). Third, my proposal is pretty straightforward and easily adopted. That's great news, given that the acceptance of my proposal would clarify and regiment usage among those interested in psychiatric disorders and their classification. As a consequence, there would be much less confusion about what is claimed and argued about in situations like the BMJ debate. Fourth, and finally, the weighty issues do not simply disappear within my overall framework. As a matter of fact, the various issues to be raised in sections 3.4, 4.2, and 5 below would get their own *explicit* treatment. In my view, this is preferable to any alternative that does not clearly distinguish between them, or mischaracterizes some of them (for example, normative issues) as being something they are not (for example, empirical issues).

3.4 Worries about the Application of the Analysis to Particular Cases

There is one more point I need to address in order to clarify the application of my approach to particular examples. When I make the argument for the existence of schizophrenia above, I *assume* that the relevant usage of the diagnostic term "schizophrenia" is one of those officially sanctioned by the American Psychiatric Association (APA) and the World Health Organization (WHO). Why? There are three reasons for this. First, it is *this* usage that is at issue in the BMJ debate among Jim van Os, Stephen M. Lawrie, Mohammed T. Abou-Saleh and Helen L. Millar. Second, and more generally, this is the way it and other psychiatric diagnostic terms are *supposed* to be used, according to the APA and WHO (the two biggest and most influential organizations in the realm of psychiatry), and for good reasons (First et al. 2014). Third, and finally, this is also the way "schizophrenia" and other terms are de facto used in the majority of clinical and research settings around the world (First et al. 2018; Halpin 2016).

None of this is to say that "schizophrenia" could not be used or is not actually used differently by various researchers and mental health professionals. As I already acknowledge above, there are likely other uses of this term. Is that a problem for my account? At first glance, it might seem so. For example, according to one anonymous reviewer, there are many psychiatrists who routinely use "schizophrenia" to refer to a yet-to-be-identified neurobiological disease. If this is indeed the case, showing that some people qualify for a DSM or ICD diagnosis of schizophrenia would not be enough to show that schizophrenia exists. Instead, we would have to show that there are people who actually have the said neurobiological disease. As a consequence, it looks as if my whole argument for the existence of schizophrenia would fall apart. How would I respond to this?

I do not disagree with the conditional claim that if "schizophrenia" is used to refer to a neurobiological disease, showing that it exists means showing that someone has this neurobiological disease, in line with principle (P_1). However, if it is so used, the claim made by an utterance of "schizophrenia does not exist" will differ from that made if it were used according to the DSM and ICD criteria. As a consequence, there cannot be any *factual* disagreement between someone who uses it one way and somebody else who uses it differently. They are simply talking about two different things—one about the existence of a neurobiological disease, the other about a DSM- or ICD-defined syndrome. Thus, even if it

turns out that there is no schizophrenic disease, there would still be a schizophrenic syndrome, as I argue above.[8]

Still, someone might respond, does this not at least show that the actual *application* of my analysis to specific disorders is not quite as straightforward, or "easy", as I make it out to be above? Well, yes, but only insofar as there is actual disagreement as to what it is that we are talking about when we use a particular diagnostic term, such as "schizophrenia." If we can presuppose a particular type of usage for "X," there is no issue. If we cannot presuppose a particular type of usage, we have to establish *explicitly* what it is we are talking about (that is, what actually counts as a case of *X*). While this may complicate the application of my analysis in some cases, it should be noted that in order to be able say *anything* about *anything,* and be understood, we have to be clear about what it is that we are talking about. This is just a fact of life, given the inherent flexibility of human languages and the way they evolve over time.

4. Ontology and Psychiatric Nosology

Although the above analysis of existence claims in psychiatry may be attractive in and of itself, its real value becomes evident when we use it to help clarify other issues in the philosophy of psychiatry. This is what I do in the rest of this paper. In particular, in this section, I spell out the consequences this analysis has for our view of nosological decision making. In the final section, I use it to clarify the relationship between claims about the existence of psychiatric disorders and claims about their reality.

4.1 The Existential Approach to Nosological Inclusion

What diagnoses should be included in our official psychiatric classification systems? This is the main question psychiatric nosologists have to address. I argue that what might initially seem like a reasonable response to this question turns out to be unsatisfactory. Let us call this response the *existential approach to nosological inclusion*. This approach contends that the existence of a particular psychiatric disorder should be taken as a *precondition* for the inclusion of the corresponding diagnosis in our official diagnostic systems—that is to say, only existing disorders should be included. Given that we typically want our classifications to be *comprehensive,* proponents of this approach might want to add a second norm to the first one. According to this second norm, *all* existing disorders should be covered. Putting these two norms together, we arrive at the idea that all and only diagnoses of *existing* disorders should be contained in our psychiatric classification systems.

Who is committed to this kind of approach? Anyone who wants to argue for or against the inclusion of diagnoses based on the idea that the corresponding disorder does or does not exist. The historian Edward Shorter (2015), for instance, tries to make a book-length case for the idea that some discarded diagnoses should be re-adopted based on the fact that they exist, while other currently used diagnoses should be tossed out. As he puts it at one

[8] Just think of a humdrum example for comparison. The same existential sentence—"There is a bat in the shed"—can be used to say two different things in the same circumstances, depending on how the term "bat" is used. If, unknowingly, I use it to talk about a type of animal while you use it to talk about a type of sporting equipment, whatever each of us would be claiming about "bats in the shed" would be *compatible* with what the other is saying, given that we would simply be talking past each other.

point: “We have plenty of diagnoses today that don’t actually exist as separate entities in nature, such as ‘social anxiety disorder.’ The idea that we might have omitted some that do exist is not such a stretch” (Shorter 2015, 3).

Is this a reasonable approach to nosology? In order to evaluate this, it is easiest if we consider the two norms in turn. Let us first examine whether we should really only adopt diagnoses of existing disorders. On the face of it, this seems like a reasonable idea. After all, we should focus our attention on the conditions that people actually *have*. Why bother including diagnoses for conditions no one is affected by? Well, there are two reasons for this. First, there are some conditions, such as smallpox, that used to be quite prevalent, but that have been *eradicated* by now—that is to say, no one is afflicted by these conditions anymore. This does not mean, however, that we should exclude the corresponding diagnoses from our classifications—given that these conditions might make a comeback, and we would need to be able to diagnose them if that were to happen. Second, there might be some very rare conditions that go in and out of existence—sometimes there are people who have them, sometimes there are not. Should we really take the corresponding diagnoses in and out of our classifications, accordingly? Of course not. We need to have the diagnosis available in case we are confronted with a new case, even if there are no other cases already presenting at that point in time.

As the considerations above show, we have good reasons to adopt diagnoses for conditions that do not exist (anymore), and we should reject the first norm proposed by the existential approach to nosological inclusion. What about the second norm? Should we not at least include diagnoses for all existing conditions? Well, no. Just because a condition exists does not imply that we *have* to worry about it and include the corresponding diagnosis in our classification systems. This becomes clear once we consider reasons for excluding diagnoses. In *some* cases we exclude a diagnosis because we come to think that the respective condition does not actually qualify as a psychiatric disorder, as something *pathological*. This is what happened in the case of homosexuality, for instance (Drescher 2015). No one would deny that homosexuality *exists*. However, we now reject the idea that homosexuality should be seen as pathological, as a diagnosable psychiatric condition to be treated by healthcare professionals.

In other cases, neither the existence nor the pathological nature of the condition is really in question. Instead, the corresponding diagnosis is simply replaced by or incorporated into another diagnosis, or other diagnoses. For instance, although the existence of sleep disorder related to another mental disorder was never in question, and there were enough patients qualifying for the diagnosis, its diagnosis was superseded by the diagnoses of insomnia disorder and disorder of hypersomnolence in DSM-5 (APA 2013). Notably, the main motivation for this replacement was the DSM-5 workgroup’s conviction that, in most cases, “the individual has a sleep disorder *warranting independent clinical attention,* in addition to any medical and mental disorders that are also present, and [that this nosological decision] acknowledges the bidirectional and interactive effects between sleep disorders and coexisting medical and mental disorders” (APA 2013b, 13; emphasis added).

Whether one agrees with the final decision in this particular case, what matters is simply *that* such a change was made, although the existence of the condition was not in question. As will become even more clear below, there are various considerations that can and do shape the nosological decision-making process, yet the existence of the condition is typically

not one of them.[9] As a consequence, the existential approach to nosological inclusion should be rejected.

4.2 An Alternative View of Nosological Decision Making

If it is not the existence of the condition that provides us with *the* reason for including the corresponding diagnosis in our classification systems, what *are* the reasons that should guide our nosological decision making? In my view, there are various pertinent considerations that can and should play a role here—considerations that may, at times, pull us in different directions (Sadler et al. 2001; Decker 2013). Roughly, these can be divided into four domains: epistemic, pragmatic, normative, and impact-related. I will say more about these below. What should be noted first, however, is that these considerations *are* relevant insofar as they help ensure that our nosological choices are in service of the overarching, extra-classificatory goals of psychiatry. In the most general terms, these goals are the alleviation of suffering and the smooth functioning of society.

Given that psychiatry is an applied *science,* the most pertinent questions concern the *epistemic value* of the diagnoses under consideration. Will the adoption or replacement of a diagnosis, or set of diagnoses, enable us to instigate or improve relevant explanatory and inferential practices? Put differently, do people who share a diagnosis have interesting features in common, features that people who do not have the diagnosis lack? In psychiatry, questions like this are typically dealt with under the label of "validity."[10] Although there are various ways to spell out what the validity of a diagnosis, or a set of diagnoses, consists in, given current nosological *practice* (Kendler et al. 2009), it is best to think of the process of validation as a means of showing that the diagnosis, or set of diagnoses, provides us with *relevant surplus-information.* As Robert L. Spitzer, the driving force behind the DSM-III revolution (Decker 2013), once put it:

> A diagnostic concept is assumed to have validity to the extent that the defining features of the disorder provide useful information not contained in the definition of the disorder. This information may be about etiology, risk factors, usual course of the illness, whether it is more common among family members, and most important, whether it helps in decisions about management and treatment. (Spitzer 2001, 353)

Again, all this surplus information is considered *relevant* insofar as it helps us achieve our extra-classificatory goals in psychiatry. "Ultimately, a diagnosis is valid if it predicts future outcome so as to facilitate reducing the burden of mental health problems" (Kraemer 2015,

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[9] There might, of course, be cases where nosologists reject a diagnosis because they come to think that it would be *impossible* for anyone to actually have the condition in question. Such a diagnosis would then, indeed, be superfluous—not because the condition does not exist, but thanks to the fact that it could not exist.

[10] The literature on "validity" and "validation" in psychiatry is voluminous and diverse, and there is no general agreement on what the validity of a diagnosis actually amounts to. For an overview of the debates, see Zachar and Jablensky (2015) and some of the other contributions in the same volume. In the philosophy of psychiatry, discussions of validity are often framed in relation to the philosophical literature on "natural kinds." Although I do think that the relation to the epistemic concerns in said literature is obvious, I do not think that it is helpful to bring in this particular philosophical term of art here, given how varied and contested its use has become (Hacking 2007).

1164). Generally speaking, nosologists should strive to adopt valid diagnoses and replace less valid ones with more valid alternatives whenever possible.[11]

Given that psychiatry is an *applied* science, there is a different set of considerations, which is pragmatic, in a down-to-earth sense. In psychiatrists' own terms, these considerations pertain to the *clinical utility* of a diagnostic system. We need the diagnoses to be usable, not only in a research setting but also in routine clinical practice. It is thus important to have a diagnostic system that is relatively easy to employ, even if there are constraints on time and diagnostic resources. Ease of use will improve the acceptance of the system by clinicians and other affected parties (such as patients and administrative staff). As Michael First and his colleagues point out, a "mental disorders classification that is difficult and cumbersome to implement and does not provide information of value to the clinician has no hope of being implemented accurately at the encounter level in real world health settings" (First et al. 2015, 89). This matters because a diagnostic system is only of use if it is actually put to use. For instance, if the diagnoses are not applied properly in the clinic, all the information that has been gathered in a research setting cannot really be taken advantage of (First et al. 2014). Moreover, ease of use will likely improve the inter-rater reliability of the diagnoses (that is, the diagnostic agreement between clinicians assessing the same case around the same time, or based on the same information). Given that the provision of a common language for healthcare professionals is one of the main goals of official diagnostic systems like the DSM and ICD, ensuring "adequate" reliability of diagnostic assessments has been one of the main objectives of nosologists over the past 50 years (Spitzer and Fleiss 1974; Kendler et al. 2009)—and rightfully so.

A quite different type of consideration is *normative* and concerns the pathological status of conditions considered for inclusion in our classifications. Given that our classifications are classifications of mental *illness,* of *psychopathology,* we should only include conditions that we judge to be pathological. *Why* we judge certain conditions to be pathological is a complicated question, one that has yet to find a satisfying answer.[12] What is relatively uncontroversial, however, is that judgments about the psychopathological status of any given condition depend, at least in part, on social norms and value judgments of one kind or another (Sadler 2013; Murphy 2015). For a condition to be judged pathological, it has to be seen as something *bad*—an undesirable or harmful deviation from some norm of behavior, thinking, feeling, or functioning; one that justifies medical attention of one kind or another and allows the affected individuals to assume a sick role, with everything that may entail (for example, gaining and losing various rights and obligations).[13]

[11] When we are dealing with real nosological decisions, we typically do not know beforehand whether a given choice will provide us with the desired epistemic benefits in the long run. That is one reason why it is so hard to replace the current DSM diagnoses with something completely different. So much time, money, and effort has gone into validating DSM diagnoses, we have by now acquired a good amount of relevant surplus information—even if it has not been of the kind that most nosologists had hoped for (Hyman 2010). The same is typically not true of "unproven vague alternatives" (Lawrie 2016). Thus, in order to make a convincing case for major change, diagnostic alternatives will have to emerge from well-funded research initiatives, such as the Bipolar and Schizophrenia Network for Intermediate Phenotypes (Tamminga et al. 2017) or the National Institute of Mental Health's Research Domain Criteria project (Cuthbert 2014).

[12] In the philosophical and psychiatric literature, this question is typically tackled through an examination of "the concept of mental disorder." Radden (2019) provides a comprehensive overview of these debates.

[13] Given the value-laden nature of these judgments, people with different values might end up with different judgments, potentially leading to conflicts. For instance, conflicts of this kind have impacted decisions about homosexuality (Decker 2013) and premenstrual dysphoric disorder (Zachar and Kendler 2014). It should be

The last set of considerations to take into account in our nosological decision making sits somewhere between the pragmatic and normative ones. These considerations concern the *impact* a given nosological choice will have—on medical practice, on patients' lives, and on society at large. For instance, if we choose to recognize a new diagnosis in our classifications, this will have a variety of important social consequences:

> We inform medical scientists that they should try to discover a cure for the condition. We inform benefactors that they should support such research. We direct medical care toward the condition, making it appropriate to treat the condition by medical means, such as drug therapy, surgery, and so on. We inform our courts that it is inappropriate to hold people responsible for the manifestations of the condition. We set up early warning detection services, aimed at detecting the condition in its early stages when it is still amenable to successful treatment. We serve notice to health insurance companies and national health services that they are liable to pay for the treatment of such a condition. (Reznek 1987, 1)

Notably, given that all of the resources mentioned here are limited, directing them toward one condition always means taking them away from other conditions. Relatedly, if we loosen our disease or mental disorder definitions in such a way as to include more and more patients with less severe clinical presentations, or "patients at risk" that have yet to develop any clinically relevant symptoms, this will take away resources from those with more harmful versions of the relevant conditions (Doust et al. 2017).

On a personal level, different diagnoses may impact individuals in a variety of ways, not all of these positive. For instance, being diagnosed as "schizophrenic" can lead to the experience of stigma and discrimination, anxiety and pessimism about one's future, as well as a changed view of oneself—leading some to advocate for renaming or replacing the diagnosis (Lasalvia et al. 2015; Moncrieff and Middleton 2015). It is thus important to think carefully about the potential consequences our nosological decisions may have: "Modifying a disease definition should be guided by a balanced assessment of the anticipated benefits and harms, using the best evidence available. The definition should reflect the values and preferences of patients and the wider community and include the impact on resource usage" (Doust et al. 2017, 1023).

As the discussion in this section shows, there are a variety of issues to consider when making changes to our official diagnostic manuals. And there are more.[14] Nosology is a messy business. Getting things right is typically not an easy matter. In fact, different stakeholders may hold different views about what "getting it right" would actually amount to in any given scenario. In the end, however, *we* should choose to make those changes that *we* consider most conducive to the achievement of *our* goals.

In general terms, my view of nosological decision making could thus be described as a form of *diagnostic engineering*. Diagnostic engineering, as I conceive of it, is a fundamentally pragmatic enterprise. It is concerned with answering questions about what

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noted, moreover, that one might be critical of the whole idea that psychological distress is a *medical* problem—to be diagnosed, studied, and treated in the same way as other medical conditions (Kinderman et al. 2013; Boyle 2006; Moncrieff and Middleton 2015).

[14] For instance, another pragmatic *and* impact-related reason to adopt or change diagnoses is to increase diagnostic coverage for insurance-reimbursement purposes. While this probably helps patients financially in the short term, this may have negative consequences in the long run (Hyman 2010).

diagnoses and classifications we *should* adopt, in light of our particular values, interests, and needs, and given the various uses we will make of them. Diagnoses are tools, and some tools will work better than others when we try to accomplish a given set of tasks. When diagnostic engineering, we try to pick out or develop the most suitable diagnostic tools for the particular issues at hand.

4.3 Reinterpreting the BMJ Debate

I have presented and defended a deflationary approach to existence questions in psychiatry, and outlined what is at stake when we decide to introduce, change, or discard particular diagnoses. Let us now return to the initial BMJ debate about the existence of schizophrenia. What sort of sense can we make of the views proffered by the psychiatric nosologists mentioned in the introduction (Van Os 2016; Abou-Saleh and Millar 2016; Lawrie 2016)? How could their disagreement be reinterpreted; how should it be resolved?

Ostensibly, the disagreement seems to be about the following claim:

(1) Schizophrenia does not exist.

According to Van Os, this claim is true. According to Abou-Saleh and Millar, it is false. And according to Lawrie, it is meaningless. Who is right? Who is wrong? And what is really going on here?

As I argued above, there is a perfectly obvious way to interpret (1). In light of this, Lawrie's verdict of "meaninglessness" has to be rejected. It is worth noting, moreover, that the argument Lawrie provides for his verdict is itself fallacious.[15] He says that (1) is meaningless because it is "meaningless to suggest that any abstract noun or concept does or does not exist" (Lawrie 2016). Yet (1) is a claim about the existence of *schizophrenia,* the condition, not about the *noun* "schizophrenia" or the *concept* of schizophrenia. Even if claims about the existence of nouns and concepts *were* meaningless, it simply would not follow that claims like (1) are meaningless as well.

So, (1) is meaningful. Is it true? I have already argued above that it is not (see section 3.1). Thus, Van Os (2016) is wrong. Moreover, it looks like I would agree with Abou-Saleh and Millar (2016), but I do not. Why? Well, they think that schizophrenia exists *because* there is "extensive research demonstrating that it is a brain disease" (Abou-Saleh and Millar 2016). Yet such research is simply *irrelevant* when we ask whether schizophrenia exists. Schizophrenia exists if, and only if, there are people who have schizophrenia—whether it is a brain disease or not. Schizophrenia, as currently defined by the DSM and ICD, could be a syndrome and still exist. In fact, it is and it does.

I have just explained why I disagree with all of the participants in the debate—insofar as we take the debate to *be* about the existence of schizophrenia. There is, however, reason to suspect that that's not what's actually at stake here, after all. Indeed, all three parties devote most of their discussion to the question of whether the *diagnosis* should be retained, renamed, or replaced. Thus, Lawrie (2016) argues that "'Schizophrenia' is a useful concept," that a change of name "won't do anything to help [patients]," and that a replacement with "vague unproven alternatives may or may not reduce stigma but runs the risk of increasing

[15] As it happens, exactly the same argument has previously been made by Kendell (1991, 59–60).

misdiagnosis and would inevitably lose what we already know about how to help patients in clinical settings." Van Os (2016), on the other hand, maintains that "disease classifications should drop this unhelpful description of symptoms" and replace it with a diagnosis of "psychosis spectrum syndrome." Finally, Abou-Saleh and Millar (2016) endorse retaining the diagnosis, but "propose renaming schizophrenia, Kraepelin's disease/syndrome" in light of the potential advantages such a name change might bring with it, according to prior research (Lasalvia et al. 2015).

Given that it is *not* the *existence* of schizophrenia that is at stake in these discussions, I suggest we reinterpret Van Os's and Abou-Saleh and Millar's respective assertion and denial of (1). Instead of understanding their claims literally, as about the existence of schizophrenia, we should see them as moves in a *metalinguistic negotiation*.[16] What is really at issue here is whether we should retain, change, or abandon the diagnosis. According to Abou-Saleh and Millar, we should keep it (albeit renamed); according to Van Os, we should replace it. This is what their disagreement is about. It is a disagreement about *what to do,* not about *what there is*.[17]

5. Existence and Reality

So far, I have said a lot about the existence of psychiatric disorders. Yet I have said next to nothing about their reality, or "realness." This may come as a surprise to some, given how prominent disputes about the reality of mental illness have been historically ever since the publication of *The Myth of Mental Illness* (Szasz 1960, 2011 [1961]). Let us now examine this issue, in light of what has been established above.

What is the relationship between claims about the existence of a disorder and claims about its reality, or realness? Are all existing disorders real? Are only existing disorders real? I do not think these questions have straightforward answers. Instead, the answers will depend on what understanding of "being real" we presuppose. Here, I will spell out different ways of interpreting claims about the reality of psychiatric disorders.

It should be noted that this discussion is not meant to be exhaustive, but rather representative of the main concerns addressed by people talking about the reality of psychiatric disorders in the literature. Unfortunately, many of these claims are often run together, as if we were dealing with just one issue. It should also be noted that I am not taking a stance on what should be considered the *right* way to understand claims about the reality of psychiatric disorders in this context. In fact, I would prefer to replace vague talk about the reality of disorders with detailed discussions of more specific questions, as below.

Typically, questions about the reality of psychiatric disorders come down to one or more of the following concerns:

1. worries about the existence of a given psychiatric disorder;
2. worries about the pathological status of a given psychiatric disorder;

[16] The term "metalinguistic negotiation" is due to Plunkett and Sundell (2013). In short, a metalinguistic negotiation "is a dispute in which speakers each use (rather than mention) a term to advocate for a normative view about how that term should be used" (Plunkett 2015, 832)—or about whether it should be used at all (Thomasson 2017a, 16).

[17] That this is the right interpretation of the dispute is reinforced if we take into consideration Van Os's other writings on the topic (especially Guloksuz and Van Os 2018, 2019). Here, we find no claim to the effect that schizophrenia does not exist, only arguments for the *replacement* of one nosological approach to psychosis (based on the concept of schizophrenia) with another (based on the concept of a psychosis spectrum disorder).

3. worries about the disease status of a given psychiatric disorder;
4. worries about the validity of the respective diagnosis;
5. worries about the medicalization of psychological distress;
6. worries about the coherence of the phrase "mental illness;"
7. worries about the value-laden nature of judgments about the pathology of conditions; and
8. worries about the metaphysical status of psychiatric disorders not addressed by (1)–(7).

Quite often, claims about the reality of psychiatric disorders are treated as equivalent to claims about their existence, as per (1). In that case, I have already provided an analysis of both types of claims above. Of course, even those, like Thomas Szasz (1960), who have treated them as equivalent might not actually have had deflationary existence claims in mind—even though they should have. Instead, they might have worried, as per (2), whether a specific condition, such as attention-deficit hyperactivity disorder (ADHD), should *really* be seen as pathological (Berezin 2015). In these cases, questions of the form "Is condition *X* real?" should be read as shorthand for "Is condition *X* really pathological?".

A different type of worry concerns the disease status of specific disorders. For instance, someone who queries whether ADHD is real might also be questioning whether it should be considered a *real disease* (Wedge 2018). The same goes for schizophrenia. Given that schizophrenia is not defined in terms of etiology, pathological anatomy, or dysfunctional physiology, this worry would be justified. This does not mean, however, that schizophrenia doesn't exist, as I have explained above.[18]

Questions about the reality of a given disorder are often addressed by producing evidence for the validity of the respective diagnosis. To show that a disorder is real, we have to show that the respective diagnosis is valid. "The validation of psychiatric diagnoses establishes them as 'real entities'" (Andreasen 1995, 162). Insofar as the validity of a diagnosis *can* be considered a matter of degree, the same *could* be said about the reality of the respective disorder:

> The best diagnoses we have are the ones that are strongly connected with other things we know about—that is, are "well validated". For individuals assigned to that diagnostic class, we follow the connecting pieces and see all the other things that we learn about them—genetic risk factors, premorbid susceptibilities, imaging findings, neurochemistry, course, prognosis, treatment, etc. As a disorder becomes more valid, it becomes more connected with our knowledge-base and, from a coherence perspective, more real. (Kendler 2016, 9)

A quite different type of worry about the "reality of mental illness" (5) concerns the appropriateness of biomedical approaches to psychological abnormalities, emotional distress, and behavioral problems in general. Should we really employ medical terminology (that is, talk about "symptoms," "illness," "dysfunction," "pathology," "etiology," "syndrome," "disorder") when we are conceptualizing these issues? Should physicians really

[18] Nor does it exclude the possibility that we might find a neurobiological anomaly in all and only those people currently diagnosed as schizophrenic. If that were to happen, in spite of current evidence (Zipursky, Reilly, and Murray 2013; Keshavan, Nasrallah, and Tandon 2011), we would likely *redefine* the diagnosis, and turn "schizophrenia" into the name of a brain disease.

be the ones dealing with those affected ("patients")? Aren't we just *medicalizing* ordinary "problems in living" in order to enforce social norms? From a moral or practical perspective, wouldn't it be more justified to adopt a non-medical view of these people and their problems, their distress and deviance, and to provide them with an alternative form of care, all while holding them accountable in the same way we do everybody else? If you are inclined to answer "yes" to these questions, you might express this by saying that "mental illness is a myth," as Szasz (1960) and his many followers did.

The original reason why Szasz (2011 [1961], 1988) questioned the reality of mental illnesses in general has to do with the very idea of "mental illness", as per (6). According to Szasz (2011 [1961], iii), if we accept "the materialist-scientific definition of illness," "then it follows that mental illness is a metaphor, and that asserting that view is asserting *an analytic truth, not subject to empirical falsification*." Nothing can be both an *illness* and something *mental* at the same time. Illness presupposes that there is something wrong with the body, that there is some type of pathological alteration of cells, tissues, or organs present. If that's the case, however, we are dealing with a bodily issue (for example, a brain disease), not a mental one. If there is no bodily pathology, whatever we are dealing with (for example, a "problem in living"), it cannot be a *real* illness. "Real medicine thus helps real physicians to treat or cure real patients; fake medicine (psychiatry) helps fake physicians (psychiatrists) to influence or control fake patients (the mentally sick)" (Szasz 1988, 39).[19]

The next worry, (7), grows out of the fact that our nosological decision making is dependent upon value judgments. If that is the case, the complaint goes, psychiatric disorders cannot be real because the respective diagnoses are not "objective" (that is, value-free). Given that decisions about what counts as a psychiatric disorder are *relative* to personal values or social norms, they cannot be seen as "mind-independent parts of reality."

This leaves us with the final type of worry, or set of worries, about the reality of psychiatric disorders—worries of a metaphysical nature, not yet addressed above. What seems to be at issue here, in debates between "realists" and "anti-realists", are questions that are orthogonal to the ones addressed in this paper. Are the medical conditions we recognize in our classifications Really Real? Are they universals? Realists say "yes," anti-realists say "no."

I have just outlined eight different ways in which claims about the "reality" of psychiatric disorders can be understood. Consequently, when we affirm or deny the reality of psychiatric disorders, we should always be clear about what type of claim we are actually trying to make. Knowing whether a particular disorder does or does not exist only helps us answer the question "Is disorder *X* real?" if we presuppose the equivalence of reality and existence claims. In all the other cases—(2)–(8)—it does not matter whether particular disorders do or do not exist; their reality is independent of their existence.

6. Conclusion

In this paper I have developed and defended a deflationary analysis of existence claims involving psychiatric disorders. According to this analysis, a given psychiatric disorder exists if, and only if, there are people who have the disorder. With this analysis in hand, answering questions about the existence of any given disorder, like schizophrenia, becomes

[19] For critical discussions of Szasz's argument, see Champlin (1981) and Kendell (1991).

a rather straightforward exercise. All that is needed is knowledge of how the relevant diagnostic term is to be used, along with the empirical study of people potentially affected.

I have also explored the relationship between ontology and psychiatric nosology. What diagnoses should we include in our psychiatric classification systems? As I have shown, once we take the deflationary analysis of existence claims into account, one particular way of answering this question turns out to be unsatisfactory. According to this approach, all and only diagnoses of existing disorders should be contained in our psychiatric classification systems. If we were to accept this idea, nosological decision making could not be the kind of pragmatic enterprise I contend that it is. Instead, our decision to adopt a given diagnosis would be based on the fact that the corresponding disorder exists, and nothing else. It is *this* idea that I have challenged above. In particular, I argued that the existence of a disorder should be considered neither necessary nor sufficient for the nosological adoption of the corresponding diagnosis, thus opening up the decision-making process to various normative, epistemic, and interest-relative considerations.

These various normative, epistemic, and interest-relative considerations, outlined in some detail in sections 4.2 and 5, should be the focus of discussions about nosological decision making in psychiatry. Moreover, we would do well to distinguish clearly between them, instead of lumping them all together through loose talk about the "reality" of psychiatric disorders. However, even if we continue using this idiom, when affirming or denying the "reality" of psychiatric disorders, we should at least qualify our claims in order to make clear what type of claim we are actually trying to make. This will keep discussions productive and free from confusion.

In an appearance on the Carol Burnett Show in 1970, the comedian Joan Rivers once quipped: "I'm a philosophy major—what good does philosophy do me now? I can go to the butcher, prove the meat doesn't exist! What good?" In light of ongoing debates about the existence of *ordinary* things, such as tables and chairs, within mainstream philosophy journals, it may seem like this kind of comic exasperation is still in order. But it is not. As I have tried to show in this paper, paying philosophical attention to the way we go about asking and answering questions concerning the existence of psychiatric disorders does have a point. Although doing so from a deflationary point of view doesn't solve all the hard problems confronted by psychiatric nosologists, at least it will let us see many important issues in a new light—and that's progress.

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References

Abou-Saleh, Mohammed T. and Helen L. Millar. 2016. "Schizophrenia Does Exist: It Is Kraepelin's Disease." *British Medical Journal* 352 (Responses, 23 February). https://doi.org/10.1136/bmj.i375.

Andreasen, N.C. 1995. "The Validation of Psychiatric Diagnosis: New Models and Approaches." *American Journal of Psychiatry* 152, no. 2: 161–162. https://doi.org/10.1176/ajp.152.2.161.

APA (American Psychiatric Association). 2013a. *Diagnostic and Statistical Manual of Mental Disorders*. 5th edition. Washington, DC: American Psychiatric Publishing.

———. 2013b. "Highlights of Changes from DSM-IV-TR to DSM-5." https://www.psychiatry.org/File%20Library/Psychiatrists/Practice/DSM/APA_DSM_Changes_from_DSM-IV-TR_-to_DSM-5.pdf.

Berezin, Robert. 2015. "No, There Is No Such Thing as ADHD." *Mad in America,* 17 March. https://www.madinamerica.com/2015/03/no-no-thing-adhd/.

Bird, Graham H. 1995. "Carnap and Quine: Internal and External Questions." *Erkenntnis* 42: 41–64. https://doi.org/10.1007/BF01666811.

Boyle, Mary. 2006. "Developing Real Alternatives to Medical Models. *Ethical Human Psychology and Psychiatry* 8, no. 3: 191–200. https://psycnet.apa.org/doi/10.1891/ehppij-v8i3a002.

Boysen, Guy A. and Alexandra VanBergen. 2013. "A Review of Published Research on Adult Dissociative Identity Disorder 2000–2010." *Journal of Nervous and Mental Disease* 201, no. 1: 5–11. https://doi.org/10.1097/nmd.0b013e31827aaf81.

Bradley, Darren. 2018. "Carnap's Epistemological Critique of Metaphysics." *Synthese* 195: 2247–2265. https://doi.org/10.1007/s11229-017-1335-x.

Cambrosio, Alberto, Peter Keating, Thomas Schlich, and George Weisz. 2006. "Regulatory Objectivity and the Generation and Management of Evidence in Medicine." *Social Science & Medicine* 63, no. 1: 189–199. https://doi.org/10.1016/j.socscimed.2005.12.007.

Canfield, John Vincent. 1974. "Criteria and Rules of Language." *Philosophical Review* 83, no. 1: 70–87. https://doi.org/10.2307/2183874.

Carey, Robert M. and Paul K. Whelton. 2018. "Prevention, Detection, Evaluation, and Management of High Blood Pressure in Adults: Synopsis of the 2017 American College of Cardiology/American Heart Association Hypertension Guideline." *Annals of Internal Medicine* 168, no. 5: 351–358. https://doi.org/10.7326/m17-3203.

Carnap, Rudolf. 1950. "Empiricism, Semantics and Ontology." *Revue Internationale de Philosophie* 4, no. 11: 20–40. https://www.jstor.org/stable/23932367.

Champlin, T.S. 1981. "The Reality of Mental Illness." *Philosophy* 56, no. 218: 467–487. https://doi.org/10.1017/S003181910005052X.

Cuthbert, Bruce N. 2014. "The RDoC Framework: Facilitating Transition from ICD/DSM to Dimensional Approaches that Integrate Neuroscience and Psychopathology." *World Psychiatry* 13, no. 1: 28–35. https://doi.org/10.1002/wps.20087.

Decker, Hannah S. 2013. *The Making of DSM-III: A Diagnostic Manual's Conquest of American Psychiatry*. New York: Oxford University Press.

Doust, Jenny, Per O. Vandvik, Amir Qaseem, Reem A. Mustafa, Andrea R. Horvath, Allen Frances, Lubna Al-Ansary, et al. 2017. "Guidance for Modifying the Definition of Diseases: A Checklist." *JAMA Internal Medicine* 177, no. 7: 1020–1025. https://doi.org/10.1001/jamainternmed.2017.1302.

Drescher, Jack. 2015. "Out of DSM: Depathologizing Homosexuality." *Behavioral Sciences* 5, no. 4: 565–575. https://doi.org/10.3390%2Fbs5040565.

First, Michael B., Tahilia J. Rebello, Jared W. Keeley, Rachna Bhargava, Yunfei Dai, Maya Kulygina, Chihiro Matsumoto, Rebeca Robles, Anne-Claire Stona, and Geoffrey M. Reed. 2018. "Do

Mental Health Professionals Use Diagnostic Classifications the Way We Think They Do? A Global Survey." *World Psychiatry* 17, no. 2: 187–195. https://doi.org/10.1002/wps.20525.

First, Michael B., Geoffrey M. Reed, Steven E. Hyman, and Shekhar Saxena. 2015. "The Development of the ICD-11 Clinical Descriptions and Diagnostic Guidelines for Mental and Behavioural Disorders." *World Psychiatry* 14, no. 1: 82–90. https://doi.org/10.1002/wps.20189.

First, Michael B., Venkat Bhat, David Adler, Lisa Dixon, Beth Goldman, Steve Koh, Bruce Levine, David Oslin, and Sam Siris. 2014. "How Do Clinicians Actually Use the Diagnostic and Statistical Manual of Mental Disorders in Clinical Practice and Why We Need to Know More." *Journal of Nervous and Mental Disease* 202, no. 12: 841–844. https://doi.org/10.1097/nmd.0000000000000210.

Garb, Howard N. 2005. "Clinical Judgment and Decision Making." *Annual Review of Clinical Psychology* 1, no. 1: 67–89. https://doi.org/10.1146/annurev.clinpsy.1.102803.143810.

Global Initiative for Chronic Obstructive Lung Disease. 2019. *Global Strategy for the Diagnosis, Management, and Prevention of Chronic Obstructive Pulmonary Disease*. https://goldcopd.org/wp-content/uploads/2018/11/GOLD-2019-v1.7-FINAL-14Nov2018-WMS.pdf.

Glock, Hans-Johann. 2002. "Does Ontology Exist?" *Philosophy* 77, no. 2: 235–260. https://doi.org/10.1017/S0031819102000268.

———. 2003. *Quine and Davidson on Language, Thought, and Reality*. Cambridge: Cambridge University Press.

———. 2015. "Meaning and Rule Following." In *International Encyclopedia of the Social and Behavioral Sciences,* edited by Neil J. Smelser and Paul B. Baltes, 841–849. 2nd edition. Oxford: Elsevier.

Glüer, Kathrin, Åsa Wikforss, and Marianna B. Ganapini. 2022. "The Normativity of Meaning and Content." In *Stanford Encyclopedia of Philosophy,* edited by Edward N. Zalta. https://plato.stanford.edu/entries/meaning-normativity/.

Guloksuz, S. and J. van Os. 2018. "The Slow Death of the Concept of Schizophrenia and the Painful Birth of the Psychosis Spectrum." *Psychological Medicine* 48, no. 2: 229–244. https://doi.org/10.1017/S0033291717001775.

———. 2019. "Renaming Schizophrenia: 5 × 5." *Epidemiology and Psychiatric Sciences* 28, no. 3: 254–257. https://doi.org/10.1017/S2045796018000586.

Hacking, Ian. 2007. "Natural Kinds: Rosy Dawn, Scholastic Twilight." *Royal Institute of Philosophy Supplement* 61: 203–239. https://doi.org/10.1017/S1358246100009802.

Halpin, Michael. 2016. "The DSM and Professional Practice: Research, Clinical, and Institutional Perspectives." *Journal of Health and Social Behavior* 57, no. 2: 153–167. https://doi.org/10.1177/0022146516645637.

Hyman, Steven E. 2010. "The Diagnosis of Mental Disorders: The Problem of Reification." *Annual Review of Clinical Psychology* 6, 155–179. https://doi.org/10.1146/annurev.clinpsy.3.022806.091532.

Jablensky, Assen John McGrath, Helen Herrman, David Castle, Oye Gureje, Mandy Evans, Vaughan Carr, Vera Morgan, Ailsa Korten, and Carol Harvey. 2000. "Psychotic Disorders in Urban Areas: An Overview of the Study on Low Prevalence Disorders." *Australian and New Zealand Journal of Psychiatry* 34, no. 2: 221–236. https://doi.org/10.1080/j.1440-1614.2000.00728.x.

Kendell Robert E. 1991. "Schizophrenia: A Medical View of a Medical Concept." In *What Is Schizophrenia?,* edited by William F. Flack, Morton Wiener, and Daniel R. Miller, 59–72. New York: Springer. https://doi.org/10.1007/978-1-4613-9157-9_5.

Kendler, Kenneth S. 2016. "The Nature of Psychiatric Disorders." *World Psychiatry* 15, no. 1: 5–12. https://doi.org/10.1002/wps.20292.

Kendler K.S., D. Kupfer, W. Narrow, K. Phillips and J. Fawcett. 2009. "Guidelines for Making Changes to DSM-V." Unpublished manuscript. Washington, DC: American Psychiatric Association. https://web.archive.org/web/20160402065255/http://www.dsm5.org/ProgressReports/Documents/Guidelines-for-Making-Changes-to-DSM_1.pdf.

Keshavan, Matcheri S., Henry A. Nasrallah, and Rajiv Tandon. 2011. "Moving Ahead with the Schizophrenia Concept: From the Elephant to the Mouse." *Schizophrenia Research* 127, nos. 1–3: 3–13. https://doi.org/10.1016%2Fj.schres.2011.01.011.

Kinderman, Peter, John Read, Joanna Moncrieff, and Richard P Bentall. 2013. "Drop the Language of Disorder." *Evidence-Based Mental Health* 16, no. 1: 2–3. https://doi.org/10.1136/eb-2012-100987.

Kraemer, Helena Chmura. 2015. "Research Domain Criteria (RDoC) and the DSM: Two Methodological Approaches to Mental Health Diagnosis." *JAMA Psychiatry* 72, no. 12: 1163–1164. https://doi.org/10.1001/jamapsychiatry.2015.2134.

Kriegel, Uriah. 2013. "The Epistemological Challenge of Revisionary Metaphysics." *Philosophers' Imprint* 13, no. 12: 1–30. http://hdl.handle.net/2027/spo.3521354.0013.012.

Lasalvia, Antonio, Elena Penta, Norman Sartorius, and Scott Henderson. 2015. "Should the Label 'Schizophrenia' Be Abandoned?" *Schizophrenia Research* 162, nos. 1–3: 276–284. https://doi.org/10.1016/j.schres.2015.01.031.

Lawrie, Stephen M. 2016. "'Schizophrenia' Is a Useful Concept." *British Medical Journal* 352. https://doi.org/doi:10.1136/bmj.i1046.

Moncrieff, Joanna and Hugh Middleton. 2015. "Schizophrenia: A Critical Psychiatry Perspective." *Current Opinion Psychiatry* 28, no. 3: 264–268. https://doi.org/10.1097/yco.0000000000000151.

Murphy, Dominic. 2015. "Validity, Realism, and Normativity." In *Alternative Perspectives on Psychiatric Classification: DSM, ICD, RDoC, and Beyond,* edited by Peter Zachar, Drozdstoj Stoyanov, Massimiliano Aragona, and Assen Jablensky, 60–75. Oxford: Oxford University Press.

National Geographic. 2016. "The Plague." https://web.archive.org/web/20170309164327/https://www.nationalgeographic.com/science/health-and-human-body/human-diseases/the-plague/.

Plunkett, David. 2015. "Which Concepts Should We Use? Metalinguistic Negotiations and the Methodology of Philosophy." *Inquiry* 58, no. 7: 1–47. http://dx.doi.org/10.1080/0020174X.2015.1080184.

Plunkett, David and Timothy Sundell. 2013. "Disagreement and the Semantics of Normative and Evaluative Terms." *Philosophers' Imprint* 13, no. 23: 1–37. http://hdl.handle.net/2027/spo.3521354.0013.023.

Price, Huw. 2009. “Metaphysics after Carnap: The Ghost Who Walks?” In *Metametaphysics: New Essays on the Foundations of Ontology,* edited by David Chalmers, David Manley, and Ryan Wasserman, 320–346. Oxford: Oxford University Press.

Radden, Jennifer. 2019. “Mental Disorder (Illness).” In *Stanford Encyclopedia of Philosophy,* edited by Edward N. Zalta. https://plato.stanford.edu/archives/sum2019/entries/mental-disorder/.

Reznek, Lawrie. 1987. *The Nature of Disease*. London: Routledge & Kegan Paul.

Saatsi, Juha. 2017. “Explanation and Explanationism in Science and Metaphysics.” In *Metaphysics and the Philosophy of Science: New Essays,* edited by Matthew H. Slater and Zanja Yudell, 163–192. Oxford: Oxford University Press.

Sadler, John Z. 2013. “Values in Psychiatric Diagnosis and Classification.” In *The Oxford Handbook of Philosophy and Psychiatry,* edited by K.W.M. Fulford, Martin Davies, Richard Gipps, George Graham, John Sadler, Giovanni Stanghellini, and Tim Thornton, 753–778. Oxford: Oxford University Press.

Sadler, John, Joseph F. Hulgus, and George John Agich. 2001. “Hindsight, Foresight, and Having It Both Ways: A Rejoinder to R.L. Spitzer.” *Journal of Nervous and Mental Disease* 189, no. 8: 493–497. https://doi.org/10.1097/00005053-200108000-00001.

Shorter, Edward. 2015. *What Psychiatry Left out of the DSM-5: Historical Mental Disorders Today*. New York: Routledge.

Spitzer, Robert L. 2001. “Values and Assumptions in the Development of DSM-III and DSM-III-R: An Insider’s Perspective and a Belated Response to Sadler, Hulgus, and Agich’s ‘On Values in Recent American Psychiatric Classification.” *Journal of Nervous and Mental Disease* 189, no. 6: 351–359. http://dx.doi.org/10.1097/00005053-200106000-00002.

Spitzer, Robert L. and Joseph L. Fleiss. 1974. “A Re-analysis of the Reliability of Psychiatric Diagnosis.” *British Journal of Psychiatry* 125, no. 587: 341–347. https://doi.org/10.1192/bjp.125.4.341.

Stanford, P. Kyle. 2017. “So Long, and Thanks for All the Fish: Metaphysics and the Philosophy of Science.” In *Metaphysics and the Philosophy of Science: New Essays,* edited by Matthew H. Slater and Zanja Yudell, 127–140. Oxford: Oxford University Press.

Szasz, Thomas S. 1960. “The Myth of Mental Illness.” *American Psychologist* 15, no. 2: 113–118. https://psycnet.apa.org/doi/10.1037/h0046535.

———. 1988. *Schizophrenia: The Sacred Symbol of Psychiatry*. 2nd, revised edition. New York: Syracuse University Press.

———. 2011 [1961]. *The Myth of Mental Illness: Foundations of a Theory of Personal Conduct*. Revised edition. New York: HarperCollins.

Tamminga, Carol A., Godfrey D. Pearlson, Ana D. Stan, Robert D. Gibbons, Jaya Padmanabhan, Matcheri Keshavan, and Brett A. Clementz. 2017. “Strategies for Advancing Disease Definition Using Biomarkers and Genetics: The Bipolar and Schizophrenia Network for Intermediate Phenotypes.” *Biological Psychiatry: Cognitive Neuroscience and Neuroimaging* 2, no. 1: 20–27. https://doi.org/10.1016/j.bpsc.2016.07.005.

Thomasson, Amie L. 2008. “Existence Questions.” *Philosophical Studies* 141, no. 1: 63–78. https://doi.org/10.1007/s11098-008-9263-8.

———. 2009. “The Easy Approach to Ontology.” *Axiomathes* 19, no. 1: 1–15. http://dx.doi.org/10.1007/s10516-008-9057-9.

———. 2014. *Ontology Made Easy*. Oxford: Oxford University Press.

———. 2016. “Carnap and the Prospects for Easy Ontology.” In *Ontology after Carnap,* edited by Stephan Blatti and Sandra Lapointe, 122–142. Oxford: Oxford University Press.

———. 2017a. “Metaphysical Disputes and Metalinguistic Negotiation.” *Analytic Philosophy* 58, no. 1: 1–28. https://doi.org/10.1111/phib.12087.

———. 2017b. “Metaphysics and Conceptual Negotiation.” *Philosophical Issues* 27, no. 1: 364–382. https://doi.org/10.1111/phis.12106.

Van Os, Jim. 2016. “‘Schizophrenia’ Does Not Exist.” *British Medical Journal*, 352. https://doi.org/doi:10.1136/bmj.i375.

Wedge, Marilyn. 2018. “Is ADHD Real?” *Psychology Today,* 24 March. https://www.psychologytoday.com/au/blog/suffer-the-children/201803/is-adhd-real.

Whiting, Daniel. 2016. “What Is the Normativity of Meaning?” *Inquiry* 59, no. 3: 219–238. https://doi.org/10.1080/0020174X.2013.852132.

Whooley, Owen. 2010. “Diagnostic Ambivalence: Psychiatric Workarounds and the Diagnostic and Statistical Manual of Mental Disorders.” *Sociology of Health & Illness* 32, no. 3: 452–469. https://doi.org/10.1111/j.1467-9566.2010.01230.x.

Woodward, James. 2014. “Methodology, Ontology, and Interventionism.” *Synthese* 192: 3577–3599. https://doi.org/10.1007/s11229-014-0479-1.

———. 2017. “Interventionism and the Missing Metaphysics. In *Metaphysics and the Philosophy of Science: New Essays,* edited by Matthew H. Slater and Zanja Yudell, 193–225. Oxford: Oxford University Press.

WHO (World Health Organization) 1993. *The ICD-10 Classification of Mental and Behavioural Disorders: Diagnostic Criteria for Research*. Geneva: WHO.

———. 2017. “Lassa Fever.” https://www.who.int/news-room/fact-sheets/detail/lassa-fever.

Zachar, Peter and Assen Jablensky. 2015. “Introduction: The Concept of Validation in Psychiatry and Psychology.” In *Alternative Perspectives on Psychiatric Classification: DSM, ICD, RDoC, and Beyond,* edited by Peter Zachar, Drozdstoj Stoyanov, Massimiliano Aragona, and Assen Jablensky, 3–24. Oxford: Oxford University Press.

Zachar, Peter and Kenneth S. Kendler. 2014. “A Diagnostic and Statistical Manual of Mental Disorders History of Premenstrual Dysphoric Disorder.” *Journal of Nervous and Mental Disease* 202, no. 4: 346–352. https://doi.org/10.1097/nmd.0000000000000128.

Zimmerman, Mark. 2016. “A Review of 20 Years of Research on Overdiagnosis and Underdiagnosis in the Rhode Island Methods to Improve Diagnostic Assessment and Services (MIDAS) Project.” *Canadian Journal of Psychiatry* 61, no. 2: 71–79. https://doi.org/10.1177/0706743715625935.

Zipursky, Robert B., Thomas J. Reilly, and Robin M. Murray. 2013. “The Myth of Schizophrenia as a Progressive Brain Disease.” *Schizophrenia Bulletin* 39, no. 6: 1363–1372. https://doi.org/10.1093/schbul/sbs135.