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Diagnosis and Ideal Types: A Contribution to Psychiatric Classification

Michael Alan Schwartz and Osborne P. Wiggins

Most recent discussions of classification and diagnosis in psychiatry ignore the underlying methodologic and philosophic issues. The authors directly address these issues by redefining a classical approach that was already employed in psychiatry by Karl Jaspers in his *General Psychopathology*. This conceptual approach, termed "ideal types," was first developed by the sociologist Max Weber. Many diagnostic entities of clinical psychiatry, such as schizophrenia, manic-depressive illness, and the various neuroses and personality disorders, can be best conceived, the authors argue, as ideal types. After contrasting ideal types with monothetic and polythetic concepts, the authors show how ideal types provide a scientific vocabulary that is capable of both guiding the practice of the clinician and of structuring the investigations of the Researcher.

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PSYCHIATRIC CLASSIFICATIONS provide us with ways of conceiving mental disorders. If we inquire into the best ways to conceive mental disorders, however, we encounter debates regarding methodology that have raged for many decades in the human sciences.¹⁻⁶ Surveying such long-winded debates, some people have been tempted to bypass them altogether by selecting one conceptual framework without bothering to consider alternatives. Yet the fact remains that there exist alternative ways for conceiving human realities.

Many psychiatrists have managed thus far to skirt these manifold options by viewing their field as included within medicine, but by viewing medical science within a narrow context.

Medicine is presumed to become more scientific when it develops causal explanations and mathematical models, quantifies its data, and operationalizes its concepts.^{7,8} This view assumes that the paradigmatic science is physics and that the paradigmatic method is mathematics. And, moreover, it assumes that ultimately all of the biopsychosocial components of illness should be conceived through these paradigmatic approaches. To the extent that this view is criticized as too restrictive, its critics frequently contend that it still understands mathematical sciences as Newtonian mechanics and that this antiquated understanding will have to be superseded by an appreciation of more modern approaches, such as quantum physics or information and cybernetic theory.^{9,10}

Such a conception of scientific progress is strongly influenced by the positivistic spirit of the last 100 years. This spirit distinguishes sharply between what can qualify as "hard science" and what remains too "soft-minded" to deserve this honorific label. Especially during the past several decades, this positivistic spirit reigned while psychiatry was increasingly attacked as pseudo-scientific or entirely unscientific. During the 1960s and 1970s much of this attack was aimed at psychiatric diagnosis and categorization.¹¹⁻¹³ Furthermore, these criticisms found a vulnerable target insofar as a scientific approach to psychiatric nosology had indeed been neglected for decades. The revisions of nosology undertaken in Diagnostic and Statistical Manual of Mental Disorders (ed. 3) (DSM-III) provided psychiatry with a timely opportunity to enhance its scientific credentials as well as to respond to these disturbing critiques.^{16,17} Out of this positivistic spirit we can appreciate the concerns of DSM-III: an approach to classification that is more descriptive and less theoretical than DSM-II, the operationalization of terminology, and the emphasis on reliability as the first step toward validity.¹⁸ It was never assumed that DSM-III would present a definitive and final classificatory system for psychiatry. It was rather hoped that it would initiate progress toward the genuinely scientific psychiatry of the future.¹⁸⁻²⁰ The boldness of this pioneering work represents a true landmark.

As we have maintained in an earlier article, however, this project was shaped by a particular philosophy of science, the positivistic philosophy of science known as "logical empiricism."²¹ We do not contend that the architects of DSM-III were knowingly committed to logical empiricism. We rather suspect that scientific methodology was not examined critically enough. And for this reason, the methodologic "spirit of the times" embodied in logical empiricism was able to play a dominant role. Logical empiricism expresses and defends the

unified conception of science we have described above: all sciences should aim at the development of causal-nomologic explanations and mathematical-logical models, the quantification of data, and the operationalization of concepts²²

Fortunately for psychiatry, one of the most important of the logical empiricists, Carl G. Hempel, was invited by the American Psychopathological Association in 1959 to explicate the basic issues of psychiatric classification.²³ Hempel presented his views during the era of DSM-I. We have described how these views are in fact embodied in DSM-III.²¹ And his essay, which remains a classic in the philosophic literature, could provide guidelines for future revisions of DSM-III should psychiatry choose knowingly to adopt the methodology of logical empiricism. We submit, however, that an alternative methodology of science would prove more fruitful.

The alternative we shall propose is found in the work of the great German social scientist. Max Weber. Although Weber himself used these methods primarily in historic sociology, they can, we contend, prove advantageous in psychiatry. This view is not ours alone, however. The eminent pioneering psychiatrist, Karl Jaspers, strictly adopted Weber's methods and applied them to nosology and to his classification of psychiatric disorders.²⁴ Moreover, Kurt Schneider, Jaspers' student and colleague, used these Weberian methods in his own work.^{25,26} Always respected on the European continent, Jaspers' ideas have become increasingly prominent in American psychiatry since the translation of his masterful *General Psychopathology* into English in 1963.²⁴ In Great Britain, Jaspers has exercised considerable influence, initially through Mayer-Gross, Slater, and Roth's *Clinical Psychiatry*,²⁷ More recently, Jaspers' importance is witnessed by the naming of volume I of the new British handbook of psychiatry *General Psychopathology*.²⁸ Yet today Jaspers' approach to nosology and classification continues to be ignored, even in Europe.

We contend that the methodology developed by Weber and Jaspers would prove more fruitful than Hempel's logical empiricism or the approach of DSM-III. In this essay we shall return to Weber's conception of ideal types and demonstrate its relevance for psychiatric classification and clinical practice.

In the last few years an approach that in several respects resembles that of Weber and Jaspers has been advanced under the label of prototypes. This orientation was developed by E. Rosch^{29,30} and was then applied to psychiatric diagnoses by N. Cantor, E.E. Smith, R. French, and others.³¹⁻³³ More recently, W. John Livesley endorsed this approach for the

classification of personality disorders in psychiatry.^{34,35} Without broaching areas of disagreement here, we hope that our discussion of ideal types will clarify some of the issues addressed by these other investigators.

PSYCHIATRY AS A PRACTICAL SCIENCE

Psychiatric classification systems must be evaluated in the light of their success in serving the basic underlying goals of psychiatry: *the promotion of mental health and the amelioration of mental illness*. Psychiatry always employs an extensive body of scientific knowledge. But this knowledge is subordinated to the practical goal of improving the lives of patients. This subordination of scientific knowledge to practical purposes makes psychiatry a practical discipline rather than a pure science.⁸

In the service of these practical goals, psychiatrists may avail themselves of a wide variety of ideas, techniques, instruments, and approaches. These procedures and concepts have diverse sources and justifications, but they prove useful in psychiatry if they help us understand and treat an individual patient. Following Wilhelm Windleband, Max Weber called such investigations of individual persons idiographic.¹ Idiographic investigations of human beings examine individuals precisely in their individuality and uniqueness. These inquiries are concerned with the individual qua individual. Therefore, the clinical understanding and treatment of individual patients is an idiographic task.

Idiographic inquiries can be contrasted with nomologic ones.^{1,2} Nomologic science is a knowledge of universal explanations. Nomologic research consists in the logical construction and the controlled empirical testing of general law-like regularities and systematic theories. In the idiographic investigations of clinical psychiatry, the aim of the investigation is the understanding and treatment of an individual. In nomologic investigations, on the other hand, individuals are viewed as examples or particular instances of general concepts and laws. Typical illustrations of nomologic research would be investigations into dose-response and time-action of new medications or into the causes of illness such as Alzheimer's disease. In such nomologic studies we are seeking what is universal in individual responses to these new medications or in all cases of Alzheimer's disease. Consequently, medical research into the

general causes and conditions of illness remains a nomologic task. However, once researchers uncover and test the nomologic explanations of a condition such as Alzheimer's, these explanations can be used by clinicians in treating individual patients: the general nomologic hypotheses become tools of idiographic treatment. Although clinicians also avail themselves of other techniques, they do use in their investigations of individual patients the general nomologic knowledge provided by researchers.

The ideal classification scheme for psychiatry would provide a common set of categories for both clinicians and researchers. This ideal scheme would thus orient and guide both idiographic and nomologic investigations in psychiatry. Furthermore, such a classification scheme would have to be common to these two groups in order to facilitate communication between them. The classifications we shall describe will be neither idiographic nor nomologic. They shall rather function as heuristic conceptual devices for moving either toward individual patients or toward nomologic explanations.

FROM THE MULTIPLICITY OF EMPIRICAL FACTS TO GENERAL CLASSIFICATORY SCHEMES

Any adequate classification scheme in psychiatry must be able to orient and guide clinicians in their idiographic task of diagnosing and treating individual patients. The task of comprehending any individual patient, however, presents an initial problem: the facts pertaining to any person, when considered in their concrete fullness, are virtually infinite. This infinity of facts poses a problem because it requires the establishment of criteria for selecting some of them as relevant and disregarding most of the others as irrelevant. Idiographic knowledge of an individual can begin, then, only by being simplified and organized according to some criteria of relevance.

Acknowledging the infinity of data pertaining to a concrete human being, Max Weber wrote,

...as soon as we attempt to reflect about the way in which life confronts us in immediate concrete situations, (we realize that) it presents an infinite multiplicity of successively and coexistently emerging and disappearing events, both "inside" and "outside" of ourselves. The absolute infinity of this multiplicity is seen to remain undiminished even when our attention is focused on a single "object." as soon as we seriously attempt

an exhaustive description of all the individual components of this "individual phenomenon" to say nothing of trying to explain it causally (p. 72).¹

This multiplicity of events, because of its infinite complexity, would prove to be scientifically unmanageable and unintelligible. Some way must thus be found to reduce the complexity of the actual data.^{36.37} We are able to reduce this complexity by abstracting from its infinity and focusing exclusively on those data that interest us. As Weber would probably phrase it, order can be imposed on this infinity only by an abstractive process that attends to certain facts as alone important or worthy of being known. Our values furnish the initial criteria with reference to which we select certain features of reality as deserving our attention. Values are necessary for deciding which finite portion of this infinite mass of facts we select because, as Weber writes, "there is nothing in the things themselves to set some of them apart as alone meriting attention." Weber continues,

Order is brought into this chaos only on the condition that in every case only a *part* of concrete reality is interesting and significant to us, because only it is related to the *cultural values* with which we approach reality. Only certain sides of the infinitely complex concrete phenomena, namely those to which we attribute a general cultural significance, are therefore worth knowing (p. 78).¹

By deeming only certain portions of reality worthy of being known, the different sciences can thus reduce the complexity of data by constructing abstract concepts that refer exclusively to selected groupings of them and which, accordingly, disregard others.

For the practical science of psychiatry in particular, the values that determine which components of a person are worth knowing are, as we mentioned earlier, the values of promoting mental health and ameliorating mental illness. From the psychiatric point of view, then, aspects of a person's life are significant or important only if they are related to his or her mental health or illness. Because these specific values have been institutionalized for some time in the profession of psychiatry, we do not always realize that they implicitly undergird and guide all psychiatric activities - from daily clinical practice to medical education, the publication of psychiatric literature, and laboratory research. But without such values to orient and direct psychiatric interests, anything and everything (or nothing at all) about an individual might seem interesting. Weber would maintain, then, that when we focus on any circumscribed aspects of

reality to the exclusion of other aspects, we do so because these selected aspects are relevant to our values. Or, in Weber's more succinct phrase, these aspects alone are "value-relevant."

This focusing upon people exclusively with regard to their mental health or illness means that the psychiatric approach will remain, in Weberian terms, "one-sided." It will disregard many other aspects of people and other ways of investigating and treating human beings. The values of psychiatry, accordingly, render the psychiatric approach to human beings perspectival: human beings are examined and treated only from psychiatric points of view. It is only by taking up such "one-sided" points of view on patients that psychiatrists manage to simplify and organize the "infinite multiplicity of data " that emerges regarding patients.^{24,38}

IDEAL TYPES AND PSYCHIATRIC DIAGNOSIS

According to Weber, the one-sided perspectives through which we approach concrete reality can be articulated and expressed in concepts that he called "ideal types."³⁹ Ideal types are special kinds of scientific concepts. They are concepts defined for the purpose of explicitly enunciating those aspects of the infinite multiplicity of events that interest us. We are all familiar with Weber's own ideal types, "the protestant ethic" and "the spirit of capitalism," because they have moved beyond the science of sociology to become part of general culture.⁴⁰ We shall contend that some of the basic diagnostic categories of psychiatry, such as schizophrenia and manic-depressive illness, are also ideal types. Acknowledging that these diagnostic categories have this conceptual status sets the controversies and discussions about classification in anew and more illuminating light.

We have argued in an earlier article, however, that the explicitly defined concepts of psychiatry can arise only out of preconceptual skills we have called typifications.^{37,41} Psychiatrists who have acquired these skills are able to see patients as displaying certain kinds of mental disorders. On the basis of their preconceptual seeing, psychiatrists are then able to conceptualize these different sorts of disorders. The ideal types that provide the explicit categories of nosology thus presuppose these more fundamental psychiatric skills for identifying mental distress.

How then do ideal types arise out of preconceptual typifications? Weber describes the explicit definition of ideal types in the following way:

An ideal type is formed by the one-sided accentuation or one or more points of view and by the synthesis of a great many diffuse, discrete, more or less present, and occasionally absent concrete individual phenomena, which are arranged according to those one-sidedly emphasized viewpoints into a unified thought-construct (p. 90).¹

We have already explained why, for Weber, any focusing on human beings arises from some particular point of view and consequently remains one-sided: our values lead us to attend to only those aspects of infinite reality that we deem significant or important. When, as scientists of human reality, we define an ideal type, we accentuate this valued point of view in the sense that we explicitly enunciate what it lays open to our gaze and disregard whatever falls outside of it.

As scientific concepts, ideal types are idealized descriptions of those aspects of concrete reality that interest us. By idealized we mean descriptions that attempt to draw clear conceptual boundaries around features of things that, as directly given to us in immediate concrete situations, are ambiguous and unclear. The various components of concrete events, as they are immediately given to us, may prove difficult to distinguish from one another, their identities may remain fuzzy and indefinite, or they may vary so widely that each individual seems incomparable to others. In defining an ideal type we try to set aside this indistinctness, ambiguity, and extreme variation and imagine a pure case in which the relevant features are distinct, unambiguous, and invariant.

Ideal types are thus idealized definitions of typifications. To some extent at least, ideal types overcome the fuzziness and ambiguity that permeates preconceptual typifications. Although based on typifications, ideal types reshape them by being more specific and definite in meaning.

Ideal types are also idealizations in the sense that many of the realities we wish to subsume under a type may nonetheless lack some .or even most of the features enumerated in that type. The type depicts the perfect case: the case in which the most characteristic features are fully present. But in imperfect reality some of these features may be absent, or some may be only roughly present, i.e., present only to some degree or other. Features which appear quite prominently and indisputably in the perfect cases may appear only minimally or debatably in others. Ideal types depict the features of only the perfect cases. The clinician is

then able to recognize the many imperfect cases by their resemblance or approximation to the perfect case described by the ideal type.

In this way, Weber's ideal types approach what Rosch, Livesley, and others have called prototypes.²⁹⁻³⁵ As Livesley describes prototypes, "Prototypic categories are organized around prototypical examples (the best examples of the concept) with less prototypical examples forming a continuum away from these central cases."³⁴

The researchers who have studied prototypes have not, however, discussed what we deem the primary advantage of ideal types for clinical psychiatry. By depicting the typical features of a disorder, ideal types permit us to pinpoint in specific terms the areas that require further inquiry. For any given disorder, deviations from the pure case – the ideal case – raise questions regarding the nature and causes of these deviations. A particular disorder may deviate from the typical case in two ways: the disorder can lack some of the features that the ideal type specifies and/or it can present some features not specified by the ideal type. In both cases we are led to wonder why these deviations have occurred. When some of the typical features are missing in a particular patient, we know that it might prove fruitful to inquire into the causes for the absence of these typical features. Similarly, if some "atypical" features are present in the patient, then we know that it might be informative to learn why these atypical features happen to occur here. Ideal types thus guide us in formulating some of the main questions that need to be answered regarding a particular patient.

Suppose, for example, that a deflated mood, a lack of confidence, vegetative signs, diminished energy, and the loss of the ability to experience pleasure are deemed most characteristic of endogenous depression. Now, utilizing such an ideal type, we may encounter Mr. Hall. Let us assume that Mr. Hall definitely displays depressed mood, diminished confidence, and vegetative signs. On the other hand, his energy level is ambiguously affected, and he manifests anhedonia only slightly. In addition, Mr. Hall may display obsessions and compulsions that we judge to be related to his deflated mood. Now we might wish to consider Mr. Hall as endogenously depressed. The fact that Mr. Hall does not exhibit all the features of the ideal type and that he exhibits features not contained in the type does not prevent us from using the ideal type in our comprehension of Mr. Hall's problems. Mr. Hall, we judge, does indeed suffer from endogenous depression although his disorder fails to be a perfect example of it. And moreover, the fact that Mr. Hall's case deviates from the ideal type leads us to

formulate some important questions: Why is Mr. Hall's energy level unaffected by his depression? Why is his anhedonia not greater than it appears to be? Why should his deflated mood lead to obsessions and compulsions rather than some other states? Framed in terms of ideal types, our inquiry takes shape and direction.

IDEAL TYPES V MONOTHETIC AND POLYTHETIC CONCEPTS

We can now contrast ideal types with both monothetic and polythetic concepts. Monothetic concepts specify necessary and sufficient conditions for class membership. Necessary conditions: any individual case, in order to qualify as an instance of the concept, would necessarily have to exhibit all the attributes enumerated in the concept. Or, to formulate the idea negatively, any individual who failed to possess one or more of the attributes specified by the concept could not qualify as a member of the class. If, for instance, we defined endogenous depression monothetically by referring to features that we cited above, any person who failed to exhibit one or more of these features could never be considered endogenously depressed. But such reasoning is rarely true in psychiatry. Any experienced clinician is aware of the scarcity of pure cases as compared to the abundance of patients who are slightly atypical. Sufficient conditions: if any individual case exhibited all of the attributes of the class, we could not deny that this case was a member of the class. Any patient who displayed all of these features would have to be diagnosed as endogenously depressed, no matter what features of illness he or she also possessed. But since Jaspers' time, psychiatry has been aware that the presence of some conditions (organic disorders such as syphilis, for example) diminishes the diagnostic value of signs and symptoms exemplifying other conditions (for instance, affective disorder or schizophrenia (p. 604-614)).²⁴

With ideal types, in contrast to monothetic concepts, some real individual may fail to exhibit one or more of the properties designated by the type, and we might still wish to deem the individual an instance of the type. Some schizophrenic patients, for example, will have delusions and hallucinations, but others will not. Some patients will behave in bizarre ways while others appear quite conventional. Symptoms such as social isolation, flat or inappropriate affect, bizarre ideation, or unusual perceptual experiences will be, in Weber's words, "more or less present and occasionally absent" in any individual case.

Polythetic concepts list a number of the attributes which members of the class may have without specifying any of these attributes as necessary for class membership.² Psychiatric interest in polythetic classifications has increased substantially since the appearance of DSM-III because many of the diagnoses in DSM-III are constituted polythetically.⁴³⁻⁴⁶ The polythetic concepts of DSM-III establish sufficient conditions for class membership by stipulating the number of the attributes listed that an individual must exhibit in order to qualify as a member of the class. For example, borderline personality disorder is diagnosed from a list of eight criteria: patients are borderline if they match up to five of these eight items, but no particular item is necessary for the diagnosis. As Livesley writes of polythetic categories, "each member (of the class) possesses a large number of the attributes which define the category and each attribute is possessed by a large number of members, but no attribute is possessed by all members" (p. 354).³⁴ In contrast to polythetic concepts, ideal types specify only the most characteristic attributes of the class. Polythetic concepts do not distinguish between those features that are more typical and those that are not. Therefore, polythetic concepts fail to provide clinicians with the guidelines for further investigation that we mentioned above. Ideal types predelineate at least some of the questions that need to be addressed to a particular case; we need to know why the typical is absent and the atypical is present.

In the literature on psychiatric classifications, reference is occasionally made to Ludwig Wittgenstein's view of concepts as expressing "family resemblances."^{30,31,47,48} With the image of family resemblances, Wittgenstein seems to us to capture the essence of polythetic concepts. The polythetic concepts of scientific classifications and the family resemblances discussed by Wittgenstein display one important difference, however. Wittgenstein is primarily concerned with the terms of ordinary, prescientific language in which we do not worry too much about precise definitions and delimitations.⁴⁷ Polythetic concepts, however, are scientific terms, as precisely defined and as exactly delimited as possible. Hence, we cannot expect Wittgenstein to offer much insight into the best way to determine scientific concepts. All we can learn from him is that the fuzziness of some scientific notions finds its correlate in a similar fuzziness in ordinary language. The problem for science remains then: what is the most effective way to overcome this fuzziness. polythetic concepts or ideal types?

IDEAL TYPES AS GUIDING AND ORIENTING EVALUATION AND TREATMENT

It is the clinical entities and disorders of psychiatry conceived as Weberian ideal types that in fact orient and direct psychiatrists throughout their examination and treatment of patients. Ideal types are necessary because they tell psychiatrists what to look for, what is relevant and what is irrelevant, what is typical and what is atypical, in the various types of mental disorder. By doing this, ideal types predelineate the kinds of questions that require further investigation in a particular case. The psychiatrist's understanding of the patient will move progressively beyond these general types, however, as his or her understanding grows more and more detailed, concrete, and specific. As the psychiatrist succeeds in understanding the patient in his or her uniqueness, this understanding will become, in Weber's terms, "individualized." This eventual individualized understanding of the patient will be an understanding which grasps solely this particular patient and does not apply to others. The ultimate aim of an examination of an individual, for Weber, is precisely this individualized conception of the individual as unique and distinct from others. In psychiatry such an individualized grasp of the patient is required for effective treatment. The patient's disorder can perhaps be subsumed under a general type. But the components of the disorder are always related to and embedded within other aspects of the patient's life. The psychiatrist must consider these other aspects of the patient's being precisely, because they shape and influence his or her disorder. But, as we have indicated, the psychiatrist certainly cannot possess such a detailed understanding of the individual at the outset. And at the outset of the examination ideal types must be used in order to provide a general orientation and direction for the psychiatrist. General ideal types, therefore, help orient a psychiatric investigation whose ultimate aim is to leave the generality behind and grasp the individual as unique.

Because ideal types are constructed only in order to guide a more detailed understanding of the individual, such types do not pretend to furnish adequate descriptions of individuals. On the one hand, certain components of the type may prove inapplicable to the patient under examination. Yet the fact that types specify features that are occasionally not found in actual cases does not necessarily detract from their usefulness: the psychiatrist may learn something significant about the patient precisely by asking why these features are absent in this case. On the other hand, some facts may emerge regarding the patient that the definition of the type had omitted but that prove nonetheless to be central for comprehending and treating this particular patient. But the fact that types may fail to include features that in

fact prove crucial for understanding some individual patient does not necessarily discredit ideal types: the psychiatric investigation that turned up these unexpected features might have been guided nonetheless by the types.

For these reasons, Weber insists that ideal types should not be considered true or false definitions of general classes of individuals. Ideal types are merely useful or useless in orienting clinicians in their idiographic inquiries into particular patients. Ideal types do not have a truth value; they have solely a heuristic value.¹ Either they provide a helpful orientation for the psychiatrist, or they do not. If some type does not prove helpful in progressively making sense of a patient, then the psychiatrist should discard that type and resort to others. Because the sole value of types lies in guiding and predelineating more detailed investigations, they prove valueless when they cannot effectively furnish such guidance.

In a recent essay the eminent British psychiatrist R. E. Kendell appears to support this Weberian view that classificatory schemata in psychiatry possess merely a heuristic value rather than a truth value. While evaluating the achievements of DSM-III, Kendell writes that its "diagnostic terms are no more than convenient labels for arbitrary groupings of clinical phenomena" and that these are "concepts justified only by their usefulness (p. 56)."⁴⁶

Ideal types are concepts justified only by their usefulness because they merely guide the psychiatrist's examination of an individual patient. But, as a result of this examination, the psychiatrist arrives eventually at particular beliefs regarding the nature of the patient's problem. These particular beliefs regarding the particular patient can and should be considered true or false. The criteria of truth or falsity here are the evidence, facts, or data pertaining to this particular patient. In other words, the beliefs that the psychiatrist has developed can in principle be proven false by further direct evidence or data regarding this patient that contravenes these beliefs. Karl Popper's well known principle of falsifiability applies in clinical psychiatry, therefore, precisely here: in clinical psychiatry, evidence regarding the patient confirms or falsifies not some general theory, but rather particular claims or beliefs about that patient.⁴⁹ From a Popperian standpoint, consequently, clinical psychiatry qualifies as a genuine science insofar as it makes particular claims about an individual patient and these claims are in principle falsifiable when confronted with the evidence pertaining to this individual.

IDEAL TYPES AS GUIDING AND ORIENTING PSYCHIATRIC RESEARCH

In clinical psychiatry truth and falsity play roles different from their functions in medical research. Because much research aims at establishing nomologic claims, it is precisely such general claims that the facts either refute or confirm. With regard to the idiographic purposes of clinical practice, on the other hand, only particular psychiatric beliefs can be proven true or false. Nomologic research aims at evidentially based knowledge of the universal law; idiographic practice aims at evidentially based knowledge and treatment of the individual patient.

And nomologic research must also be guided—at least at first—by psychiatric ideal types. Because present-day psychiatry possesses few, if any, well confirmed nomologic concepts or theories, non-nomologic concepts are required to orient experimental thinking and postulating. Researchers would never know how to formulate testable hypotheses or to devise controlled experiments unless some non-nomologic ideas first provided them with intellectual direction and guidance. It is ideal types, we submit, that inform the initial surmising and conjecturing of the psychiatric researcher.

Ideal types themselves, however, are not even in principle testable or provable because they never claim truth or falsity. If they are useful at all, their utility consists in providing the basic intellectual framework and direction for an examination that does lead to confirmable or falsifiable claims. For psychiatric research, ideal types furnish the initial conceptual guidelines for the postulation of law-like regularities and the design of experiments to test such postulates. For clinical practice, ideal types predelineate the features of disorders so that clinicians know what to search for, focus on, and examine in particular patients. In summary, then, the question regarding the usefulness of ideal types is this: Do these types help clinical practitioners arrive at particular beliefs about individual patients and do they help researchers arrive at general nomologic hypotheses? If the ideal types help psychiatrists develop testable particular claims and universal hypotheses, then they are useful. If they do not, they are worthless.

KARL JASPERS' APPROPRIATION OF IDEAL TYPES

Karl Jaspers accepted Weber's conception of ideal types and applied them to psychiatry in his masterful book, *General Psychopathology*.²⁴ The sample sentences from Jaspers' work quoted below manifest its agreement with the Weberian method we have sketched above. Here

Jaspers assigns the name of 'generic group' to what we have called monothetic concept. And, just as we have, he sharply distinguishes generic groups, i.e., monothetic concepts, from types, i.e., ideal types:

A case either belongs or does not belong to a generic group (e.g.. paralysis) whereas a case only corresponds more or less to a type (e.g.. hysterical personality). A generic group is the concept which represents an actually existing and definable variant. A type is a fictitious construct which in reality has fluid boundaries; it serves to assess a particular case. Generic groups either exist or they do not. Types reveal themselves as either fruitful or not for the comprehension of individual cases. Through the use of generic groups, real boundaries are established; through the use of types we only give structure to a transient manifold (p. 560).²⁴

Subsequently, Jaspers' student and colleague, Kurt Schneider, developed a typology of personalities that uses these methodologic principles.^{25,26} Paradoxically, Jaspers' fruitful insights in this regard are ignored today although his influence on international psychiatry continues to grow.

IDEAL TYPES CAN HAVE A VARIETY OF CONTENTS

In this essay, we have restricted ourselves to describing some methodologic rules for constructing ideal types. We might say alternatively that we have specified formal rules for constructing them. By formal rules we mean rules that in no way specify the contents or meanings of the types. Ideal types, accordingly, could have various kinds of meaning contents. It is important, we think, to recognize the variety of meaning contents that ideal types could have in order to disclose the broad range of meanings that ideal types lay open for psychiatry.

It is sometimes maintained, however, that the range of possible meanings in any genuine science should not remain too broad. Indeed, it is sometimes thought that one of the virtues of science consists in its capacity to restrict the range of acceptable meaning contents.^{50,51} Science, so the assumption goes, can establish strict boundaries between acceptable and unacceptable meanings (pp. 253-292).⁴⁹

Such a thesis holds, we maintain, only for nomologic concepts. Because nomologic concepts must express what is universally invariant for any class of realities, acceptable and

unacceptable concepts can be determined through the empirical sampling of instances of those classes. For ideal types this is not so. Because the value of ideal types consists in their heuristic function and not in their truth value, there are as many different kinds of ideal typical meanings as there are purposes and goals in psychiatry. And there remains no way to delimit a priori the acceptable kind of conceptual meanings because there remains no way to specify a priori the tasks and goals of psychiatry. As long as ideal types are constructed in terms of their relevance to our values, their meanings will vary as our professional values vary. We should consider this a virtue. Because of the liberty and breadth afforded by ideal types, psychiatric work need not be cramped or confined by a limited set of concepts that, for some reason, is deemed the only acceptable one.

We shall now merely allude to some of the different kinds of purposes that could determine the meaning contents of ideal types.

1. Ideal types could be either theoretical or descriptive. (a). Descriptive (i.e., atheoretical) types would remain closer to directly given evidence. DSM-III, for example, explicitly seeks to keep its criteria close to direct evidence (pp. 6-8).⁵² (b) Theoretical types would move away from direct evidence by referring to hypothetical processes or entities at work behind the direct givens. In postulating that a phenomenon, such as an obsessive symptom, arises as a defense against anxiety, DSM-II provided theoretical types.²³ One could include here mythologic types, such as Freud's Oedipus complex and Jung's archetypes.

2. Ideal types could distinguish between the pathogenic and pathoplastic features of mental disorders. They would thus distinguish between the relatively invariant constituents of illness (the pathogenic) and the more variable features (the pathoplastic).⁵³ For example, manic people in Western cultures may fall into spending sprees. But this particular expression of the manic state may be pathoplastic because it may simply reflect the dominant values of Western societies. Other components of the manic condition -- overconfidence, for instance -- could then be viewed as pathogenic. Karl Birnbaum, who coined the terms "pathogenic" and "pathoplastic" developed a structural analysis that systematically distinguished pathogenic from pathoplastic features.⁵³ Schneider sought to isolate pathogenic features in his characterization of psychopathic personalities. He attempted to depict pure personality types that were devoid of sociohistoric features (p. 28).²⁵ Birnbaum, in contrast, depicted pathoplastically determined forms of illness, such as compensation illness and Ganser's

pseudodementia (p. 209).⁵³ Illnesses like these constitute a sociohistoric psychiatry, typologies of disorders that are culturally and historically relative.⁵⁴ Such ideal types portray disorders that are peculiar to particular cultures and historic periods.

3. Ideal types could (a) remain merely qualitative conceptions of disorders, or (b) some of the attributes designated in ideal types could be characterized in quantitative terms. Because the features expressed in ideal types appear in different patients in varying degrees, these gradations could be quantified.⁵⁵ We could then specify the degree to which each patient exhibited the features mentioned. In this way ideal types could serve as dimensional categories (pp. 69-97).³⁸

4. Ideal types could (a) simply specify core features of disorders; for example, "hypervigilance" for paranoid personality disorder. Or (b) they could provide operational definitions for these core features.²³ Such operational definitions would designate the various observable phenomena of patients that manifest the core features such as hypervigilance. Many authors have argued that greater reliability in diagnosis is to be obtained through developing operational definitions that securely connect classificatory schemes with observable phenomena.^{23,35,56,57} This argument relies, however, on a definite distinction between the observable and the unobservable that most present-day philosophers of science view as highly problematic.^{58,59}

CONCLUSION

Natural sciences such as physics and chemistry can usually succeed in articulating their concepts and hypotheses in nomologic form. If psychiatrists should view the natural sciences as the paradigmatic sciences, therefore, psychiatrists will assume that the nomologic form is the (only acceptable) form of scientific reasoning. And this nomologic form of logically connected general laws has indeed been proposed as the paradigm of scientific reasoning by logical empiricists such as Hempel.² We submit, however, that psychiatry should jettison such a viewpoint. For even if we did possess a nomologic explanation for each disorder: this would not eliminate the need for idiographic investigation. Nomologic explanations can be reliably applied only within the context provided by an idiographic understanding of the individual patient. And this idiographic comprehension of the patient is the basis for any decision regarding the relevance of nomologic hypotheses.

Moreover, such idiographic investigation of individual patients is fundamental for all of clinical medicine, not just for psychiatry. We would like to share some remarks on this subject by George Engel, who, with his characteristic kindness, has read and commented on this essay. As Engel has written in a letter to us:

Idiographic investigations characterize what every physician does with each patient, and thus defines what characterizes the nature of the scientific work of the clinician, irrespective of his discipline and, certainly, irrespective of the eventual diagnosis, It is no less typical of the processes whereby we make a clinical diagnosis of congestive heart failure than it is of schizophrenia or depression, other than that there is more in the way of nomologically derived information that we can draw upon in the former case.

What we have said of idiographic inquiries in psychiatry, therefore, can also be said of clinical medicine in general: knowledge of the unique features of the patient serves as the evidential basis for skillful medical practice.

Present-day psychiatry is able, to varying degrees, to cast some of its knowledge in nomologic form. For example, those parts of psychiatry that do possess knowledge of the etiology of illness can portray these causal agents in general law-like explanations. For some psychiatric disorders, such as certain forms of delirium and dementia, we appear to be progressively acquiring nomologic knowledge. But we remain quite distant from this knowledge for most other psychiatric disorders. Despite recent progress, the neuropathologies and pathophysiologies of the functional psychoses, schizophrenia, and manic-depressive illness, are still quite obscure. So are psychosocial causal factors. And of course, we appear to be even farther from causal knowledge for the neuroses and character disorders.

Nonetheless, we are able to conceptualize these disorders through ideal types. And indeed, ideal types are well suited both to guide the practice of the clinician and to structure the investigations of the researcher. That is to say, they can orient both the practice that progresses towards the uniqueness of the individual patient and the research that seeks the etiology common to a universal class of illness. Ideal types, therefore, can serve as the point of intersection for the clinical work that can proceed without a general knowledge of causes and the empirical research that strives for such general knowledge.

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