Escritos de Psicología
Psychological Writings

Vol. 18, nº 2, pp. 113-122
Julio-Diciembre 2025
https://doi.org/10.24310/escpsi.18.2.2025.20821

Epistemology of mental disorders: a transversal perspective from naturalistic and constructivist metaphysics and the pragmatic approach

Epistemología de los trastornos mentales: una perspectiva transversal desde la metafísica naturalista y constructivista y el enfoque pragmático

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Abstract

Can we affirm that the current nosologies for mental disorders are accurate? In this paper, I present a concise epistemological review related to mental disorders and their conceptualization from three positions within the philosophy of mind. First, I address the naturalistic approach, delving into Szasz's eliminativist view, Boorse's biostatistical account, and the Wakefield's harmful dysfunction, while also highlighting main challenges to this approach. Second, I analyze the constructivist approach and the arguments provided to critique and oppose the naturalistic perspective, as well as pointing out its weaknesses. Third, I outline the pragmatic approach, whose considerations help transcend the dialectic and confrontations between naturalistic reductionism and sociocultural constructivism. Lastly, I summarize the main conclusions and directly respond to the primary question of this paper.

Keywords: clinical psychology, mental disorders, ontology, philosophy of medicine, psychiatry

Resumen

¿Podemos afirmar que las nosologías actuales para los trastornos mentales son correctas? En este artículo, presento una minuciosa revisión epistemológica relacionada con los trastornos mentales y su conceptualización desde tres posiciones de la filosofía de la mente. Primero, abordo el enfoque naturalista, profundizando en la visión eliminativista de Szasz, la explicación bioestadística de Boorse y el modelo de disfunción dañina de Wakefield, a la vez que destaco las críticas generales dirigidas a este enfoque. En segundo lugar, analizo el enfoque constructivista y los argumentos propuestos para criticar y oponerse a la perspectiva naturalista, señalando también sus debilidades. En tercer lugar, expongo el enfoque pragmático, cuyas consideraciones ayudan a trascender la dialéctica y las confrontaciones entre el reduccionismo naturalista y el constructivismo sociocultural. Finalmente, resumo las principales conclusiones y respondo directamente a la pregunta principal de este artículo.

Palabras clave: psicología clínica, trastornos mentales, ontología, filosofía de la medicina, psiquiatría

Cómo citar: Romero-Castillo, J. (2025). Epistemology of mental disorders: a transversal perspective from naturalistic and constructivist metaphysics and the pragmatic approach. *Escritos de Psicología – Psychological Writings, 18*(2), 113-122. https://doi.org/10.24310/escpsi.18.2.2025.20821

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Escritos de Psicología – Psychological Writings es una revista *Diamond Open Access* publicada por la Facultad de Psicología y Logopedia de la Universidad de Málaga
ISSN: 1989-3809 | @PsyWritings | revistas.uma.es/index.php/espsi

Introduction

Within the Philosophy of Medicine, an ontological debate emerges concerning maladaptive behaviors, or deviations from "normality", exhibited by some individuals in all or most of their contexts. These behaviors challenge the traditional boundaries of what is considered "normal" and raise questions about the nature of mental disorders. According to the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), a mental disorder is defined as a syndrome that must meet the following elements: a clinically significant disturbance in an individual's cognitive state, emotional regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental function, and that is usually associated with significant distress or disability in social, occupational, or other important activities (American Psychiatric Association [APA], 2013). This definition highlights the complexity and multifaceted nature of mental disorders, which cannot be fully encapsulated by a single definition but must meet certain criteria, such as significant distress or impairment in social, occupational, or other important areas of functioning. Alongside this conceptualization, it is later clarified that stress associated with the death of a loved one and socially anomalous behaviors (political, religious, or sexual) are not mental disorders (APA, 2013). This distinction is critical in avoiding the pathologization of behaviors that deviate from societal norms but do not constitute a disorder *per se*.

It is necessary to highlight that this conceptualization, and the rest of the conceptualizations of mental disorder provided by the various versions of the DSM, are not without controversy. The DSM has a profound impact on what is considered "normal" or "abnormal" behavior, which in turn affects treatment decisions, insurance coverage, and social stigma. One of the key criticisms is that the DSM tends to pathologize a wide range of human behaviors, potentially leading to over-diagnosis and unnecessary treatment (Bingham & Banner, 2014). Moreover, the DSM fails to offer a robust theoretical framework that adequately distinguishes between mental disorders and other forms of distress or deviant behavior. This lack of a clear and consistent definition raises ethical concerns about the potential for subjective interpretation and cultural bias in diagnosing mental disorders. In other words, it is problematic for an influential tool like the DSM not to offer any "satisfying" definition of mental disorder (Gagné-Julien, 2021).

Beyond the definitional issues and the classificatory system rooted in the biomedical model, a deeper philosophical debate emerges: is the diagnosis of a mental disorder grounded in objective natural facts or shaped by contingent social norms? This question lies at the heart of a broader discussion about the concept of "disease" in Medicine. Within the biomedical paradigm, diseases are typically regarded as deviations from normal biological functioning, identifiable through empirical investigation and treatable through medical intervention. Yet, mental disorders resist straightforward classification within this framework. Their complex etiology (often involving an intricate interplay of biological, psychological, and sociocultural factors) challenges the assumption that they can be understood solely as natural kinds (Wakefield, 1992). This tension raises a critical epistemological question: to what extent do current nosological systems for mental disorders reflect underlying realities, rather than constructed categories informed by normative judgments? In other words: can we affirm that the current nosologies for mental disorders are accurate? Here, the term «disease» will be used to emphasize a strictly medical or biological orientation, whereas «disorder» will refer specifically to mental conditions. Additionally, the term «illness» will be employed to maintain a neutral stance between these perspectives. At a later stage, a conceptual discussion will be introduced on the distinctions between disease, illness, and sickness, as articulated by Hofmann (2002), in order to enrich the central philosophical debate addressed herein.

In this regard, psychiatry and psychology are the two clinical disciplines that address mental disorders. Both disciplines share a clinical focus on alleviating suffering and promoting well-being. Yet they do so from different methodological and epistemological standpoints. Psychiatry is a specialty of medicine and, therefore, differs from Psychology in that it can and does use medications to treat mental disorders—used in the same sense as it is with physical diseases. In contrast, psychology (with reference to the branch that focuses on individuals with mental disorders, known as clinical psychology) typically addresses these disorders through psychotherapeutic interventions (predominantly cognitive-behavioral) that aim to analyze and modify individual behavioral patterns and subjective experiences, without using medications (Hollon et al., 2006; Nakao et al., 2021). These distinct frameworks reflect not only divergent clinical practices but also deeper ontological assumptions about the nature of mental disorders, which become especially relevant in the philosophical debate between naturalism and constructivism. This point will be examined in connection with the main objective of this work, namely to ontologically debate the concept of mental disorder from the perspectives of naturalism, constructivism, and pragmatism.

Naturalistic approach

The naturalist approach, also known as objectivism, holds that mental disorders, like the concept of health, are predominantly driven by natural categories and objective facts related to biological function and dysfunction, and that they exist independently of social values and norms and can thus be determined (Aftab, 2017). This approach falls within a broader tradition in the philosophy of medicine that seeks to identify and classify diseases in terms of quantifiable and verifiable deviations from an optimal biological state. By emphasizing the biological and physiological aspects of mental disorders, naturalism proposes that these disorders can be studied, diagnosed, and treated similarly to physical diseases, using the tools and methods of biomedical sciences. This implies that mental disorders have a basis in specific biological dysfunctions, such as neurochemical imbalances, genetic abnormalities, or developmental brain

dysfunctions. The scientific literature reveals that there is no clear consensus on whether this is the position accepted by the majority of active biomedical science professionals. Some authors, such as Kenneth Kendler (2016), argue that the naturalist approach remains influential among scientists and clinicians, who view mental disorders as natural dysfunctions that can be objectively identified and treated. On the other hand, other authors argue that few people claim that currently available psychiatric taxonomies accurately classify natural mental disorders. Peter Zachar (2015) points out that although psychiatry has made significant advances in understanding the biological mechanisms underlying certain disorders, there is still considerable uncertainty as to whether these disorders correspond to well-defined natural categories. This critique of naturalism suggests that although mental disorders may have biological components, their classification and understanding are inevitably influenced by cultural, historical, and social factors, complicating any attempt to categorize them as purely natural entities.

The literature review has identified three main branches of the naturalist approach, which are: Szasz's eliminative view, Boorse's biostatistical theory, and Wakefield's harmful dysfunction (Aftab, 2017; Kingma, 2013). It is crucial to recognize that these differences reflect the internal tensions within naturalism itself.

Szasz's eliminativist vision

Thomas Szasz was one of the most radical critics of the concept of mental disorder. His reasoning has been interpreted as reflecting the influence of positivism, Enlightenment rationalism, and a general adherence to Cartesian dualism (Kelly et al., 2014). According to Szasz, the mind, being non-physical, cannot be afflicted by illness in the same way as the body. As he stated, "the error lies in making a symmetrical dualism between mental and physical (or bodily) symptoms" (Szasz, 1960, p. 114). He famously labeled mental disorders as a "myth", asserting that these conditions are not "real" in the medical sense. His reasoning can be broken down into a logical syllogism (Kingma, 2013):

Premise 1. (Naturalist premise): What constitutes a disorder is a dysfunction or injury at the structural, cellular, or molecular level.

Premise 2. (Empirical premise): Mental disorders occur without such physical injuries.

Conclusion: Mental disorders do not exist.

Szasz considered it illegitimate to use the term disorder to refer to mental problems, labeling them as human conflicts, problems in life, and deviations from psychosocial, ethical, and legal norms (Szasz, 1960; Kelly et al., 2010). He is regarded as a central figure in the anti-psychiatry movement, along with David Cooper, Franco Basaglia, and Ronald D. Laing, for criticizing the moral and scientific foundations of psychiatry. These critics argue that psychiatry, under the guise of medicine, creates diagnostic labels that serve as tools of social control, effectively pathologizing behaviors and experiences that deviate from societal norms. They contend that these labels are used to marginalize, isolate, and stigmatize individuals who do not conform to expected social behaviors. However, this perspective tends to overlook a crucial point: medical classifications, including those in psychiatry, are fundamentally methodological tools. While it is true that psychiatry (and medicine) has a history marred by instances of misuse and unethical practices, the primary goal of psychiatric diagnoses is to provide a systematic way of identifying and treating symptoms that are real and distressing to the patient. According to critics of Szasz's view, the denial of the existence of mental disorders ignores the neurobiological evidence that increasingly links these conditions to dysfunctions at the molecular or structural level of the brain, such as abnormalities in neurotransmitter systems. A diagnosis of a mental disorder refers to a grouping of specific symptoms that are experienced as real by the patient and must be medically addressed (Saborido, 2020).

However, his primary error becomes evident in his flawed premise: asserting that a biological dysfunction can only manifest as a physical injury. In other words, he fails to accept that mental disorders can be associated with neurobiological dysfunctions at the structural, cellular, or molecular level (e.g., in neurotransmitters). Szasz's argument is an intriguing case, as it also reflects a broader tension between naturalist and constructivist approaches within medicine. While he embraced a naturalist view regarding physical diseases—seeing them as objective entities rooted in biological dysfunction—he adopted a constructivist stance on mental disorders, viewing them as constructs of societal norms rather than genuine medical conditions. This dichotomy highlights a fundamental inconsistency in his philosophy, particularly in his refusal to acknowledge that mental disorders can have a biological basis even if they do not manifest as overt physical injuries (Aftab, 2017). It is important to note that Szasz wrote his essay in the 1960s, based on the contemporary knowledge available at that time (Kingma, 2013).

Boorse's biostatistical theory

Christopher Boorse, possibly the most well-known and influential philosopher of Medicine, argues that mental disorders can be defined entirely scientifically and objectively without resorting to value judgments (Aftab, 2017). Boorse's most influential contribution is his Biostatistical Theory (BST), which he first proposed in the late 1970s. He proposed the most widely accepted and discussed naturalist explanation of mental disorders, which can be summarized as "health is the absence of ailment". In his explanation, two key points are highlighted (Boorse, 1977):

1. Disease as dysfunction. Boorse defines disease as an internal state that causes a reduction in an organism's ability to perform one or more of its biological functions with typical efficiency. He suggests that this dysfunction must be caused by environmental agents or internal malfunctions.
2. Health as statistical normality. Health, in Boorse's framework, is the state in which an organism's biological functions operate within the range of typical efficiency for its species, age, and sex. This perspective implies that health is the statistical norm, while disease represents a deviation from this norm. That is, health is a normal function that contributes to survival and reproduction, while a disorder is a deviation from such contribution.

Boorse's framework has been widely discussed and debated, with significant implications for how mental disorders are classified and understood. His view suggests that mental disorders are just as susceptible to scientific analysis as physical diseases, a position that has influenced both medical practice and philosophical debates about the nature of mental health. However, several objections have been raised against his account. First, statistical rarity is neither necessary nor sufficient to define a mental disorder, since highly prevalent conditions such as anxiety or depression would then fall outside the pathological domain. Moreover, Boorse fails to define reference classes objectively, leading to a circular reasoning: biological function is determined by the reference class, but the reference class itself is defined in terms of presumed functions (Binney, 2024). Additionally, there is no clear, non-arbitrary statistical threshold for normality, particularly regarding psychological traits, which further undermines the claim to objectivity in defining disorder (Doust et al., 2017).

Furthermore, Boorse does not entirely eliminate value judgments from his framework, despite his naturalist intentions (Aftab, 2017). The example of homosexuality illustrates this problem: from the standpoint of the general population, it may appear to deviate from reproductive norms; however, within the reference class of homosexual individuals, it constitutes a statistically normal variation. This dilemma (identifying the "correct" reference class) extends to many conditions and reveals an implicit normative dimension. Likewise, the fact that Boorse's theory could classify fertility suppression by contraceptive pills as an ailment exposes its counterintuitive consequences. Additionally, it has been argued that Boorse's postulates are unsustainable in a modern context, where human mental life is no longer solely oriented toward survival and reproduction, undermining the idea that such functions can serve as a universal criterion for normality (Kingma, 2013). In this sense, it has been proposed that disease is better understood not merely as statistical dysfunction, but as an undesirable condition—an outcome of bad luck that warrants medical intervention (Cooper, 2002). Such perspectives underscore the limitations of a purely biostatistical model in capturing the full complexity of mental disorders.

As a counterargument to these criticisms and supporting Boorse's ideas, it has been considered that these critiques are not value-neutral either and do not offer an objective explanation of health, but rather a pluralistic and pragmatic stance, opening the possibility for the conception of health to vary with social context or evolve with society's values (Hershenov, 2020). BST remains a cornerstone of debates in the philosophy of medicine, particularly in discussions about the nature of mental disorders.

Wakefield's harmful dysfunction

Jerome Wakefield has emerged as a hybrid author between the two previous positions. Building on the work of Donald Franklin Klein (1978), which proposed a definition of mental disorder dependent on biological processes, he proposes the "harmful dysfunction" model, an evolutionary explanation for mental disorders that requires both a value criterion and a factual criterion. That is, the condition must be harmful according to the culture to which the person belongs, and there must be a biological dysfunction independent of any value, implying the disruption of both social and biological order (Wakefield, 1992). Wakefield defines dysfunction as the failure of a mental or behavioral mechanism to function as designed by evolution through natural selection (Wakefield, 2007).

This hypothesis is controversial because, for example, if we consider the case of a serial rapist, his behavior could be justified as a good strategy to increase the probability of reproduction, which is the goal of evolution, and in such a case, it cannot be considered a mental disorder. It is troubling that, in response to this criticism, Wakefield himself remained firm and reiterated that if such a condition is an effect of a trait that drove selection, then it is not a disorder, no matter how distasteful it might be (Kingma, 2013; Wakefield, 2000). This position raises ethical and philosophical concerns, as it seems to bypass the moral implications of behavior by focusing exclusively on its evolutionary function. Ignoring the fact that such a condition is not evolutionarily useful in any human society, one could even debate whether it appeals to a naturalistic fallacy, or not, since, at present, we cannot attribute sufficient consciousness to other non-human animals to allow them to distinguish between procreation and rape. By grounding dysfunction in evolutionary terms, Wakefield's model risks implying that evolved functions are inherently good or desirable, which is not necessarily the case. Just because a behavior or mental mechanism has an evolutionary purpose does not mean it aligns with societal values or individual well-being (Kingma, 2013).

The hypothesis of Wakefield is also uncertain because mental disorders may exist that do not have an underlying "evolutionary design" failure but lead to distress that justifies treatment. Furthermore, the dysfunction associated with a mental disorder can arise from a mismatch between the "evolutionary design" and the environment, and not as a failure of the "evolutionary design" itself, as a clear distinction between these origins cannot be made (Aftab, 2017).

Conditions such as specific phobias or anxiety disorders might represent mismatches between the human brain's evolved functions and the modern environment, rather than outright dysfunctions in evolutionary terms (Aftab, 2017). This view aligns with the mismatch hypothesis, which posits that the rapid changes in human environments over recent centuries may have outpaced the evolutionary adaptations of the brain, resulting in heightened sensitivity to modern stressors. This perspective suggests that some mental disorders may arise because the brain's "design" does not align well with contemporary demands, not necessarily because of any internal flaw in the mental or behavioral mechanism (Nesse, 2005).

Main challenges to the naturalist approach

One major challenge for naturalism lies in the continued failure to identify reliable biomarkers for any mental disorder. Despite decades of neuroimaging and genetic research, no specific biological markers have achieved diagnostic utility or replicable validity across populations (Stein et al., 2010; Insel et al., 2015). This absence undermines one of the core promises of biological psychiatry: that mental disorders are brain diseases identifiable through objective measures. Without such empirical grounding, the biological claims of naturalism remain aspirational rather than demonstrable.

Closely related to this limitation is the criticism of reductionism, whereby complex psychological, social, and existential experiences are explained solely through neurobiological mechanisms. This approach tends to neglect the first-person dimension of suffering and the narrative contexts in which symptoms emerge. As Kirmayer & Gold (2012) argue, the reduction of lived experience to brain dysfunction not only fails to capture the meaning of mental distress but also risks alienating patients from their own subjectivity. In clinical terms, this may lead to an over-reliance on pharmacological treatments and the marginalization of psychotherapeutic and psychosocial interventions.

In addition, naturalism often relies on categorical classification systems such as the DSM-5 or ICD-11, which—though indispensable for clinical and research purposes—have been widely criticized for their rigid boundaries, diagnostic inflation, and limited cultural sensitivity (Zachar, & Kendler, 2007). While naturalist approaches tend to assume that these classifications reflect natural kinds, empirical evidence suggests otherwise: many psychiatric (or psychological) syndromes exhibit substantial heterogeneity, comorbidity, and symptom overlap. This challenges the assumption that current nosological systems map onto stable biological entities.

A deeper philosophical concern lies in defining a clear, objective, and scientifically robust boundary between typical and atypical (normal and abnormal) human functioning—an issue that becomes particularly complex in the context of mental disorders (Aftab, 2017). In addressing this problem, Kendler (2016) turns to Kuhn (1992) and draws upon what has been termed the "pessimistic induction," a philosophical argument rooted in the works of Laudan (1981) within the realist tradition of the philosophy of science. This line of reasoning highlights how many scientific theories once accepted as true were eventually discarded, suggesting that our current conceptual frameworks—including those employed in mental disorders—may likewise prove transient. Crucially, this does not entail scientific defeatism but rather invites epistemic humility: an awareness that current diagnostic categories and theoretical models should not be mistaken for definitive ontological truths.

Kendler's application of this argument to psychiatry does not seek to reject naturalism outright, but to foster a more critical and provisional stance toward its metaphysical assumptions. In this sense, the pessimistic induction functions as a philosophical caution, warning against the reification of diagnostic constructs whose empirical and conceptual foundations remain unsettled. From this perspective, the constructivist approach does not emerge as an opponent to science, but as a complementary framework that foregrounds the historical and cultural contingencies shaping our understanding of mental disorders.

Constructivist approach

As previously noted, Thomas Szasz is the most extreme anti-psychiatric author of this movement. He conceives mental disorders from a radical constructivist perspective. Szasz published a work titled *The Myth of Mental Illness* to assert that the designation of mental problems is merely a label for life's problems (Szasz, 1960). From the previous naturalistic approach, Szasz's conception is understood as a speculative way to delegitimize the fields of psychiatry and psychology (Kendler, 2016). As Aftab (2017) notes, "Thomas Szasz is an intriguing case, as he is naturalist about physical disease but a constructivist about mental disorders" (p. 10). His position reflects a dual stance: accepting biological disease in the traditional sense, while rejecting the application of that model to mental phenomena (for a critical reflection on the major ideas and legacy of Thomas Szasz, see Benning, 2016).

This radical constructivist stance highlights not only epistemological tensions but also ethical and political concerns surrounding the biomedical model. Among these is the critique that medical authority can be used to legitimize the pathologization of behaviors that deviate from social norms. One of the most significant risks here is not solely theoretical, but also institutional: the commercial exploitation of psychiatric diagnoses. This concern is exemplified in the phenomenon known as *disease mongering*—a term coined by journalist Lynn Payer in 1992—which refers to the expansion of diagnostic boundaries for non-clinical purposes, often driven by pharmaceutical and market interests (Moynihan & Henry, 2006). It involves practices such as redefining thresholds of normality or exaggerating prevalence data in order to medicalize ordinary human experiences, thus fostering the consumption of psychotropic drugs.

The constructivist approach opposes naturalism (or objectivism) and posits that mental disorders are socially constructed labels. From this perspective, it is maintained that the concept of «disease» is normative and denies that a biological dysfunction can be identified independently of human values (Aftab, 2017). It is argued that the use of normative diagnostic tools (such as the DSM and the ICD) creates problems for individuals who fall outside the normative groups with which these manuals are constructed, such as non-Western cultures. However, the notion of mental disorder proposed by the American Psychiatric Association is not entirely criticized, as it has led to outstanding research findings and significant treatment innovations. Instead, the focus is on the fact that the nature of mental disorders is not well supported by cross-cultural psychopathological research. It is considered that context is vital for classification and diagnosis and that the perception of mental disorder is inextricably linked to customs and language, aspects that are not included in a typical diagnostic situation (van Riel, 2016).

For constructivism, the correct level of analysis is the “self”, the individual person, as the disorder manifests in observable experience and felt experience. It is not necessary to consider the actual etiology of the mental disorder (genetic, contextual—or a combination of both—, psychological, social, or spiritual), as the diagnosis of a mental disorder applies to the person, their thoughts, feelings, and behaviors (Banner, 2013). The importance of this constructivist understanding of mental disorder lies in the notion of a complex system with the “self” at the center. This is a system through which the various aspects of psychopathology interact, comprising biological, psychological, and socio-cultural variables, with direct interactions also existing among these variables. From this viewpoint, a mental disorder is a systemic collapse that involves the disruption of one or more aspects or levels of functioning, which in turn affects the system as a whole (Thakker et al., 1999).

The idea that biological, psychological, and social play a significant role in health and ailment is shared by the WHO definition, which posits that humans are biopsychosocial beings (APA, 2013), as originally proposed by George Engel (Engel, 1977). While this model appears to represent a synthesis of these three components of mental health, its epistemological orientation remains somewhat ambiguous. It does not explicitly adhere to a constructivist metaphysics, yet it clearly departs from a strictly naturalist position by recognizing that mental disorders are influenced by meaning, culture, and context. In this regard, the model may be understood as partially aligned with constructivist assumptions—particularly in its rejection of reductionism and its emphasis on contextualized diagnosis and intervention. However, the biopsychosocial model has also been criticized for its lack of theoretical coherence and operational specificity (Ghaemi, 2009), which has allowed it to be adapted pragmatically in ways that sometimes dilute its critical potential. Importantly, the constructivist reading of this model would not necessarily entail rejecting biological explanations but, rather integrating them into a pluralistic account of mental disorder—one that resists defining such disorders as natural kinds. Thus, the biopsychosocial model may be seen as occupying an intermediate position: compatible with certain aspects of constructivism—particularly its attention to meaning and context—but not reducible to it. It reflects an ecumenical strategy that pragmatically accommodates various levels of explanation, without necessarily committing to a single philosophical foundation. Clarifying this ambiguity is essential for understanding both the strengths and the limitations of this widely adopted framework.

Additionally, the biopsychosocial model recalls Lennart Nordenfelt’s holistic approach, whose core concept is the notion of well-being. The holistic theory states that a person is healthy if they feel well and can achieve in their environment what makes them happy (Saborido, 2020). However, concerning mental disorders, this theory fails to explain conditions such as pyromania, psychopathy, sadism, or pedophilia, to name a few examples. These disorders generate happiness in the person by producing well-being, but clearly, they do not constitute an appropriate adaptation to the environment, as such happiness would be based on the suffering of others. Thus, acting in ways that disregard the harm caused to others—even if such actions result in personal well-being—cannot be considered a sign of mental health. This observation underscores the necessity of including ethical and social dimensions in any framework for understanding mental disorder. Therefore, while the constructivist approach enriches the debate by emphasizing the normative and cultural underpinnings of diagnosis, it must also account for the relational and intersubjective dimensions of the self, particularly when personal well-being conflicts with collective harm.

A final and interesting approach to mental disorders from more traditional philosophy has proposed that psychiatry and psychology are committed to a practical and logical condition. Thus, the exploration of the ontology of mental disorders might be better approached using, for example, the Aristotelian perspective and its doctrine of the four causes. According to this analysis, the aim is to develop the social and cultural dimension of mental disorders in the contingencies of life (material cause), in the way the clinical condition itself serves as a model for “having an ailment” in society (formal cause), in individuals, the pharmaceutical industry, and the media (efficient cause), and in the different adaptive functions of the disorder (final cause) (Pérez-Álvarez et al., 2009).

In summary, the constructivist approach highlights the importance of the socio-cultural dimension, not only in the manifestation of mental disorders but also in their developmental course. It criticizes that this dimension is not fully addressed by the biomedical perspective of classical manuals. This approach could paraphrase Protagorean relativism: humans are the measure of all things.

Main challenges to the constructivist approach

Despite offering a valuable counterbalance to naturalistic models, the constructivist approach is not exempt from criticism. One major challenge is the risk of falling into relativism, where the notion of mental disorder becomes so dependent on sociocultural context that it undermines the possibility of establishing coherent diagnostic and treatment criteria across populations (Graham, 2010). Without a well-grounded phenomenological framework that enables intersubjective validation and systematic description, diagnostic categories may become idiosyncratic and clinically ambiguous, weakening both professional communication and the ability to design consistent therapeutic interventions. Such relativism may also hinder cross-cultural research, the development of global health policies, and the implementation of evidence-based treatment guidelines.

Moreover, constructivist approaches often underemphasize the role of neurobiological and genetic factors in psychopathology, which may result in an incomplete understanding of etiology and limit the development of effective biological interventions (Kendler, 2005). Recent research underscores the importance of integrating genomics and clinical neuroscience tools (electrophysiology or functional neuroimaging) to obtain relevant relationships between neural circuits and behaviors through models such as the Research Domain Criteria (RDoC), which attempt to bridge the gap between neuroscience and clinical practice (Insel et al., 2010).

Another concern lies in the challenge of ensuring that constructivist frameworks maintain both scientific rigor and operational utility. When diagnoses rely too heavily on subjective interpretation and lack empirical criteria, their clinical usefulness and reliability may be compromised (Parnas & Gallagher, 2015). In response to such concerns, some scholars advocate for a "weak" constructivism that acknowledges the influence of social norms while preserving the empirical foundations and taxonomic structure provided by medical models (Zachar & Kendler, 2007).

Pragmatic approach

In response to the metaphysical speculation associated with both the naturalistic and constructivist approaches, the pragmatic approach has emerged as an alternative. It remains close to instrumentalism, a stance in the philosophy of science that views concepts as "instruments" for understanding the world. In other words, this approach does not judge whether the categories encompassing mental disorders are "real" or not, but whether they work in practice (Kendler, 2016). Pragmatism does not make value judgments about whether the labels of mental disorders proposed by classical manuals (DSM and ICD) are naturalistic or constructivist; rather, they are useful as long as they improve people's lives. Pragmatic considerations can help transcend the dialectic and conflicts between naturalistic reductionism and sociocultural constructivism. Psychiatry and psychology must tolerate uncertainty in the absence of complete knowledge of mental disorders and strive to integrate rigorous, evidence-based explanatory concepts. It suggests embracing epistemological ambiguity and respecting the provisional nature of explanatory models, in addition to seeking favorable treatment outcomes for each patient (Brendel, 2003).

The philosopher George Agich has been one of the leading theorists of pragmatism related to mental disorders. He argues that both models are unsatisfactory for understanding the nature of mental disorders. His stance is even more critical of Boorse's naturalism. However, he does not seek to refute it but to show that the value of the diagnostic categories offered by the manuals is their practical importance, and this replaces concerns about metaphysics (Agich, 1997). Regarding the pessimistic induction argument, which criticizes the naturalistic approach, several perspectives could be added from the pragmatic approach to counter this argument. First, it is assumed by those who use these manuals that the labels do not have an undeniable neurobiological basis; similarly, it is understood that disorders, and the perception of such disorders by society, evolve with cultures. Second, the assumption that an ideal and perfect model of categorizing mental disorders may not exist should not hinder our approach to it, even though the interaction between psychophysiological function and sociocultural variables is highly complex. Third, and most importantly, the possibility that current knowledge may be proven false in the future, if guided by history, should not prevent the pursuit of the most appropriate treatment for mental disorders based on current knowledge. The advancement of science improves treatments, despite not making them unsurpassable, but they are useful for daily practice.

Ultimately, scientific taxonomy is a useful simplification device (Zachar, 2015), and the conceptual understanding of mental disorder is irrelevant for most clinical decisions. The pragmatic approach is a perspective that recognizes that labels acquire meaning in the context of their use and is characterized by adopting a pluralistic perspective. That is, each professional must decide which criterion (etiological—cause, mechanistic—underlying mechanism, or clinical—symptomatology) offers the best results for each case (Saborido, 2020).

Main challenges to the pragmatic approach

While the pragmatic approach offers a promising avenue to transcend the dialectical tension between naturalism and constructivism—by focusing on the utility of concepts in clinical contexts—it is not without significant criticism. One of the main concerns is that pragmatism, when overly focused on what "works" in clinical practice, may neglect fundamental ontological and epistemological questions about the nature of mental disorders. It is not merely a philosophical luxury to ask whether mental disorders are "real" or in what sense they exist. Rather, such questions are intrinsic to both scientific integrity and ethical responsibility. As Thornton (2007) asserts, philosophical reflection is not optional in psychiatry (and psychology), but necessary, as the discipline deals with human beings, values, and norms.

While a purely pragmatic stance may avoid speculative metaphysics in favor of practical clinical outcomes, this renunciation comes at a cost. Such avoidance can obscure the ethical and theoretical dimensions that are fundamental to how mental disorders are diagnosed, treated, and understood within society. Pragmatism's emphasis on what is clinically useful should not preclude deeper philosophical inquiry into the conceptual foundations of psychiatry. In fact, returning to concepts such as real, true, and objective is not only useful for reflecting on other notions central to psychopathology, but also essential in themselves as objects of philosophical analysis. To think philosophically about these metaphysical categories is to resist the flattening of psychiatry and psychology into mere utility, and to uphold its intellectual integrity as a science concerned with persons and meaning (Zachar, 2014).

Furthermore, pragmatism often presupposes a consensus about clinical aims—such as reducing suffering or restoring functionality—but these aims themselves require philosophical scrutiny. Who defines what counts as "functioning" or "suffering"? To what extent are these concepts shaped by cultural, political, or institutional values? If these foundations are left unexamined, the pragmatic approach risks uncritically reinforcing existing power structures or marginalizing alternative understandings of mental distress (Kirmayer & Gold, 2012).

Conclusions

The various approaches that have emerged from the philosophy of medicine to address mental disorders align with the understanding derived from research in psychiatry and psychology. In this regard, it is important to highlight two key aspects. First, if we place the research within a historical framework, we discover that it is relatively recent compared to the broader history of medical research. The first experimental psychology laboratory began operating under Wilhelm Wundt in the late 19th century (in 1879) at the University of Leipzig, Germany (with most of the work focusing on sensations and perceptions) (Ash, 1980). Just a few years later, in 1883, Emil Kraepelin, who worked with Wilhelm Wundt and is considered the founder of modern scientific psychiatry, established that psychiatric disorders have a fundamentally biological and genetic etiology and developed the first universal classification of mental disorders (Müller et al., 2006). In other words, scientific research on mental disorders has existed for only about 150 years. Second, most mental disorders have been shrouded in a veil of supernatural mysticism, leading people to believe that those afflicted were possessed by some strange, spiritual, or extraterrestrial entity (for example, in the case of epileptic seizures or hallucinations), and in many societies, this belief still persists (Rashed, 2020), which has hindered and continues to hinder the search for appropriate treatments to address these conditions. Thus, the concept of mental disorder and the need for a scientific approach are relatively recent developments, which may help explain the extreme positions and debates that arose among naturalists, constructivists, and pragmatists throughout the 20th century.

In relation to the main disputes between naturalists and constructivists, the debate could extend beyond the ontology of mental disorders and focus on the treatment of choice. From the constructivist perspective, it is criticized that, for naturalism, mental disorders must be "cured" with medications since they are biological and natural phenomena that exist independently of societies. However, this consideration should be directed toward psychiatry, not psychology, as it is the former discipline that has the authority to prescribe medications. Psychological treatments, because they focus on the functional analysis of the individual and primarily employ a cognitive-behavioral approach, could be considered more aligned with a constructivist approach. Considering these factors, the methodological differences between psychiatry and psychology in terms of treatment choice should be highlighted in the debates between naturalists and constructivists, with the aim of increasing epistemological rigor.

Continuing with the distinctions between naturalist and constructivist perspectives, Hofmann's (2002) triad—disease (biological dysfunction), illness (subjective experience), and sickness (social role)—provides a valuable conceptual lens for analyzing the nature of mental disorders. According to this framework, naturalism aligns mental disorders with the category of disease, emphasizing objective biological dysfunctions as their core. Constructivism, in contrast, primarily interprets them as illnesses, centered on the individual's subjective suffering, while also recognizing the influence of cultural and social norms (sickness) that define what is considered acceptable or pathological behavior (Saborido, 2020; Hofmann, 2002). These perspectives not only analyze the starting points of both approaches but also impact the treatment choices in psychiatry and psychology, as discussed in the previous paragraph. While psychiatry tends to adopt standardized, pharmacologically oriented treatments grounded in biological models, psychology (particularly clinical psychology) often relies on narrative-based and context-sensitive psychotherapeutic interventions, such as cognitive-behavioral therapy.

To conclude, the main question of this work is revisited: can we affirm that the current nosologies for mental disorders are accurate? Based on the review conducted, the answer cannot be definitively affirmative or negative. If we understand that the manuals offer a naturalistic or constructivist view of mental disorders, then it could be argued that they are not correct, as they have been modified over time, and it is highly doubtful that the current ones have reached their peak. On the other hand, if viewed from a practical standpoint, it could be concluded that they are correct, as they are the best way to identify deviant behaviors and contribute to better treatments to improve the population's mental health. However, it is clear that any advancement in the understanding of mental disorders will not close the epistemological debates between the various philosophical approaches.

Author notes
Acknowledgements: I would like to thank the reviewers for their valuable comments and suggestions, which helped improve the quality of this article. I am especially grateful to Cristian Saborido, Full Professor, for his insightful feedback during an earlier presentation of this work.
Funding: The author has no funding to disclose.
Competing Interest: The author declares that he has no conflict of interest to disclose.

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RECIBIDO: 11 de noviembre de 2025
MODIFICADO: 2 de agosto de 2025
ACEPTADO: 5 de agosto de 2025