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VALUES, DISAGREEMENT, AND PSYCHIATRIC CLASSIFICATION

Valores, desacuerdo y clasificación psiquiátrica

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Abstract

It has been argued that non-epistemic values have legitimate roles to play in the classification of psychiatric disorders. Such a value-laden view on psychiatric classification raises questions about the extent to which expert disagreements over psychiatric classification are fueled by disagreements over value judgments and the extent to which these disagreements could be resolved. This paper addresses these questions by arguing for two theses. First, a major source of disagreements about psychiatric classification is factual and concerns what social consequences a classification decision will have. This type of disagreement can be addressed by empirical research, although obtaining and evaluating relevant empirical evidence often requires interdisciplinary collaboration. Second, there is also a type of disagreement over value judgments; namely, disagreements over which aims of psychiatric classification should be prioritized. To address this type of value disagreement, it is helpful to develop a plurality of different psychiatric classification systems, each targeted toward satisfying a different subset of stakeholder aims.

Key words: Values; Value-Laden; Expert Disagreement; Value Conflict; Psychiatric Classification.

Resumen

Se ha argumentado que los valores no epistémicos tienen roles legítimos en la clasificación de los trastornos psiquiátricos. Esta visión acerca de los valores en la clasificación psiquiátrica plantea preguntas sobre hasta qué punto los desacuerdos entre expertos sobre la clasificación psiquiátrica están alimentados por desacuerdos en torno a valores y hasta qué punto estos desacuerdos podrían resolverse. Este artículo aborda estas preguntas argumentando dos tesis. Primero, una fuente importante de desacuerdos sobre la clasificación psiquiátrica es fáctica y concierne a las consecuencias sociales que tendrá dicha clasificación. Este tipo de desacuerdo puede afrontarse mediante investigación empírica, aunque obtener y evaluar evidencia empírica relevante a menudo requiere colaboración interdisciplinar. Segundo, también existe un tipo de desacuerdo sobre juicios de valor; a saber, desacuerdos sobre cuáles deberían ser los objetivos prioritarios de la clasificación psiquiátrica. Para abordar este tipo de desacuerdo en torno a valores

es útil desarrollar diferentes sistemas de clasificación psiquiátrica, cada uno dirigido a satisfacer un subconjunto diferente de objetivos de las partes involucradas.

Palabras clave: Valores; Carga valorativa; Desacuerdo entre expertos; Conflicto de valores; Clasificación psiquiátrica.

1. Introduction

Psychiatric classification, or the systematic classification of mental disorders, plays a major role in psychiatry. Classifying mental disorders helps clinicians identify, diagnose, and treat mental health disorders using appropriate therapies and medications. It also helps researchers by providing a shared language for studying the prevalence, nature, and causes of mental disorders. The most prominent systems of psychiatric classification, such as the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) published by the American Psychiatric Association (APA) and the *International Classification of Diseases* (ICD) published by the World Health Organization (WHO), are used worldwide in epidemiological research, clinical practice, and policy decisions about public health. The development and revision of these major psychiatric classification systems have a profound impact on psychiatric research and practice.

In recent decades, psychiatrists and philosophers have debated whether non-epistemic values[1] have legitimate roles to play in psychiatric classification, i.e., whether psychiatric classification should be value-laden or value-free. One type of argument in support of the value-laden view could be called the "definition-based argument". The basic idea is that the definitions and the diagnostic criteria of mental disorders should appeal to value concepts, hence the applications of these definitions and diagnostic criteria should involve value judgments. Another type of argument supporting the value-laden view could be called the "consequence-based argument". The basic idea is that many decisions about psychiatric classification systems (e.g., proposing new disease categories, changing disease names, changing diagnostic criteria, lumping or splitting categories, and removing categories) have social consequences. Insofar

[1] The distinction between epistemic and non-epistemic values has been important in discussions about the role of values in science. One way of drawing the distinction is to define epistemic values as those that promote the pursuit of truth, whereas non-epistemic values do not (Steel, 2009; Lusk & Elliott, 2022). Empirical adequacy, predictive accuracy, and logical consistency are examples of epistemic values. In contrast, ethical, social, political, economic, cultural, and aesthetic values fall under the umbrella of non-epistemic values.

as these decisions are uncertain and cannot be determined by epistemic considerations[2] alone, non-epistemic values should play a role in shaping these decisions.

The value-laden view on psychiatric classification, however, raises questions about the nature of expert disagreements over psychiatric classification and the extent to which these disagreements can be resolved. The classification of psychiatric disorders is often controversial. For instance, regarding the DSM-5, the tightening of the definition of autism, the decision to classify severe bereavement as a type of major depression, and the introduction of internet gaming disorder are just a few examples of decisions that generated considerable controversy (Nemeroff et al., 2013; Horwitz, 2021). Moreover, it is far from clear that these controversies have been resolved to everyone's satisfaction. Why does the classification of psychiatric disorders remain so controversial? Are the controversies over psychiatric classification fueled not only by disagreements over facts and evidence but also by disagreements over (non-epistemic) values? What should experts do about persistent disagreements over psychiatric classification, given how difficult it is to resolve certain non-epistemic value disagreements?

This paper aims to make progress on these questions by arguing for two theses. First, a source of disagreements about psychiatric classification is factual and concerns what social consequences a classification decision will have. For instance, in the debates over gaming disorder, many disagreements centered on whether introducing gaming disorder as a formal disease category would stigmatize normal gamers and incite moral panic about video games. I argue that this type of disagreement can be addressed on the basis of empirical research, although obtaining and evaluating relevant empirical evidence often requires interdisciplinary research and collaboration (e.g., among psychiatrists, social scientists, and media researchers).

Second, there is a source of value disagreement in controversies over psychiatric classification, namely disagreements over which aims of psychiatric classification should be prioritized. Psychiatric classification systems such as the DSM and the ICD serve the purposes of many stakeholders, including patients, clinicians, researchers, educators, policymakers, the public, and more. The aims and needs of different stakeholders sometimes come into conflict, in which case crafting diagnostic criteria that better serve one stakeholder would reduce the value of those

[2] Epistemic considerations include considerations of empirical evidence and epistemic values.

criteria to another. I argue that in order to address this type of value disagreement, it is helpful to develop a plurality of different psychiatric classification systems, each targeted towards satisfying a different subset of stakeholder aims.

This paper is organized as follows. In Section 2, I summarize the "definition-based arguments" and "consequence-based arguments" supporting the value-laden view on psychiatric classification. In Section 3, I use the dispute over gaming disorder as a case study to highlight disagreements in psychiatric classification and raise questions about the role of non-epistemic values in these disagreements. In Section 4, I examine the experts' arguments for and against including gaming disorder in the ICD-11, and I argue that much of the disagreement revolves around the potential consequences of this classification decision. In Section 5, I discuss how conflicting constraints from multiple aims of psychiatric classification contribute to disagreements and propose classificatory pluralism as a strategy to mitigate these conflicts.

2. Arguments for Value-Laden Psychiatric Classification

Psychiatrists and philosophers of psychiatry have debated over the proper role of practical, moral, and social values in the classification of mental disorders (Wakefield, 1992; Ghaemi, 2012; Cooper, 2016; Kostko, 2019). Values that are moral, social, economic, political, cultural, or aesthetic in nature are sometimes grouped together under the label "non-epistemic values", which are differentiated from "epistemic values" such as empirical adequacy, predictive accuracy, and explanatory power (Douglas, 2000; Kostko, 2019). The debate can be framed as follows: On the one hand, some argue that psychiatric classifications should be based on measurable symptoms and biological markers alone and be free from considerations of non-epistemic values. We may call this view the "value-free" view on psychiatric classification. On the other hand, some argue that psychiatric classification should involve non-epistemic value considerations. We may call this view the "value-laden" view on psychiatric classification. Both views are normative views concerning whether non-epistemic values *should* influence the identification and categorization of mental disorders, as opposed to descriptive views on whether non-epistemic values do in fact play such a role. This paper adopts the value-laden view on psychiatric classification and explores its implications for expert disagreements. In this section, I survey the main arguments that support the value-laden view.

The value-laden view on psychiatric classification can be defended by two main types of argument, which I call the "definition-based argument"

and "consequence-based argument" respectively. First, according to the definition-based arguments, defining psychiatric disorders involves drawing a line between what is normal and what is pathological in important areas of personal and social functioning, for which value judgments are indispensable (Fulford, Thornton, & Graham, 2006; Wakefield, 1992). Second, according to the consequence-based arguments, numerous decisions involved in psychiatric classification (including proposing new disease categories, moving categories from the appendix to the main classification, name change, diagnostic criteria change, lumping or splitting categories, etc.) have social consequences. Insofar as these decisions cannot be determined by epistemic considerations alone, non-epistemic values should play a role in these decisions (Biddle, 2016; Biddle & Kukla, 2017; Cooper, 2016; Kukla, 2019).

First, consider a definition-based argument for the claim that the diagnostic criteria for a particular disorder, such as schizophrenia, do and should incorporate value considerations. The diagnostic criteria for schizophrenia in DSM-VI includes Criteria B, which concerns "social/occupational dysfunction": "For a significant portion of time since the onset of the disturbance, one or more major functioning such as work, interpersonal relations, or self-care are markedly below the level prior to the onset (or when the onset is in childhood or adolescence, failure to achieve expected levels of interpersonal, academic, or occupational achievement)" (NIH, 2024).[3] Diagnostic criteria pertaining to social/occupational dysfunction are reasonable and necessary to differentiate between normal and pathological cases. Moreover, "social/occupational dysfunction" is an evaluative concept: To evaluate social, occupational or other important areas of dysfunction, it is necessary to appeal to relevant social and occupational norms. To evaluate how much social, occupational, or other areas of dysfunction count as "markedly below" prior levels, it is necessary to evaluate how much harm is caused. Judgments about norms and harms are evaluative: They value certain behaviors and states and disvalue others. It follows that to diagnose schizophrenia using the DSM criteria, it is necessary to make value judgments (Fulford, Thornton, & Graham, 2006, pp. 564-584). This argument can easily be generalized to other mental disorders such as paraphilia and obsessive-compulsive and related disorders.

Second, according to the consequence-based arguments, many decisions involved in psychiatric classification have non-epistemic and social consequences. These decisions include proposing new disorder categories,

[3] This criterion remains in the DSM-5 diagnostic criteria for schizophrenia (NIH, 2024).

lumping or splitting existing disorder categories, changing diagnostic criteria or diagnostic thresholds, and choosing one way of naming and describing a mental disorder over others (for instance, renaming "mental retardation" as "intellectual disability"). Insofar as these decisions cannot be determined by epistemic considerations alone, non-epistemic or social values should play a role in these decisions.[4] DSM-5 was the first DSM to require those proposing certain new changes to consider the potential consequences of adopting these changes, specifically whether the harms resulting from adopting a proposal exceed the benefits (Cooper, 2016, p. 103). In DSM-5, this is only an explicit requirement for those proposing to introduce new disease categories or moving categories from the appendix to the main classification. However, there is no reason why other decisions in a proposed revision (e.g., name changes, lumping or splitting categories, alternating diagnostic criteria, etc.) should not consider potential consequences as well (Cooper, 2016, p. 104).

For instance, a central use of psychiatric classification systems is to make diagnoses. When setting diagnostic thresholds of psychiatric disorders, an important type of social consequences includes those of overdiagnosis and underdiagnosis. Overdiagnosis, or false positives, means labeling mental states or behaviors that should have been considered normal as mental disorders. Overdiagnosis could have a few social consequences (Pierre, 2013, pp. 109-113): First, the more psychiatry is perceived to be encroaching the boundaries of normality, the more psychiatry's credibility will be threatened. Second, it might pathologize and stigmatize normal human behavior. Third, it is likely that "psychiatric medications will be increasingly marketed to and prescribed for those at the healthier end of the mental illness continuum" (Pierre, 2013, p. 109), which could result in unnecessary exposure to potentially harmful effects. When financial and medical resources for care are limited, overdiagnosis likely has worse consequences compared to underdiagnosis, because the former means that valuable medical resources are diverted from those who need them the most.

The flip side of the problem is underdiagnosis, or the failure to identify and treat false negatives. Underdiagnosis is supposed to have the following practical consequences: Firstly, underdiagnosis is associated with neglect of those who lie at the milder end of the severity spectrum and those who have subthreshold conditions. Even though they may suffer

[4] Consequence-based arguments are closely related to the argument from inductive risk and other similar arguments in philosophy of science literature (Biddle, 2016; Biddle & Kukla, 2017; Kukla, 2019; Brown, 2020; Douglas, 2000; Hempel, 1965; Rudner, 1952).

from less severe symptoms compared to those with more severe symptoms, they may still be in distress and suffer from functional impairments such as diminished health and work productivity (Kostko, 2019, pp. 199-200). In addition, the prevalence of those with milder symptoms is much larger compared to those with more severe symptoms. Secondly, some further argue that diagnostic inclusivity helps reduce stigma, both for patients and for psychiatry. It has been argued that

> including only the most severe mental disorders in DSM could perpetuate such stigma by reinforcing the popular notion that seeking psychiatry help is equivalent to being 'crazy'. In contrast, ensuring that mild and sub-threshold conditions are listed in DSM could help to literally normalize mental illness by communicating to the public that mental disorders are common and need not be associated with the inability to lead a meaningful life (Pierre, 2013, p. 110).

According to a consequence-based argument, when setting or revising diagnostic thresholds of psychiatric disorders, lowering the diagnostic thresholds increases the likelihood of false positives and decreases the likelihood of false negatives, and raising the diagnostic thresholds decreases the likelihood of false positives and increases the likelihood of false negatives. Balancing the social consequences of false positives and false negatives requires making non-epistemic value judgments. Consequently, decisions over diagnostic thresholds should be informed by non-epistemic value judgments.

To sum up: The value-laden view on psychiatric classification is a view that is held and defended by some psychiatrists and philosophers of psychiatry. At least two types of arguments have been advanced in support of this view, namely the definition-based arguments and the consequence-based arguments. Defenders of the value-free view on psychiatric classification could respond to these arguments in a variety of ways (Kostko, 2019). Instead of focusing on the continuing debate between the two views, however, this paper takes the value-laden view on psychiatric classification for granted and explores its implication on how the disagreements and controversies over psychiatric classification could be resolved. Disagreement over non-epistemic value judgments is a pervasive and persistent aspect of modern society, and so the value-laden view on psychiatric classification immediately raises questions about the extent to which our disagreements over non-epistemic values would contribute to disagreements over how mental disorders are classified, and about what disagreeing experts could do to help resolve controversies in psychiatric classification.

3. Disagreements in Psychiatric Classification

Classifications of mental disorders have long been a source of debate and controversy. The *Diagnostic and Statistical Manual of Mental Disorders* (DSM), published by the American Psychiatric Association, and the *International Classification of Diseases* (ICD), published by the World Health Organization, are two widely used systems for classifying and diagnosing mental disorders. Despite their global use and adoption, these classification systems are often scrutinized for how they draw the lines between what is considered normal and what is classified as a mental disorder.

The development of the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) and the final product, for instance, generated a remarkable level of criticism and debate within and outside the psychiatric community (Nemeroff et al., 2013, p. 1). Some examples of particularly controversial decisions made by the DSM-5 include: (1) The removal of bereavement exclusion from major depression in DSM-5, which allows individuals who have been clinically depressed for less than 2 months after the loss of a loved one to be diagnosed with major depression (Nemeroff et al., 2013, p. 10). (2) The introduction of the disruptive mood dysregulation disorder in DSM-5, which diagnoses children who have "persistent irritability and frequent episodes of behavior outbursts, three or more times a week, for more than a year" (Nemeroff et al., 2013, p. 10). (3) The merging of the autistic disorder, Asperger's syndrome, childhood disintegrative disorder, etc. into a single diagnostic category called "autistic spectrum disorder" (ASD), along with more stringent diagnostic criteria compared to the DSM-IV standards (Horwitz, 2021, pp. 139-140).

The inclusion of Internet Gaming Disorder as a condition for further study in the DSM-5 is another example of a controversial decision. The debate over whether excessive and compulsive gaming should be considered a legitimate mental disorder resurfaced a few years later during the revision of the 11th edition of the International Classification of Diseases (ICD-11). Even though gaming disorder (GD) was officially recognized as a mental disorder in the release of ICD-11 in 2018, it was far from clear that this decision has resolved the debate and achieved consensus within the field. In this paper, I will use the controversial history of the concept of gaming disorder as a case study to illustrate how controversies in psychiatric classification can be persistent (spanning years) and systematic (involving many participants from a variety of backgrounds), and to examine the types of reasons behind the disagreement between different sides of the debate.

Research on what is colloquially known as "gaming addiction" began to appear in psychological and psychiatric literature in the 1980s. The

studies during this time were primarily case studies based on anecdotes of patients (primarily teenage males), and the types of games played were typical "pay-to-play" arcade games such as Space Invaders (Griffiths, 2016, p. 75). The 1990s witnessed a small increase in the number of studies into gaming addiction, which began to adapt a version of the DSM-III-R or DSM-IV criteria for pathological gambling and used the adapted version of the criteria to access gaming addiction (Griffiths, 2016, p. 75). Despite these efforts at measuring gaming addiction more precisely, there is still a significant amount of disagreement on the prevalence of gaming addiction (Janzik, Wehden, Reer, & Quandt, 2020, p. 50). The 2000s saw the rise of online games, including the Massively Multiplayer Online Role-Playing Games such as *World of Warcraft*. Online games were deemed to have higher addictive potential compared to offline games, and a significant majority of the studies on gaming addiction during this decade focused on online gaming addiction (Griffiths, 2016, p. 76).

The inclusion of "internet gaming disorder" (IGD) in the 5th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) was the first landmark event concerning the formalization of gaming addiction as a diagnostic category. During the development of the DSM-5, one of the workgroups assembled by the American Psychiatric Association—the Substance Use Disorder Subgroup—was charged with considering potential candidates of non-substance or behavior addictions, including "gambling, Internet gaming, Internet use generally, work, shopping, sex, and exercise" (Petry & O'Brien, 2013, p. 1186). After examining over 250 existing publications on gaming disorder, the Workgroup voted to include internet gaming disorder (IGD) in section III ("condition for further study") of the DSM-5 because (1) it is a condition with the most evidence of clinically significant harm, among all other alleged behavior addictions, and (2) not enough evidence existed to confirm that it was indeed a mental disorder, and no diagnostic criteria was universally accepted (Petry, Rehbein, Ko, & O'Brien, 2015, p. 2).

The DSM-5 included 9 diagnostic criteria for IGD, which were chosen and worded to parallel some substance use and gambling disorder criteria (Petry et al., 2014, p. 2). The criteria that were chosen include: preoccupation, withdrawal, tolerance, unsuccessful attempts to reduce/stop, loss of interest in other hobbies and activities, continued use despite problems, deception/cover-up, escape adverse moods, risk/loss of relationships, job, or educational or career opportunities (Petry et al., 2014, p. 3). Many of these specific diagnostic criteria generated controversies; for instance, the criteria of preoccupation, withdrawal, tolerance, and deception had all come under criticism (Kuss, Griffiths, & Pontes, 2017; Starcevic, 2017). Scholars

also pointed out that games do not have to be played online to be highly addictive, so it is unclear why the proposed term "internet gaming disorder" focuses on internet games (Kuss, Griffiths, & Pontes, 2017, p. 106). Some scholars argue that the field of behavior addiction research "lacks basic theory, definitions, and properly validated and standardized assessment tools" (van Rooij & Kardefelt-Winther, 2017, p. 128), and such a flawed literature could not generate sufficiently strong evidence to support the formal adoption of a new psychiatric disorder.

After the inclusion of IGD into the DSM-5, newer attempts to refine the diagnostic criteria for gaming addiction appeared in the literature (Janzik, Wehden, Reer, & Quandt, 2020). In 2016, the WHO made a proposal for a new category of "gaming disorder" (GD) to be included in the 11th revision of the ICD. The WHO discarded some controversial DSM-5 criteria for IGD and instead proposed to define gaming disorder based on three primary criteria: (1) impaired control over gaming; (2) increasing priority given to gaming over other activities to the extent that gaming takes precedence over other interests and daily activities, and (3) continuation or escalation of gaming despite negative consequences (WHO, 2020). The WHO's proposal attracted a debate paper that argues against the inclusion of GD into ICD-11 (Aarseth et al., 2017), and a heated debate ensued. Some scholars argued that it was premature to have a formal category for GD (Aarseth et al., 2017; van Rooij et al., 2018; Etchells, 2019), while others advocated for its inclusion in the forthcoming ICD-11. (Lee, Cho, & Lee, 2017; Müller & Wölfling, 2017; Brink, 2017; Billieux et al., 2017; Saunders et al., 2017; Rumpf et al., 2018; Higuchi et al., 2017; Király & Demetrovics, 2017; Shadloo et al., 2017; Griffiths, Kuss, Lopez-Fernandez, & Pontes, 2017). Eventually, gaming disorder was formally included in the 2018 release of the ICD-11, although there is no evidence that this formal recognition by the WHO was the result of the successful resolution of disagreements from the earlier debates.

The debate over gaming disorder and other persistent controversies over the classification of mental disorders raise difficult questions about the role of non-epistemic values in psychiatric classification. First, to what extent are controversies over psychiatric classification shaped by disagreements over non-epistemic values? As we will see, non-epistemic value judgments about stigmatization, treatment options, and resource allocation frequently came up in debates over psychiatric classification. To what extent do participants disagree on these value judgments, and how much do non-epistemic value disagreements impact their views on how mental disorders should be classified?

Second, suppose that disagreements over non-epistemic values contribute to expert disagreements in psychiatric classification. According

to the value-laden view of psychiatric classification, it is legitimate for non-epistemic values to influence how experts classify mental disorders. If we accept this view, it follows that experts should not attempt to eliminate value judgments from psychiatric classification. Instead, finding consensus in psychiatric classification may require not just scientific evidence but also a careful negotiation of the non-epistemic values that influence these classifications. However, disagreements over non-epistemic value judgments can be persistent and difficult to resolve, which raises the question: how should experts make progress in addressing controversies in psychiatric classification if they are grounded on disagreements over values that are difficult to settle?

This paper does not aim to fully answer these two questions. Instead, it provides two partial but suggestive theses to help make progress on these questions. First, I argue that one source of disagreement about psychiatric classification arises from factual disagreements regarding the consequences of classification decisions. Experts may disagree over which classification decision has worse social consequences, but a significant part of this disagreement concerns what those consequences would be. In other words, if experts could reach an agreement on the potential consequences of classification decisions, they might move closer to a consensus on which classification decision yields better outcomes. I suggest that researchers should attempt to resolve these factual disagreements over the consequences of classification decisions using empirical methods, which might require interdisciplinary research and collaboration.

Second, I argue that in controversies over psychiatric classification, there is often an important type of non-epistemic value disagreement, namely disagreements over which aims of psychiatric classification should be prioritized when there are tensions and conflicts among these aims. Psychiatric classification systems often serve the aims of many stakeholders that could come into conflict, and different experts could disagree on the prioritization of aims. I suggest that to address this type of value disagreement, it is helpful to embrace *classificatory pluralism* regarding psychiatric disorders, which means that there should be multiple systems of psychiatric classification that serve different subsets of stakeholder aims.

4. Disagreeing over Potential Consequences

In this section, I support my first thesis that disagreements about psychiatric classification may partly stem from factual disagreements about the consequences of classification decisions. To illustrate this, I examine the debate over the proposal to formally include gaming disorder (GD) in

the ICD-11. I argue that much of the expert disagreement in this debate arises from differing views on the potential consequences of formalizing gaming disorder.

In response to WHO's initial proposal to formally include (i.e., formalize) gaming disorder in the ICD-11, Aarseth et al.'s (2017) open letter argued that formalizing IG would be premature and the WHO should withdraw its proposal (Aarseth et al., 2017, p. 268). Their arguments can be divided into two types: Arguments based on epistemic reasons and arguments based on non-epistemic reasons. The first type of argument contends that ICD's Gaming Disorder proposal is based on low-quality research, features nonspecific diagnostic criteria, and lacks diagnostic accuracy (Aarseth et al., 2017, p. 268). The second type argues that including Gaming Disorder in ICD-11 would have worse public health and social consequences than excluding it (Aarseth et al., 2017, p. 269). Defenders of the WHO proposal addressed both types of arguments. Since my goal is to explore the extent to which non-epistemic values shape expert disagreements in psychiatric classification, I focus on the second type of arguments presented by Aarseth et al. (2017) and the responses to them.

Aarseth et al.'s (2017) arguments based on non-epistemic reasons can be unpacked as follows. First, the formalization of gaming disorder in ICD-11 will likely make the existing moral panic[5] around the harm of video games worse. Second, the formalization of GD might result in the diagnosis and treatment of many false-positive cases, especially among children and adolescents. This in turn can lead to many terrible consequences: Most healthy gamers will be affected by the stigma[6] of being associated with the label of GD. In addition, it could lead to increasing conflict between parents and children and might lead to the forced treatment of children and the violations of their rights. Finally, the lack of consensus among experts fuels controversy about the disorder and decreases public trust in the reputation of WHO and the medical community, further decreasing the utility of the label (Aarseth et al., 2017, p. 269).

Supporters of the GD proposal, many of whom were clinicians who needed to treat individuals suffering from compulsive gaming behaviors, disagreed with Aarseth et al.'s (2017) arguments about the negative consequences of formalizing GD. They believed that Aarseth et al. (2017)

[5] Moral panic occurs when "a condition, episode, person or group of persons emerges to become defined as a threat to societal values and interests" (Cohen, 2011, p. 1).

[6] Stigma can be defined as "stereotypes that reflect a group negatively" (Corrigan, Roe, & Tsang, 2011, p. 27). Stereotypes involve factual views, evaluative attitudes and emotional responses, all of which can be measured empirically.

overestimated the harms of formalizing GD and underestimated the harms of not formalizing GD.

Regarding Aarseth et al.'s (2017) argument that the formalization of GD in ICD-11 would exacerbate moral panic about gaming, proponents of the GD proposal argue that the presence of moral panic around gaming is a factual matter that requires empirical support, and Aarseth et al. (2017) have not provided the evidence. The formalization of Alcohol Use Disorder in the DMS-5 and ICD-10, for instance, did not seem to cause moral panics about drinking alcohol (Brink, 2017). In addition, many argued that formalizing gaming disorder is more likely to reduce moral panic rather than increase it. In their view, moral panic is often caused by a combination of inconsistent information, confusion, and mainstream media with a tendency to sensationalize current news. Formalizing gaming disorder is more likely to calm moral panics because it will provide the public with consistent information and clarify which types of gaming patterns are harmful (Billieux et al., 2017; Lee, Cho, & Lee, 2017). Formalizing gaming disorder does not imply that all gaming is harmful. Even if the public misunderstands this, public health education and campaigns can help correct this misunderstanding (Király & Demetrovics, 2017; Lee, Cho, & Lee, 2017).

Regarding the point about the abundance of false positives, the stigmatization of normal gamers, and the violation of children's rights, proponents of the GD proposal argue that these consequences are unlikely. This is because formalizing GD is not about pathologizing normal gaming, but rather about pathologizing problematic or excessive gaming behavior. For instance, Billieux et al. (2017) argue that an abundance of false positives is unlikely because ICD-11's gaming disorder proposal limits the risk of overdiagnosis by explicit reference to functional impairment: In the proposal, gaming disorder is defined as a behavior pattern "of sufficient severity to result in significant impairment in personal, family, social, educational, occupational or other important areas of functioning" (Billieux et al., 2017, p. 286). Higuchi et al. (2017) agreed that clarifying what gaming disorder is can help draw a clear boundary between normality and disorder, which helps limit false positives and reduce stigmatization (Higuchi et al., 2017, p. 294). Király and Demetrovics (2017) argued that a formal diagnosis is likely to decrease stigmatization because it conceptualizes problematic gaming as a disorder rather than some personal weakness (Király & Demetrovics, 2017, p. 281). Shadloo et al. (2017) added that medicalization can help destigmatize at least in some contexts and countries (i.e., in Iran), because otherwise, there will be "overuse of restrictive and discriminative approaches, such as involvement of judiciary systems and law enforcement

agencies in some countries" (Shadloo et al., 2017, p. 311), if there are no proper diagnostic guidelines available.

Finally, supporters of the GD proposal also argued that not formalizing the disorder carries its own negative consequences and that Aarseth et al. (2017) overestimated the harms of formalizing GD and underestimated the harms of not formalizing GD. Compared to the consequences of false positives, supporters of the GD proposal were more concerned with the consequences of false negatives.

First, they pointed out the growing treatment demand for those who suffer from significant functional impairment due to excessive gaming, and the inadequacy of the existing systems in meeting these demands. Clinicians around the world reported a significant and growing treatment demand for gaming disorder in Asia, Europe, North America, and Australia (Brink, 2017; Higuchi et al., 2017; Shadloo et al., 2017).

Second, they argue that without a formalized diagnostic system for gaming disorder, it would be very difficult for demands for clinical treatment to be met. In many countries, patients of compulsive gaming would not be eligible for clinical care or treatment reimbursement if gaming disorder is not a formally recognized diagnostic category (Brink, 2017; Müller & Wölfling, 2017; Billieux et al., 2017; Saunders et al., 2017; Lee, Cho, & Lee, 2017). For instance, Higuchi et al. (2017) argued that the Japanese medical system is unable to meet the demand for treating gaming disorders, because "costs relating to IA (internet addiction) patients have been set at a low level relative to those for patients with other psychiatric disorders, and the diagnostic guidelines for IA or GD are not included in 10th revision of the International Classification of Diseases (ICD-10)" (Higuchi et al., 2017, p. 294). Shadloo et al. (2017) pointed to the insufficient capacity in the Iranian healthcare system for providing health care services for gaming disorder patients, because "due to ambiguities around the diagnosis, treatment protocols have remained underdeveloped and clients and their families cannot benefit from insurance coverage" (Shadloo et al., 2017, pp. 310-311). In short, having formally recognized diagnostic guidelines and criteria for gaming disorder is required to provide adequate clinical service, care, and treatment. The absence of a formal diagnostic system will continue to place those who suffer from severe impairments caused by problematic gaming outside of the public health system.

In response, critics of the GD proposal acknowledged that there are benefits of formalizing gaming disorder; but they reiterated that the benefits do not outweigh the societal and public health risks (van Rooij et al., 2018, p. 2). First, regarding their opponents' point that having a gaming disorder may reduce moral panic, critics of the GD proposal responded by

pointing to the proliferation of dubious treatment centers and authoritarian regimes restricting children's rights in the name of gaming addiction, and they argued that "a historical analysis of moral panics finds that they usually work in the inverse direction — official reification promotes the panic, not eases it" (van Rooij et al., 2018, p. 5).

Second, regarding the fact that a formal diagnosis is often required for medical care and insurance reimbursements, critics of the GD proposal replied that for many problems, it is not necessary to have a formal diagnosis to receive therapeutic treatment, e.g., we don't need to have a "family disorder" to consult family therapists (van Rooij et al., 2018, p. 3). There might very well be other healthcare reform options that could provide care and insurance reimbursements to compulsive gamers, without having to formalize gaming disorder as a diagnostic category. Critics also doubted that formalizing GD would result in better treatment of those who suffer from problematic gaming. They argued that based on the current state of research on gaming disorder, there was no clear conception of what gaming disorder is. Is it a coping behavior for some other problems? Is it gaming-specific or more generally applied to other types of technologies? Without solid answers to these questions, it isn't clear that having a gaming disorder in the classification system will help clinicians treat patients effectively (van Rooij et al., 2018, p. 3).

To summarize, a focal point in the debate over whether gaming disorder (GD) should be formalized in ICD-11 concerns which option has worse social consequences. Critics argue that formalizing GD would have worse consequences, while proponents believe the opposite. This is indeed a non-epistemic value judgment that the two sides disagree on. However, the most salient source of this disagreement seems to be different views on what the potential consequences of formalizing versus not formalizing would be. Critics of the Gaming Disorder (GD) proposal argued that formalizing GD would increase moral panic about gaming and stigmatize healthy gamers, which supporters denied. On the other hand, supporters argued that not formalizing GD would deprive those with problematic gaming behaviors of effective treatment and care, a point that critics doubted.

A problem shared by the two sides of the debate is that neither side produced much evidence for their claims about the potential consequences of classification decisions. For instance, Griffiths et al. (2017) pointed out that when critics of the GD proposal discussed the potential consequences of formalizing GD, they frequently used terms such as "might," "may," "likely," "expect," and "potentially," which indicates that their claims about consequences are speculative. Moreover, critics often replace "might" with "will" in their arguments to make their conclusions sound more definitive

and convincing (Griffiths, Kuss, Lopez-Fernandez, & Pontes, 2017, p. 297). However, supporters of the GD proposal do the same when discussing the consequences of formalizing versus not formalizing. For example, Griffiths et al. (2017) argue that formalizing a diagnostic framework for Gaming Disorder (GD) *may* reduce false positives, while not formalizing *could* make insurance and treatment providers reluctant to offer specialized and effective treatments (Griffiths, Kuss, Lopez-Fernandez, & Pontes, 2017, p. 299). Therefore, both sides of the debate could benefit from stronger empirical evidence to support their claims about the consequences.

In general, when a classification decision involves multiple options, disagreements about which option has worse consequences can arise from two possible sources: disagreements over the likely consequences of each option, and disagreements over how to evaluate these consequences (e.g., how good or bad they are). The first type of disagreement is factual and contributes to the overall disagreement. In the case of the Gaming Disorder debate, experts clearly disagree on the likely consequences of different options. However, it is unclear whether, and to what extent, they also disagree on how to evaluate these consequences[7]. Resolving factual disagreements first can help reduce part of the disagreement and clarify the extent of any remaining disagreements over values.

Resolving factual disagreements about the consequences of different classification options requires empirical investigations. To comprehensively evaluate these consequences, it is helpful to integrate perspectives from various disciplines, including psychiatry, public health, sociology, legal and policy studies, and anthropology. For instance, psychiatrists can examine how psychiatric classification influences clinical practices, while public health experts assess the broader implications of the classifications on the healthcare system and access to healthcare. Sociologists explore the societal impacts of the classifications, including stigma and moral panic. Legal scholars and policy analysts investigate how psychiatric classification affects regulatory frameworks and patients' rights, whereas anthropologists study the perception and impact of psychiatric classifications across cultures. Researchers from different fields could also collaborate to design studies

[7] An anonymous reviewer notes that in the case of tobacco use, experts disagreed on whether stigmatizing smokers is harmful overall: Some viewed it as beneficial "social regulation" that promotes healthier habits, while others disagreed (Brewis & Wutich, 2019). I acknowledge that this type of value disagreement existed in the case of tobacco use. However, it is unclear if any experts disagree with the claim that stigmatizing healthy gamers is harmful overall or that moral panic about gaming is bad. Regardless, my point is that resolving factual disagreements about likely outcomes can help determine if there are remaining disagreements on how to value these consequences.

that address the complex interaction between psychiatric classification and social factors, which could lead to a more nuanced understanding of psychiatric classification's social implications.

Admittedly, reaching a consensus about the social and public health consequences of classification decisions could be difficult in practice. Motivational reasoning and disciplinary biases (biases associated with different disciplinary backgrounds) can affect experts' judgments regarding the potential consequences of classification decisions. For example, Rumpf et al. (2018) pointed out that the professional backgrounds of those who criticize the proposal to formalize GD tend to be authors coming from areas other than clinical science and public health, including "media psychology, computer games research, experimental and social psychology, sociology, educational psychology, game design, and communication science" (Rumpf et al., 2018, p. 3). In contrast, those who are in favor of the proposal predominantly come from clinical and public health disciplines, including "psychiatry, child psychiatry, mental health, internal medicine, family practice, clinical psychology, clinical neuroscience, and addiction treatment and prevention" (Rumpf et al., 2018, p. 3). Disciplinary biases might have contributed to experts' disagreements about the social and public consequences of gaming disorder.

Despite the practical difficulties in reaching a consensus on the social consequences of psychiatric classification, I believe that it is crucial for psychiatrists and scientists in other fields to conduct empirical research to evaluate these consequences. Empirical evidence, whether supporting or refuting the proposed consequences, is preferable to having no evidence at all. Robust empirical evidence can help overcome motivational and disciplinary biases. Without such evidence, disagreeing experts cannot hope to make progress beyond speculative statements about the potential consequences of classification decisions. Galanis et al. (2021) have highlighted some promising research on the stigma associated with behavioral addictions (Galanis, Delfabbro, & King, 2021, p. 2921), and further studies of a similar nature can provide valuable data for evaluating the social consequences of the diagnosis.

5. Multiple Aims and Classificatory Pluralism

Influential psychiatric classification systems such as the DSM and the ICD have been used by many stakeholders for a variety of purposes. First, they facilitate communication among clinicians, researchers, administrators, and patients by creating a common language for describing and diagnosing mental disorders. Second, they assist clinicians

by providing diagnostic criteria and guidelines on the most effective treatment options. Third, they have been used by researchers to conduct studies on specific mental disorders, their underlying causal mechanisms, and the effectiveness of drugs and other treatment options (First, 2012). Fourth, in many countries, insurance companies use the DSM or the ICD categories to determine or restrict coverage for mental health services. In the U.S., for instance, mental health professionals typically need the DSM to complete insurance forms (Cooper, 2005; Cooper, 2017). Fifth, DSM and ICD sometimes play educational and administrative roles in some countries, and legal professionals and bureaucrats must deal with rules and regulations that rely on these classification systems (Sadler, 2013). The far-reaching social consequences of adopting and revising psychiatric classification systems arise partly from the fact that these systems serve many practical purposes.

The aims and needs of different stakeholders regarding the classification of psychiatric disorders sometimes come into conflict, in which case a classification decision (e.g., setting the diagnostic threshold at a particular level) that serves one stakeholder's aims may undermine the aims of another stakeholder. In these situations, experts responsible for the psychiatric classification systems must consider which aims should be prioritized. However, disagreements among experts can arise. For two non-epistemic aims[8] X and Y, if expert A argues that a classification decision should prioritize X over Y, but expert B argues that the decision should prioritize Y over X, then the two experts are engaging in a non-epistemic value disagreement. Different views about which aims of psychiatric classification should take priority are an important source of value disagreement in controversies over the classification systems.

In the debate over formalizing gaming disorder (GD) in the ICD-11, experts disagree over whether the aims of clinicians and patients should take priority over those of the healthy gamers who could be impacted by the formalization of GD. Supporters of the GD proposal argue that the intended audience of ICD-11 is primarily clinicians and patients. For instance, Müller and Wölfling (2017) wrote: "By stating that the healthy majority of gamers will be affected by stigma and perhaps even changes in policy, it becomes more than obvious that the authors are forgetting about those the DSM-5 and the ICD-11 are meant for the patients" (Müller & Wölfling, 2017, p. 120). Similarly, Rumpf et al. (2018) argued that "we have

[8] Epistemic aims or goals include truth, knowledge, explanation, understanding, research fruitfulness, and more. Non-epistemic aims include aims that are moral, social, economic, political, cultural, or aesthetic in nature.

emphasized the arguments that relate to clinical and public health issues, which reflect the essence of the ICD" (Rumpf et al., 2018, p. 3). The idea of this line of argument seems to be that the primary goal of the ICD is to be clinically useful, hence clinicians' and patients' needs take priority over the needs of others. Critics of the GD proposal, in contrast, argue that even if formalizing GD satisfies the aims of the clinicians, it "neglects the wider non-clinical societal context" (van Rooij et al., 2018, p. 3), where the negative social consequences (e.g., stigmatization) are primarily shouldered by the general population of healthy but highly engaged gamers (van Rooij et al., 2018, p. 4). According to these critics, there is no reason why the needs of clinicians and patients should always take priority over the needs of gamers (e.g., not being stigmatized and not self-stigmatizing), especially if the threat to the latter is sufficiently acute.

When discussing controversies over the DSM-5, Pierre (2013) distinguishes between the "clinical utility" (or alternatively, clinical objectives) versus the "contextual utility" of psychiatric classification. Clinical utility is defined as "the extent to which DSM assists clinical decision-makers in fulfilling the various clinical functions of a psychiatric classification system that include communication, selecting effective interventions, and predicting future clinical management needs" (Pierre, 2013, p. 114). Contextual utilities depend on the uses of psychiatric classification systems in non-clinical contexts, e.g., DSM categories may be required for obtaining funding for psychiatric research, government disability programs, private or public insurance, etc. (Pierre, 2013, pp. 112-3). Pierre argues that it is impossible for a given psychiatric classification system to satisfy clinical utilities and all contextual utilities simultaneously because different utilities require different diagnostic thresholds (Pierre, 2013, p. 113). To address this issue, Pierre recommends prioritizing clinical utility over other contextual considerations, on the ground that the primary purpose of the DSM should be to guide clinical work (Pierre, 2013, p. 116).

Another common type of conflict in the aims of psychiatric classification is the conflicting aims of clinicians and researchers. An example that illustrates this type of conflict occurred during the DSM-5 development process, where debates arose over whether mental disorders should be conceptualized as being on a continuum versus being discrete categories. The so-called dimensional systems, which assume that mental characteristics vary continuously (e.g., intensity, severity, duration), are favored by researchers. In their view, conceptualizing DSM categories, particularly personality disorders, as positions on a spectrum rather than as discrete categories constitutes a more productive research approach (Widiger & Samuel, 2005). The Personality Disorders Work Group

proposed eliminating diagnostic thresholds for personality disorders, but the proposal faced fierce opposition from clinicians. Clinicians found dimensional systems unfamiliar, confusing, and burdensome to use. They were concerned about the implications of the dimensional system for reimbursement and were unconvinced about its clinical utility in practice. At its annual meeting in 2012, the APA Assembly, primarily composed of clinicians, voted to relegate all dimensional scales to the appendix of DSM-5. The DSM-5 retained the categorical approach for personality disorders as a result (Horwitz, 2021, p. 132). In this example, the contention is whether the researchers' epistemic aims (e.g., research fruitfulness) should take precedence over the clinicians' practical aims (e.g., to have diagnostic criteria that are easy to use in clinical settings) with respect to the decision to adopt a dimensional approach in the DSM. Ultimately, the APA prioritized the needs of clinicians over those of researchers, a decision that researchers find unsatisfactory (Horwitz, 2021, p. 132).

The problem of resolving disagreements about how to prioritize conflicting aims of psychiatric classification can be difficult. While I do not have a full solution to this problem, I do believe that one source of the problem is that major psychiatric classification systems such as the DSM and the ICD have been burdened with fulfilling too many aims for too many stakeholders. We should reconsider the purposes these systems are intended to serve. Instead of relying on single systems to meet all these diverse needs, we should develop multiple psychiatric classification systems, each designed to satisfy different subsets of aims. This approach, known as classificatory pluralism, could help ease disagreements at least in some cases.

Scholars have noted that the diverse uses of psychiatric classification systems have imposed numerous constraints on whether and how these categories and their diagnostic criteria could be revised. Sadler (2013) argues that the DSM plays administrative roles in the U.S. healthcare system, and revisions to the DSM tend to be conservative because changes incur administrative costs (Sadler, 2013, p. 27). Cooper (2017) remarks that revising the DSM's diagnostic categories and criteria is challenging because they are used by a diverse range of users. The various users have different requirements, and it is hard to revise the classification while ensuring that these requirements continue to be met (Cooper, 2017, p. 13). For instance, in the U.S., a diagnosis of Asperger's or autism used to come with costly entitlements like one-on-one therapies, which depended on the diagnosis. The DSM-5 merged several autism-related conditions into a new autistic spectrum disorder (ASD). During its development, several studies predicted many diagnosed with Asperger's under DSM-IV would not qualify for ASD. Autism groups learned about these studies and pressured the DSM

committee to resist these changes. Eventually, the DSM committee added a proviso to ASD's criteria, ensuring those with DSM-IV diagnoses of Asperger's or autism that they would receive an ASD diagnosis (Cooper, 2017, p. 5).

I argue that, rather than trying to rely on a single psychiatric classification system such as the DSM or ICD to meet the needs of all stakeholders and navigate their various constraints, it is better to develop multiple classification systems tailored to different subsets of uses. This approach is sometimes referred to as "classificatory pluralism" and can be characterized by three main claims (Cuypers & Reydon, 2023; Cuypers, Reydon, & Artois, 2022; Zachar, 2002): First, classifications can only be understood and evaluated relative to the specific aims and objectives for which they are used. Second, multiple classifications of the same phenomena should be allowed to co-exist. This does not mean that any classification is acceptable; rather, there could be multiple correct ways of classifying the phenomena, each fitting different aims and contexts. Third, different aims could favor different classifications, which leads to conflict and disagreement if one classification is treated as if it were an all-purpose gold standard. In short, classificatory pluralism provides an explanation for *some* of the disagreements that can occur in classification contexts and offers a solution to these disagreements. So far, classificatory pluralism has mainly been advocated regarding biological taxonomies (Cuypers & Reydon, 2023; Cuypers, Reydon, & Artois, 2022). I propose that this approach should also be applied to psychiatric classification.

An example in psychiatry that illustrates classificatory pluralism is the development of the Research Domain Criteria (RDoC). Given that the primary goal of the DSM and ICD is to be clinically useful, there is a limit to how they can be modified to satisfy the needs of the researchers. In 2013, the National Institute of Mental Health (NIMH) announced the development of a dimensional psychiatric classification system called the "Research Domain Criteria" (RDoC), which was intended to facilitate neuroscience research. Proponents of RDoC emphasized that RDoC was not intended as a diagnostic tool and did not replace current clinical classification systems such as the DSM (Carpenter, 2013). They acknowledged that the DSM is crucial for clinical insurance reimbursement, determining disability status, and service eligibility (Casey et al., 2013). However, they argued that there is a growing consensus among researchers that current classifications for many disorders are insufficient for advancing scientific knowledge. The RDoC was developed specifically to facilitate neuroscience research on mental disorders. Consequently, RDoC serves a different set of equally legitimate purposes and should be allowed to coexist alongside the DSM and ICD systems (Carpenter, 2013, p. 945).

My proposal to use classificatory pluralism to help resolve expert disagreements in psychiatric classification faces several objections.[9] First, an important aim of psychiatric classification is to facilitate communication among clinicians, researchers, administrators, and patients by creating a shared language for mental disorders. However, classificatory pluralism arguably undermines this goal by eliminating a common language. Second, some aims of these classification systems, like clinical and administrative uses, are intertwined and hard to separate. For instance, creating a classification system for insurance coverage that is disconnected from diagnostic criteria seems challenging. Third, classificatory pluralism may shift rather than resolve disagreements. With a single all-purpose system (such as the DSM or the ICD), experts disagree on which aims to prioritize; with multiple systems, they might disagree on which systems to use instead. Fourth, even if classification experts clarify the aims of different classification systems, they can still be misused by patients and the public. Despite clarifications by the American Psychological Association (APA), people often misuse DSM categories, either by using them loosely (e.g., calling neat people "OCD") or by reifying them (e.g., treating Asperger's syndrome as a natural kind and part of one's identity). These misuses can generate conflicts and disagreements between different communities, which are not easily resolved by classificatory pluralism.

I believe that these objections can be addressed. First, having multiple psychiatric classification systems does not prevent communication between users of different systems, since relationships or mappings between different systems could be established. Cuypers and Reydon (2023) argue that in biological taxonomies, information tools that map relationships between entities in different classification systems (called "taxonomic alignments") enable the translation of data, research, and policies across classifications, which facilitates communication between these systems (Cuypers & Reydon, 2023, p. 17). Similarly, relationships exist between different psychiatric classification systems. Aftab et al. (2024) describe relationships between DSM and HiTOP (Hierarchical Taxonomy of Psychopathology), a system that uses statistical analysis of symptom patterns to create a hierarchy of dimensions. They argue that the DSM's categories can be seen as coarse-grained approximations of HiTOP's dimensions and hierarchy. Although DSM categories are not officially part of HiTOP, clinicians can use the level of syndromes to translate between the two frameworks (Aftab, Banicki, Ruffalo, & Frances, 2024, p. 451).

[9] The objections in this paragraph are based on comments by two anonymous reviewers.

Second, while clinical uses of DSM and ICD are currently intertwined with administrative functions —such as education benefits, treatment approvals, and insurance reimbursements— this entanglement is neither desirable nor inevitable. The entanglement is not desirable because administrative uses of diagnostic labels favor conservatism, keeping labels unchanged over time, whereas research and clinical uses require flexibility to accommodate new discoveries. Additionally, using diagnostic labels for healthcare resource allocation presses clinicians to apply these labels inappropriately, risking harm and injustice (Werkhoven, Anderson, & Robeyns, 2022, p. 945). The entanglement isn't unavoidable because clinicians have already been straying from the formal, operationalized diagnostic criteria in the DSM and ICD, which they use for administrative documentation and billing purposes. In practice, instead of always strictly adhering to the formal and operationalized diagnostic criteria, clinicians frequently use prototypes learned from their training—typical examples with fuzzy boundaries—to match clinical descriptions to diagnoses. They also supplement diagnoses with narrative descriptions and utilize various quantitative clinical rating scales, such as the Quick Inventory of Depressive Symptomatology or the Yale-Brown Obsessive Compulsive Scale (Aftab, Banicki, Ruffalo, & Frances, 2024, p. 446). The incorporation of these alternative approaches and resources in clinical practice already represents a form of pluralism. Therefore, it is not inconceivable to design separate classification systems for clinical and administrative uses respectively.

Third, classificatory pluralism does not merely shift disagreements; it can resolve some of them. As mentioned before, a major issue with the DSM and ICD is that they are often treated as all-purpose classification systems, applied across all contexts despite differing aims and needs in different contexts. This universal application leads to disagreements regarding whether and how to revise these systems. By developing different classification systems tailored to specific contexts, at least some disagreements can be eliminated. For example, a system designed solely to help identify neurological mechanisms underlying mental disorders would not need to address clinical or administrative needs.[10] This separation would prevent conflicts between research, clinical, and administrative utilities, as each structure would be optimized for its specific purpose.

Finally, I acknowledge that psychiatric classification systems can be misused by the public, even when their intended purposes are clarified.

[10] This is true at least in the short term while research is ongoing and uncertain. In the long term, successfully identifying the neurological mechanisms of psychiatric disorders can inform and improve clinical practices.

Classificatory pluralism aims to resolve some disagreements among experts about which goals should be prioritized in classification decisions. It does not seek to eliminate all the misunderstandings and misuses of psychiatric labels by users and stakeholders. Nevertheless, classificatory pluralism can help mitigate some sources of public misuse. While clinicians and researchers tend to view classification systems like the DSM and ICD as works in progress, many people in the general population still reify psychiatric labels, treating them as biologically grounded natural kinds (Singh, 2024). Clear communication about the purposes and limitations of multiple psychiatric classification systems may help more people understand that diagnostic labels in the DSM and ICD do not yet approximate natural kinds and do not reflect immutable aspects of their identity. While this won't fully resolve public reception issues, it's important to recognize that official and private uses of psychiatric classification systems will always coexist, with some degree of divergence between them.

In short, while embracing classificatory pluralism may not resolve all the conflicts and disagreements regarding psychiatric classification, it can reduce the number of conflicting constraints that current main classifications are subjected to. Classificatory pluralism also encourages a critical reevaluation of the roles and responsibilities of psychiatric classification, including reconsidering which aims should be addressed by psychiatric classification systems and which are better served by other institutions. For instance, should psychiatric classification systems be so closely tied to insurance coverage and educational benefits? Are there alternative ways to ensure that those in need can access psychiatric care and treatment without requiring a diagnostic category in the classification manuals? Reflections on these questions may help reduce disagreements concerning how to classify disorders.

6. Conclusion

The value-laden view complicates the resolution of expert disagreements over psychiatric classification. However, there are strategies that can help mitigate, if not fully eliminate, these disagreements. Experts from diverse disciplines could collaborate to assess the potential consequences of various classification decisions. Additionally, developing multiple classification systems tailored to different subsets of stakeholder aims could reduce the conflicting constraints on existing systems like the DSM and the ICD.

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