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Elodie Boissard

Is "depression" a vague concept in psychiatry?

SOCIÉTÉ DE PHILOSOPHIE DES SCIENCES (SPS)
École normale supérieure
45, rue d'Ulm
75005 Paris
www.sps-philoscience.org

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Sommaire

Dans cet article, je cherche à savoir si la "dépression" est un concept vague en psychiatrie et quelle en est la conséquence pour les philosophes qui voudraient contribuer à l'élaboration d'une définition objective de ce concept. En supposant que ce concept vise à désigner un trouble mental, je montre que sa définition actuelle est controversée : nous manquons d'un modèle scientifique unifié, et donc d'une définition objective consensuelle de la dépression. Il en existe bien une définition clinique dans les classifications de la psychiatrie, mais cette définition, qui consiste en une liste de critères, est accusée d'être insuffisante pour tracer une démarcation nette entre des cas de souffrance affective normale et des cas pathologiques. Cela confère des limites floues à l'extension du concept de dépression, en tant qu'il devrait être réservé aux cas pathologiques. De plus, les critères cliniques, étant descriptifs et non distinctifs, doivent être interprétés par les cliniciens d'une manière qui reste implicite et contextuellement variable, et sont une liste disjonctive si bien qu'ils peuvent correspondre à des tableaux cliniques complètement différents. J'interprète cela comme une variabilité de la définition descriptive de la "dépression", de sorte que les conditions d'usage du concept dépendent du contexte, et qu'il peut s'appliquer à deux cas qui n'ont en apparence rien en commun, si ce n'est des similitudes. En appliquant à la "dépression" la célèbre caractérisation wittgensteinienne du concept de "jeu", je soutiens que cette imprécision peut être interprétée comme montrant que la "dépression" fonctionne comme un ensemble de concepts dont les instances ne partagent que des "ressemblances de famille". Je suggère que les philosophes ne devraient pas concevoir la définition objective de la dépression comme une liste de conditions nécessaires et suffisantes pointant vers son essence, qui ne pourra être élaborée que lorsque nous disposerons d'un modèle scientifique unifié de ce trouble mental ; les philosophes peuvent au contraire contribuer dès maintenant à l'élaboration d'une définition objective de la dépression, ou bien en décrivant les "ressemblances de famille" entre les différentes versions de ce concept, ou bien en essayent de stipuler une définition lui donnant des limites nettes. L'élaboration d'une définition stipulative peut être motivée par un objectif pragmatique sans pour autant délégitimer les autres utilisations qui pourraient être faites du concept. Un tel objectif pourrait être de cibler uniquement certains cas médicalement pertinents ; ces cas ne doivent pas nécessairement être conçus comme des cas dans lesquels il existe une maladie comprise comme un processus pathologique que nous pourrions définir objectivement, mais peuvent être considérés comme les cas que nous avons les moyens médicaux de prendre en charge de façon bénéfique.

In this paper I investigate whether "depression" is a vague concept in psychiatry and the consequence of this for philosophers who would like to contribute to the elaboration of an objective definition of it. Assuming that this concept aims at referring to a mental disorder, I show that the current definition of "depression" is controverted: we lack a unified scientific model of it, so a consensual objective definition of it. Actually there is its clinical definition in the nosology but this definition consisting in a list of criteria is accused of not being sufficient to draw a sharp limit between normal and pathological cases. Hence vague boundaries of the extension of the concept as referring to a mental disorder. Moreover its clinical criteria, as descriptive and non distinctive, need to be interpreted by clinicians in a way that remains implicit and contextually variable, and they can apply to completely different clinical pictures. I interpret this as a variability of the descriptive definition of "depression", so that its conditions of use depend on the context: it may apply to two cases that have nothing in common except similarities. Applying the famous wittgensteinien characterization of the concept of "game" to "depression", I argue that this vagueness can be interpreted as showing that "depression" works as cluster of concepts whose instances only share "family resemblances". From this philosophical interpretation I draw the conclusion that the "vagueness problem" of depression at a theoretical level does not make the use of this concept problematic, since this in practice use is always related to a context conferring a specific meaning to the concept. I conclude that philosophers should not look in the clinical sciences for an objective definition of depression as a list of necessary and sufficient conditions pointing at its essence: they should rather either describe the family resemblances between the different versions of this concept, or try to stipulate a definition providing it sharp boundaries. A stipulative definition would be motivated by a pragmatic purpose while not delegitimizing other uses that could be made of the concept. Such a purpose could be to target only medically relevant conditions; actually such conditions do not necessarily have to be conceived of as conditions where there is a disease understood as pathological process that we could objectively define, but they can be seen as conditions that we have medical means to take care of with more benefits than disadvantages.

Mots clés : dépression, philosophie de la psychiatrie, vague, normal et pathologique, maladie.
Keywords: depression, philosophy of psychiatry, vagueness, normal and pathological, illness.

Depression is nowadays considered to be the most prevalent mental disorder and a serious threat to public health, being one of the most disabling diseases in the world, right after cardiac disorders (Horwitz, 2015). The prevalence of depression is high and increasing[1]. However, we lack a unified scientific theory of depression that would explain what it is and

1 *In France, the 2017 Health Barometer showed that in the working population aged 18 to 75 in France, nearly 10% of people had experienced a characterized depressive episode (CDE) in the past 12 months: there was a two points increase in its prevalence between 2010 and 2017 after a relative stability over the 2005-2010 period (Gigonzac et al., 2018; Léon et al. 2018). In 2005, the first large-scale survey on depression in France, Anadep, conducted on the entire population residing in France aged 15 to 75 years, showed that 7.8% of respondents had experienced a characterized depressive episode during the year preceding the*

what its causes are. As a consequence, we know depression as a set of symptoms, an "illness", that gets diagnosed and requires special care (medication and psychotherapy), while remaining ignorant of a corresponding "disease" that would be a pathogenic process causing the symptoms.

The distinction between a disease, an illness, and a sickness, formulated by Marinker, is still quite consensual in medicine and philosophy of medicine (Boyd, 2000; Marinker, 1975). It states the following. A disease is "a pathological process" that implies "deviation from a biological norm" and manifestations that are "signs" or "symptoms" (Marinker, 1975, p. 82). An illness is "an experience of unhealth that is entirely personal": in some cases we cannot scientifically identify any corresponding disease (Marinker, 1975, p. 82). A sickness is "the external and public mode of unhealth" (Marinker, 1975, p. 83): this recognition of an individual as "sick" is often unstable when there is no scientific knowledge of a disease explaining his illness, whereas the knowledge of a corresponding disease tends to secure a public recognition of people having an illness as "sick" and deserving support (Boyd, 2000; Marinker, 1975). In the case of mental disorders, this knowledge is generally lacking insofar as we do not know their etiology: we therefore only have clinical definitions of these disorders as illnesses and not in terms of pathogenic processes. Consequently, there is a general philosophical debate about what "mental disorders" are. Opposed views range from Wakefield's views defining mental disorders as illnesses related to diseases that are "harmful dysfunctions" of the individual (Wakefield, 1992b, 1992a), to Szasz denouncing "the myth of mental illness" (Szasz, 1960). Both argue that mental illnesses or disorders ought to be caused by a dysfunction or a lesion (that would be the disease we were looking after). But only Wakefield (1992b) argues that there are mental dysfunctions underlying mental illnesses, at least in some cases. By contrast, Szasz (1960) denies it and so argues that there are no such things as mental illnesses and that mental illness is a myth. For him, psychiatric categories are an instrument for "medicalizing" life's problems.

In particular, there is no unified model of depression, either at a neurobiological level or any other explicative level (psychological or epigenetic). We assume that the disease exists and that the clinical criteria used for its diagnosis allow the clinicians to infer it from its signs: all we have are ill people whose social recognition as sick is unstable. But we could claim that even if the only thing we know for sure is that depressed individuals have an illness, this is sufficient to justify the need for public recognition and support for their condition. The question we then face is whether we should seek to identify the essence of depression (at the neurobiological level, or the psychological level, etc.) or whether we should consider it to be a useless effort.

Why should we care if the psychiatric category of depression is properly applied to people with an illness? People diagnosed with "depression" often face huge distress due to adverse circumstances causing sadness or anxiety like grieving, aging, dealing with failure in one's professional or sentimental life, etc. Some of these people face a problematic situation but no medical issues; some are suffering for instance because of unacceptable working conditions, or because of a socially distressing environment... In such situations the diagnosis of "depression" can be seen as a way to help since it allows the individual to get some support: but is it the most efficient way to solve the problem? If the problem is not medical then why address it with medical means? Shouldn't we rather frame those cases in social terms instead of medical terms, and allow resources to social services instead of providing medical treatment? What are the problems raised by diagnosing and treating people for a disease if there is none? First of all, a medical framing of those situations may prevent us from addressing the real problem if it is rather existential, social, economic, etc. Second, an inappropriate medical treatment might even have iatrogenic effects, namely undesirable side effects (Dowrick, 2016). Moreover, it is not the same to think of oneself as undergoing the inevitable part of suffering a human life includes, or as suffering from a pathological or at least medically relevant condition. To frame an existential problem in medical terms may bear negatively on the resolution of the existential problem. This might be of some significance for individuals, but also for society as a whole, to know in which cases we are dealing with social or existential problems, or we are dealing with medical problems, and in which cases the latter are caused by the former. These are the issues at stake when it comes to "depression" used as a psychiatric category to diagnose people.

The difficulty is that this concept tends to be used in a variety of contexts with variable meanings. First of all, specific clinical concepts seem to be included in the extension of the concept "depression", for instance, the "characterized depressive episode", the "major depressive disorder", or the "subclinical depressive syndrome". But besides these clinical notions there is also ordinary blues and the tendency of many people to call "depression" any negative emotion or episode of affective suffering: in everyday language, the concept applies to a range of negative emotions, from sadness and despair to hopelessness and boredom, but also to many situations like experiencing failure, helplessness or isolation. So the concept could be a cluster of concepts sharing "similarities" and "family resemblances" even if there would not be anything common to all, as Wittgenstein notices about games (Wittgenstein, 1967, pp.

*interview, and 17.8% during their lifetime (*La dépression en France Enquête Anadep 2005*, 2021). Other studies estimate that about 20 % of the general population of any Western society undergoes depression (Horwitz, 2015).*

31-32). We could apply to "depression" what Wittgenstein famously wrote about the concept of "game" in his *Philosophical Investigations*:

> "69. How should we explain to someone what a game is? I imagine that we should describe games to him, and we might add: "This and similar things are called 'games' ". And do we know any more about it ourselves? Is it only other people whom we cannot tell exactly what a game is?—But this is no ignorance. We do not know the boundaries because none have been drawn. To repeat, we can draw a boundary— for a special purpose. Does it take that to make the concept usable? Not at all. (Except for that special purpose.)" (Wittgenstein, 1967, p. 33)

What Wittgenstein suggests here is that some concepts have no definition in terms of necessary and sufficient conditions: as a consequence there are no sharp boundaries for their extension. All we can do to define them is to point at particular cases falling under these concepts or to spell out some resemblances between these cases. But Wittgenstein highlights that, on the one hand, it is not a problem to use the concept and, on the other hand, it is always possible to stipulate a definition giving sharp boundaries to the concept if it is needed for a "special purpose". Wittgenstein further qualifies concepts like the concept of "game" as vague:

> "71. One might say that the concept "game" is a concept with blurred edges - "But is a blurred concept a concept at all?"- Is an indistinct photograph a picture of a person at all? Is it even always an advantage to replace an indistinct picture by a sharp one? Isn't the indistinct one often exactly what we need? Frege compares a concept to an area and says that an area with vague boundaries cannot be called an area at all. This presumably means that we cannot do anything with it. -But is it senseless to say: "Stand roughly there"? Suppose that I were standing with someone in a city square and said that. As I say it I do not draw any kind of boundary, but perhaps point with my hand – as if I were indicating a particular spot." (Wittgenstein, 1967, p. 34)

According to Wittgenstein there are concepts with "blurred edges": their extension is not sharply delimited, like an area with "vague boundaries". This does not mean that they are not valid concepts. Indeed, we can still use them in practice but the absence of a sharp extension implies that there is an uncertainty or a contextual instability regarding the use of the concept: it seems difficult to determine the entire series of instances falling under such a concept. The vagueness of a concept can disappear if we change its definition because it requires formulating its intension in a way that allows one to determine its precise extension, thereby excluding its uses with other meanings as illegitimate. Vague concepts could be numerous in psychiatry (Keil et al., 2017).

If we apply these considerations to the concept of "depression" it means that, even if it is not currently possible to define it in terms of necessary and sufficient conditions, it may not be a problem to use the term. Defining "depression" could consist in pointing out similarities between different versions of it. But we could also make its vagueness disappear by discovering the essence of depression and defining it accordingly in terms of necessary and sufficient conditions. Alternatively, we could stipulate such a definition for a special purpose like diagnosing some people who could benefit from medical support and no other. This paper aims to develop a specific approach to the definition of depression, namely in terms of the vagueness of the concept of "depression": this will allow us to mobilize the literature about vagueness in the philosophy of language in order to open new perspectives on the problem of the definition of "depression" in philosophy of psychiatry.

Is "depression" a vague concept in psychiatry? Does it raise a "vagueness problem" of this concept? If yes, how should we change its definition to solve this problem? First, I need to make some preliminary distinctions and provide clinical definitions of notions related to depression in psychiatric terminology. In the second section, I will argue that the psychiatric concept of "depression" is vague. In the third section I will consider the "vagueness problem" raised by vague concepts at an epistemic, semantic, and ontological level (Egré, 2018). At the epistemic level, the problem is that the judgement by which we apply this concept to some concrete cases is unstable; at the semantic level, the problem is that we have several definitions of the concept that are equally valid, depending on the context; at the ontological level, the problem is that we ignore whether the vagueness of the concept comes from the type of reality to which it is supposed to apply in the world, or whether it comes from the way our mind relates to reality. I apply this analysis of vague concepts to the concept of "depression". I will ask the question of whether we need a solution to this problem, and whether it should come from the discovery of the essence of depression. In fact, at first sight, such a discovery would remedy the concept's vagueness by providing a definition of it that includes necessary and sufficient conditions. At the same time, it would define depression as a disease. But I will conclude that we don't necessarily need this discovery to happen in order to formulate a definition of depression that would remedy the concept's vagueness. Starting from the family resemblances between several versions of the concept, we could try to elaborate the definition of a prototype or a core concept of depression. This definition would go beyond its clinical criteria, being a unified definition instead of a list of variable manifestations. It would allow us to clarify our definition of depression as an illness, while still ignoring its essence as a pathological process, putting aside a corresponding disease.

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1. Preliminary distinctions

The most immediate meaning of "depression" in psychiatry is "depressive disorder". "Depressive states" started to appear as a category or subcategory of mental disorders in the 1960s and 1970s. They were still related to "melancholy" (see the DSM-I and DSM-II). It was in the third edition of the *Diagnostic and Statistical Manual of Mental Disorders from the American Psychiatric Association*, published in 1980, that depression definitively replaced "melancholy": more precisely, a global category of "mood disorders" was created, including the "depressive disorders" sub-category as well as also the "bipolar disorders" sub-category (American psychiatric association, 1983). Its descriptive approach leads to definitions of mental disorders relying on lists of criteria supposed to be applied without any specific theoretical background about the nature of mental disorders. This "descriptive turn" was meant to improve the reliability of those categories, that is their ability to reach inter-judge agreement about diagnosis, even if their validity, that is their ability to target "real" diseases, may have simultaneously decreased (Demazeux, 2013). In the last edition of the DSM, namely the DSM-5 published in 2013, the category "mood disorders" disappeared and "depressive disorders" and "bipolar disorders" became two independent categories (American psychiatric association, 2013). The *International Classification of Diseases* (ICD) from the *World Health Organization* (WHO) adopted in its last edition (ICD-11, 2022) the same criteria as the DSM-5 for the characterized depressive episode (CDE) and the major depressive disorder (MDD). Epidemiological surveys on depression in the general population use questionnaires based on these criteria. They serve as the official definition of "depression".

In an attempt to investigate whether "depression" is a vague concept, I will put aside close but distinct problems that are other kinds of possible indeterminacies of our concepts, namely ambiguity, generality, context-dependency, and lack of precision (Keil et al., 2017).

- The ambiguity of the term "depression" refers to the fact that it refers to a mental or affective problem in individuals but also to phenomena in geography, economics, meteorology... I will focus on "depression" as a mental problem that may be a vague concept as such.
- The generality of the term "depression" refers to the fact that there is no specification of whether the speaker refers to a depressive episode undergone by an individual or whether he refers to a situation, a collective atmosphere, etc. I will focus on the narrow signification of the term as referring to an individual, subjective state.
- The context-dependency of the term refers to the fact that we need additional information to know whether we are talking about someone who is feeling depressed, who is identified as such by her entourage or by an epidemiological survey; or about a person to whom a physician prescribed a treatment; or about a person diagnosed as "depressive" by a psychiatrist and considered to undergo a "depressive episode"; or about a person diagnosed as suffering from a major depressive disorder, or the depressive stage of a bipolar disorder, etc. This terminological diversity is not sufficient as such to declare a vagueness of the concept "depression": this vagueness arises only if the definitions of these different terms are such that their extensions have no intersection common to all, which generates a contextual instability of the concept "depression", a fuzziness of its boundaries.
- The lack of precision refers to the fact the official criteria of the characterized depressive episode (CDE) are not formulated very precisely, so they do not seem to be sufficient in practice for the clinician to make the diagnosis of the CDE (Horwitz & Wakefield, 2007), and so of a major depressive disorder (MDD). The criteria are the following (American psychiatric association, 2013).

Criteria of the characterized depressive episode (CDE) and the major depressive disorder (MDD)	
Central symptoms (at least one of the two must be present)	• Depressed mood • Loss of interest or pleasure (anhedonia)
Additional symptoms (at least four must be present, besides one of the two central, during more than two weeks)	• Weight loss or gain, • Perturbations of sleep (insomnia or hypersomnia) • Psychomotor agitation or retardation, • Fatigue or loss of energy, • Feeling worthless or excessive or inappropriate guilt, • Difficulty of concentration • Recurring thought about death or suicidal ideation
Additional criteria for the CDE to qualify as a MDD	• The symptoms must cause clinically significant distress or impairment. • The symptoms must not be caused by the physiological effects of a substance or a medical condition. • The episode must not be explained by psychotic disorders (belonging to the schizophrenia spectrum). • The patient had no a manic or hypomanic episode (Otherwise the diagnosis would be of a bipolar disorder, type I or II)

Given the lack of precision in these criteria, the way clinicians apply them in practice to diagnose depression remains largely implicit. Their lack of distinctiveness suggests that clinicians need to take more elements into account, especially information about the context, in order to decide whether the individual is ill (whether he should be diagnosed a CDE and so an MDD). When the person complains about her low mood, lack of energy, sleeping, appetite, or cognitive patterns, does it qualify as a depressive symptomatology? For instance what is a clinically significant perturbation of sleep? Does this consti-

tute an illness as such? Is it a sign of a disease? I'm not going to discuss here the nature of clinical judgment, or whether it's based on reasoning and inferences from symptom interpretation elaborating signs of a disease, or on a quasi-perceptual apprehension of disease through symptoms, thanks to the "clinical gaze". I'm going to take a different approach, looking not at clinical practices but at the concept of "depression" itself: indeed, I'm going to show that, as far as this clinical category is concerned, part of the difficulty of clinical judgment lies in the concept itself, since its current definition makes it vague.

2. Vagueness of the concept of "depression" in psychiatry

Egré points out three characteristics of vague concepts: the existence of borderline cases, the blurriness or fuzziness of boundaries between extension and anti-extension of the concept, and an inter-individual and intra-individual instability of the concept (Egré, 2018). Does "depression" display these characteristics?

2.1 The problem of over-diagnosis reframed as the existence of borderline cases

Borderline cases are cases for which one cannot decide whether they fall under the concept or not. Are there borderline cases of depression? It is suggested by the problem of over-diagnosis (including medical diagnoses as well as the results of epidemiological surveys in the general population).

Horwitz and Wakefield denounce a general tendency to over-diagnose depression because of the "pathologization" of normal sadness through depression: they argue that the manifestations of normal sadness are often indiscernible from the symptoms of depression as listed in the definition of the CDE, so that, with this definition consisting only in a list of symptoms, it is impossible to know whether the person is sad or depressive (Horwitz & Wakefield, 2007). They argue that the DSM is faulty because it does not specify how to take into account the context in which the symptoms are observed, which would be necessary to distinguish normal sadness from its pathological version, namely depression (Horwitz & Wakefield, 2007). As a consequence, there would be false positives included in the numerous diagnoses of CDE and MDD, and in the epidemiological surveys on the general population, so a global over-diagnosis of depression. According to Horwitz and Wakefield, this perverse effect of the descriptive approach of contemporary psychiatric classifications would be enough to account for the apparent exponential growth of depression in the population since the publication of the DSM-III in 1980 (Horwitz, 2015). For instance:

> "Between 1987 and 1997, the proportion of the U.S. population receiving outpatient therapy for conditions called "depression" increased by more than 300%." (Olfson et al., 2002)

So far we could consider that there is only an epistemic problem to identify depression: we lack an additional criterion in order to distinguish depression as a pathological process from simulacra which are cases of an apparent depressive symptomatology that would only reflect a normal affective episode. But is there such a criterion? Whereas Horwitz and Wakefield affirm that normal sadness, contrary to depression, always has a cause and is proportionate to this cause, in practice it might be hard to determine the cause of the affective state of an individual and whether this affective state is proportionate to it or not. Moreover, depression could sometimes come from an episode of normal sadness, or start as such before something goes wrong: in such cases, it may look as if there was a cause and then it seems hard to tell when we should consider that "things went wrong" and the affective reaction to the cause becomes disproportionate. So Horwitz and Wakefield added that sadness has a natural function: that is to allow us to recover from a loss (Horwitz & Wakefield, 2007). This remains speculative. Moreover, it is doubtful that the clinician would be able to use this very general definition of sadness in practice to determine whether the patient undergoes normal or pathological sadness, namely depression: even if he knows that the patient suffered a loss, how will he be able to determine whether the affective reaction is proportionate to this loss or not? It seems that the significance of a loss has to be measured to the one of what was lost, which may be fully subjective. Facing that kind of puzzle, psychiatrists like Kendler rather pushed to reinforce the descriptive approach of the DSM when the fifth edition replaced the fourth: in the absence of a demarcation between normal and pathological, it seemed preferable to diagnose a CDE for any individual displaying the required number of symptoms for more than two weeks with clinical significance, because it means that the individual is impaired by these symptoms, and so needs to be taken care of (Kendler et al., 2008). However many clinicians remain unsatisfied with this decision since they consider that one can be sad for more than two weeks without it being abnormal and requiring medical attention.

The problem of over-diagnosing depression can then be seen as the problem of the existence of borderline cases, which are individuals who are neither clearly depressive nor clearly not depressive. They have a depressive symptomatology – they display the clinical criteria of a CDE and eventually of a MDD – but it remains unclear whether they are affected by a condition that is an illness. As we don't know the pathological

process, namely the disease, that is supposed to cause this illness, we cannot make sense of it.

2.2 Fuzzy boundaries between extension and anti-extension of the concept "depression"

The psychiatric concept of "depression" has fuzzy boundaries because of a lack of a sharp delimitation of the population that should be considered affected by this condition. It is a correlate of the existence of borderline cases of the instances of this concept. A descriptive approach was adopted in classification systems (DSM, ICD) because the psychiatric community was deeply divided between different theoretical chapels, so diagnosis practices would vary from one clinician to another, and therefore be unreliable (Demazeux, 2013). But now the absence of a dominant theoretical background means that there is no unified framework to assess how the context in which the individual displays the criteria of the CDE should be interpreted in order to distinguish pathological from normal cases. The definition of MDD in the DSM-IV included a clause specifying that the diagnosis should not be held if the symptoms were observed while the individual was grieving a loved one, except if this grief lasted for more than two months. As many other situations in life may induce sadness and with it a depressive symptomatology, the clause excluding grief from the diagnosis was finally removed in order to opt for a strictly quantitative threshold of two weeks (for a depressive syndrome to qualify as a CDE and eventually as a MDD): it is this duration that is criticized by opponents to the current definition of the CDE and more generally the idea that the distinction between normal and pathological could be quantitative, in terms of duration (Kendler et al., 2008; Wakefield, 2013; Wakefield et al., 2007, 2011; Wakefield & First, 2012). Taking this into consideration, the problem of the definition of the CDE appears to be setting the limit between the extension and its anti-extension, in the absence of an obvious sharp limit of its extension as including only pathological cases. Then it seems to me that the concept of "depression" is vulnerable to the "sorite" which is a paradoxical inductive argument that can be construed as follows:

(1) One day of feeling under the weather (feeling blue) is not a depression.

(2) If n days of feeling under the weather are not a depression, then n + 1 days of feeling under the weather is not a depression.

(3) Whatever the number of days of feeling under the weather, their reunion is not a depression.

Whereas the premises may sound right, the conclusion is problematic, which makes this argument paradoxical. That type of paradoxical argument is called a "sorite": Egré shows that it characterizes specifically vague concepts because of their lack of sharp boundaries (Egré 2018). So the vulnerability of the concept "depression" to the "sorite" confirms its vagueness.

2.3 Inter-individual and intra-individual instability of the concept "depression"

In my view, intra-individual as well as inter-individual instability characterizes "depression" because its conditions of adequacy are contextually variable. Suppose that I feel blue, "under the weather", a little depressed, etc. Am I depressive? If the concept "depression" applies to such contexts, then would its definition in these contexts account for its use in very different contexts, for instance for individuals with a very severe condition? In one case we would define "depression" as a temporary drop in morale reflected by some individual behaviors; in the other case it seems to be a pathological process inexplicably depriving them of the will to live. In between, in a wide variety of contexts, neither one definition nor the other would perfectly fit. So there is an intra-individual but also an inter-individual instability of the concept.

Once I saw a general practitioner who prescribed me a work stoppage for depression, prescribed antidepressant drugs to me, or advised me to go see a psychologist, am I depressive? The clinician may use the diagnosis and the treatment to help me face a hard lifetime due to several factors (difficulties at work, in my sentimental life, in my family…) regardless of whether I have an illness or not. This is because an illness is supposed to be the experience of a disease and my condition may not suggest that I suffer from a disease but still deserve support. So the clinician would make the diagnosis in order to allow my condition to be recognized as a "sickness" so I can get this support. Actually most of the time you don't even get diagnosed by a mental health professional: in France, half of the population treated for « depression » is treated solely by a general practitioner (*La dépression en France Enquête Anadep 2005*, 2021, p. 84). So if I get diagnosed with a CDE, what is common between my condition and the condition of someone who's been under anti-depressant drugs or followed by a psychiatrist for years, or someone hospitalized for depression and using last resort treatment like electroconvulsive therapy? There are specifications of the MDD as resistant or chronic in the current psychiatric semiology (Corruble, 2010). However this terminology is based on clinical criteria. The latter don't draw a sharp limit around people suffering from a disease as distinct from others. As a result there is no sharp boundary around the extension of the concept of "depression" as referring to an illness. A temporary solution could be to keep the concept of "depression" for the most severe cases where we seem to be justified in assuming that the individual has a disease and is undergoing a pathological process. But as the limit between the most severe cases and the others is purely clinical, and depends mostly on the number of symptoms one displays and one's responsiveness to treatments, it is stipulated in view of the consequences of

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the illness for the individual and is no indicator of an actual pathological process. So if my depressive symptomatology persists a long time after a single CDE, if I don't get back to work, or if I have another depressive episode after a period of remission, when exactly will the use of the concept of "depression" start to be appropriate for my case? Is there a threshold where we know for sure that I suffer from a disease called "depression"? Not in the actual state of medicine and science. On top of that, a CDE can also be considered in itself as a symptom of another disorder: for instance a depressive symptomatology can be the prodromal stage of a disorder belonging to the spectrum of schizophrenia, or it can manifest a bipolar disorder. In these cases, even if the clinicians avoid an MDD diagnosis, the individual is displaying a CDE: should we then consider it false to apply the concept of "depression" in such cases because another disease is assumed to cause the depressive symptomatology? This last point explains the refusal to consider the illness (the CDE) and the disease (the MDD) as co-extensive in the case of "depression". As a consequence, depending on what you mean by "depression", the concept can be appropriate or not for one and the same individual: an intra-individual instability reflects a contextual variability of the intension and extension of the concept of "depression" as such.

Moreover, the diversity of situations corresponding to the concept "depression" is extensive, adding to the inter-individual instability of the concept: as its descriptive characteristics vary a lot depending on the context, its intension and extension also vary accordingly so that individuals falling under different specific versions of the concept would have no characteristic in common, only similarities. Besides the definitions of a CDE and an MDD, you can be followed by a GP for a subthreshold depressive symptomatology, or you can be in remission after a CDE with more or less persistent symptoms, sometimes followed by a relapse; a diagnosed MDD can be specified in terms of severity and chronicity, along clinical criteria. Above all, the criteria of the CDE are a disjunctive list so the depressive symptomatology itself is highly variable and the population of people diagnosed with a CDE includes people who don't share a single criterion. Indeed, no criterion is necessary: two central criteria are depressed mood and loss of interest or pleasure, but only one out of the two needs to be observed. The other criteria are polythetic : they can take mutually exclusive determinations (for instance: insomnia versus hypersomnia for the perturbations of sleep). So there are individuals with a CDE characterized by a low mood, a lack of appetite, insomnia, feelings of self-depreciation, and thoughts of death, as well as individuals characterized by a loss of interest or pleasure, an excessive appetite, a psychomotor retardation, a decreased concentration, and fatigue or loss of energy. It means that "depression" corresponds to completely heterogeneous descriptive characteristics in different contexts.

There is intra-individual as well as inter-individual instability of the concept of "depression" that reflects a dependency of its use on context: it applies to heterogeneous cases that may have nothing in common in terms of descriptive characteristics. Moreover, there are individuals for whom we truly could just as easily say "He is depressive", "He is not depressive" or "I don't know whether he is depressive or not." depending on the context from which we use the concept "depression". In a context where someone with ordinary blues is "depressive", then another person with chronic and resistant depression cannot be called "depressive" without changing the meaning of the word, and we may need to use a different term for him, like "sick". Conversely, we could also use another term for the first one, by saying for instance that he is "in a bad mood". There may be nothing in common except family resemblances between their respective conditions. We could say the same for two individuals diagnosed with a CDE, but with opposite versions of each criterion.

Now that we characterized the concept of "depression" as vague, does it raise a "vagueness problem"? If yes, then should we solve it, and how?

3. (How) should we deal with the "vagueness problem" of depression?

For any vague concept, there can be a "vagueness problem" on different levels, according to Egré (2018): an epistemic, a semantic, and an ontological level. What about "depression"?

- On the epistemic level, there seems to be a problem with the fuzziness of the application of the criteria of the CDE and MDD in order to diagnose pathological conditions. This aspect of the problem is related to the more general problem of the demarcation of health and disease in the philosophy of medicine and psychiatry.
- On the semantic level, there seems to be a problem with the fuzziness of our use of the terminology regarding depression. It is not a sufficient definition of the concept to say that it applies to individuals displaying a depressive symptomatology: there is a high variability of this symptomatology so a considerable variability of the meaning of this descriptive definition according to the context. Moreover, in every different context the

symptomatology is interpreted as indicating a different version of "depression": a first depressive episode, a period of remission with persistent symptoms, a severe depressive disorder, and therefore a disease (a pathological process), a depressive stage in another mental disorder, etc. This problem is related to the fuzziness of current psychiatric concepts in general. Their descriptive approach remains silent about the way symptoms should be interpreted to make a diagnosis whereas this is what gives a psychiatric concept its proper extension.

- On the ontological level, there seems to be an uncertainty about depression itself as a phenomenon. Because the extension of the concept "depression" is contextually variable, it could correspond to heterogeneous phenomena sharing family resemblances that remain to be described. The lack of a definition of depression that would apply to all of its contexts of use prevents us so far from considering it to be a single identified phenomenon. We encounter here the general problem of our definitions of mental disorders: they are clinical instead of being based on known disorders etiologies, leaving the question of their very nature undecided.

The theoretical "vagueness problem" of current psychiatric concepts in general (Keil et al., 2017, p. 4) has several aspects: the problem of demarcation between health and disease, the problem of psychiatric classifications and concepts definitions, and the problem of the relevance of the current categories based on clinical criteria in the absence of known disorders etiologies. Do those problems need to be solved? And if they do, then how? Do we need to discover the essence of depression to make its definition clearer?

3.1 The general health / disease problem and the epistemic vagueness of "depression"

According to the WHO, health is "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". As health does not only exclude any disease but also requires a general state of well-being, it does not seem to be the opposite of illness or being ill. There is a gray area between health and illness, in which people may not be healthy because of a low level of well-being, without being properly "ill", since they do not suffer from a disease that would explain their impaired well-being. Besides, there is a specific issue related to "depression" as the very existence of a corresponding disease is sometimes doubted: the controversy over its current clinical definition may suggest that the current criteria for it are meant to provide a tool (a diagnosis, entailing special care) to help people facing distress, notwithstanding whether they are really suffering from the corresponding disease or not. The use of the category would not be restricted to cases where the person has the disease.

This is a "vagueness problem" of depression at an epistemic level since it is related to the assessment that someone is depressive, and so falls under the concept or diagnosis of depression. "Depression" sometimes seems to apply to conditions that are neither states of health, nor really illnesses properly speaking. Whereas the term is originally meant to refer to an illness, the uncertainty about the identification of a corresponding disease ends up in uncertainty about whether it really refers to an illness, even in some cases. On the other hand there are reasons to consider the corresponding conditions as unhealthy, in accordance with the WHO definition of health that excludes these conditions from health. To decide whether our demarcation between health and illness can be stipulated or if we should reject any illness whose definition cannot be objectified as a "pathological process" or at least as the deviation from a biological norm it causes, is an open philosophical debate. Some philosophers argue for the possibility and eventually the requirement of such an objective definition in the tradition initiated by the bio-statistical theory of Boorse (1977). Others argue that for many conditions nothing like a "pathological process" can be discovered, meaning that we should be pragmatic and determine clinical criteria on a case-by-case basis to identify a condition as medically relevant, and as an "illness" (De Vreese, 2017; Kincaid, 2008).

I suggest that even if there is no such thing as a disease corresponding to depression, and no pathogenic process can explain its symptomatology when observed, this does not mean that we cannot define it as an illness, thereby requiring medical support. As such it would be a type of condition that we could more clearly define even if it is not related to a single identifiable pathogenic process serving as its causal mechanism. In other terms, "depression" could refer to a type of unhealthy condition without referring to a disease: as such it would be an illness, thereby medically relevant even if it turned out that no corresponding disease would exist. This illness would have to be defined if the well-being of an individual with a depressive symptomatology is compromised, making her condition unhealthy according to the WHO definition of health. Medical support would be legitimate as long as it could alleviate this specific threat to the individual's health.

3.2 The general fuzziness of contemporary psychiatric classifications and concepts and the semantic vagueness of "depression"

Despite the descriptive turn of the DSM, clinicians are still relying on some implicit theoretical or at least normative background when they make diagnoses. This leads to a certain fuzziness of the classifications and concepts since the rules of their application in clinical settings are now implicit but still variable depending on the context. The cultural context in particular tends to generate highly variable clinical

pictures for one and the same syndrome or disorder[2]: the list of criteria defining the syndrome or disorder in the international classifications is interpreted by the clinician relative to a cultural context, resulting in substantially different outcomes. The symptomatology of depression has a notoriously high cultural variability.

This points to a semantic aspect of the "vagueness problem" of depression: because of this variability, it is hard to provide its general description, whereas its only current official definition is its clinical characterization. For instance, Kleinman's studies on somatization showed that there may be a bigger focus on somatic sensations in certain non-Western cultures as opposed to Western societies (Katon et al., 1982a, 1982b; Kleinman, 1982). Other studies on alexithymia, which is a lack of emotional expressiveness observed in depression, show that emotional expression varies from one society to another, or along gender or generational lines (Bermond et al., 2007; Dere et al., 2012; Salminen et al., 1999). If the symptomatology of "depression" varies according to the cultural context (besides consisting in a disjunction of subsets of individuals instancing the CDE criteria in a variable way), then we lack even a descriptive definition of "depression" that would apply to any context. The symptoms themselves define "depression" as a disjunction of subsets of individuals sharing no necessary and sufficient list of those, but only family resemblances between different clinical pictures. So the definition of "depression" is not a set of necessary and sufficient conditions providing sharp boundaries to its extension; it has contextually variable descriptive definitions – and no definition formulating its essence. This can be considered as a semantical aspect of the "vagueness problem" of depression. Discovering the essence of depression would provide a set of necessary and sufficient conditions to define it. But it is not our only option. In my opinion, even if we never discover such an essence, there is still a way we could clarify the definition of depression.

Indeed, instead of a definition in terms of necessary and sufficient conditions, we could make a list of family resemblances between different subsets of the instances of "depression", corresponding to its extension in different contexts. This would provide a prototypical definition or a core concept of depression, while its boundaries would remain open: the concept of "depression" could even be used in new contexts sharing some family resemblances with former contexts but in association with new characteristics. That would make the corresponding individuals or situations fall under a new version of the concept. As Wittgenstein (1967, p. 36-38) explains it for "game" and other similar concepts (§75-79), a concept working as a cluster of concepts sharing family resemblances has an open extension, since any family can grow by welcoming a new member.

3.3 Categories and dimensions in psychiatry and the ontological problem of "depression"

The last edition of the DSM tries to combine a dimensional approach with the traditional psychiatric categories. There is a dilemma. On the one hand, categories are the outcome of centuries of observation and characterization of mental disorders and they are useful for diagnosis. On the other hand, there don't seem to be any natural kinds corresponding to our categories of mental disorders, whereas we know different dimensions that are "transnosographic", which means transversal to different disorders: for instance, the loss of pleasure or interest (anhedonia) characterizes depression but also the schizophrenic spectrum. So it might be scientifically more relevant, and also more promising, to renounce old categories and to scientifically investigate the dimensions instead. When it comes to depression, the question of its eventual "essence" is especially complex since depression was long considered to be a mere symptom of melancholy or other disorders. Bipolar disorders and the schizophrenic spectrum are still diagnoses of exclusion for MDD when the individual undergoes a CDE. With a dimensional approach, depression is especially at risk of disappearing whereas only its main dimensions would remain, namely loss of pleasure or interest, lack of emotional expressivity (alexithymia), emotional blunting, psychomotor retardation, etc. Indeed there is such a diversity of clinical pictures of depression that we can expect that no homogeneous subset of cases would emerge and appear as the extension of the concept. This is the ontological aspect of the vagueness problem of depression. As a term for various referents that only share family resemblances, "depression" is not only semantically undetermined since the possibility of it getting new contexts of application remains open; it is also ontologically undetermined because it's unclear whether there is an essence of it, even in terms of causal mechanism explaining its variable symptomatology.

This ontological problem may not require to be solved however: we can use the concept even if it does not refer to an essence, as we already do with several other concepts like the concept of "game", or psychiatric notions like the schizophrenic spectrum or the autistic spectrum, or personality disorders. "Depression" works as a cluster of more precise and non-vague concepts that can be seen as different versions of it, each of them being relevant in a given context in which it refers to a non-vague phenomenon, and so is ontologically stable. If it were not the case of "depression" itself as such, this would account for the impossibility of formulating its intension as a list of necessary and sufficient conditions. But

2 *In the DSM and ICD there is the notion of "culture-bound syndrome" which is a syndrome that may exist only in a given culture (like "hikikomori" in Japan), but also the notion of a "cultural distress idiom" that is a way of expressing a trouble that is specific to a cultural context, and the notion of a "cultural explanation or perceived cause" that is an explanation of a trouble that provides a culturally specific way of conceiving of a disorder and its etiology.*

this would not prevent us from defining it more clearly by a list of family resemblances as a prototypical or a core concept, regardless of the fact that there may be no essence underlying these resemblances; I mean no essence understood as a natural kind or even as a causal mechanism accounting for a stable set of properties. Instead of a unified phenomenon, depression would be, from an ontological point of view, a constellation of phenomena sharing some resemblances. But this would not make the use of the concept problematic in practice, since our use of a concept does not depend on its referring to something ontologically unique.

4. Conclusion : Solving the "vagueness problem" of depression?

We saw that "depression" encompasses highly heterogeneous conditions ranging from ordinary blues to severe major depressive disorder, with a huge diversity of clinical pictures of the characterized depressive episode, including its cultural types. So the meaning of the concept is subject to variations, depending on context. It is so even if we restrict ourselves to "depression" as a mental disorder, since its current definition is strictly clinical and is based on disjunctive criteria. This raises a theoretical problem of vagueness for this concept – "depression" lacks a fixed definition consisting of necessary and sufficient conditions. Its intension varies depending on the family resemblances shared by closely related concepts. Its overall extension remains open to the inclusion of new contexts of application. There is a vagueness of the concept of "depression", reflecting a vagueness of the phenomenon in the way it is apprehended.

But it does not seem that we need to discover the essence of depression as a pathological process (a disease), to solve the vagueness problem of this concept. We could clarify its definition by recognizing that the concept refers to a set of family resemblances, instead of looking for a definition in terms of an essence. Then we would not focus on identifying necessary and sufficient conditions that would provide a fixed and non-contextually dependent intension and a sharply delimited extension of this concept. Alternatively, we could stipulate a definition giving sharp limits to the concept for pragmatic purposes, thereby stipulating which conditions are "medically relevant" to professional diagnosis.

Consequently, in order to contribute to the elaboration of a definition of "depression" beyond its clinical criteria, a philosopher could try to identify family resemblances between conditions that are already taken into consideration by clinicians: this would lead him to formulate a prototypical or core concept of depression. This concept would serve as a clearer definition of depression as an illness even if we would remain ignorant of a corresponding disease. There is no actual need to identify a disease that causally explains a given illness in order to legitimate medical care of corresponding conditions; after all, medicine has long taken care of conditions that are neither diseases, nor illnesses, like childbirth or aging. But in order to preserve the value of this diagnosis, it would be useful to have a clearer definition of "depression" as an illness, even if we never achieve a definition of it as a disease in the traditional sense of a pathological process at the neurobiological, psychological or any other explicative level. Having shown that the concept is vague, we know that this agenda will have to be fulfilled by looking for family resemblances in relation to a prototypical or fundamental concept, rather than a set of necessary and sufficient conditions.

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CONTACT ET COORDONÉES

Elodie Boissard
Université Paris 1 Panthéon-Sorbonne
CNRSIHPST
13, rue du Four 75006 PARIS
elodie.Boissard@univ-paris1.fr

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École normale supérieure
45, rue d'Ulm
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75005 Paris