

## **ORIGINAL ARTICLE**

### **The concept of mental disorder and the DSM-V**

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*In view of the publication of the DSM-V researchers were asked to discuss the theoretical implications of the definition of mental disorders.*

*The reasons for the use, in the DSM-III, of the term disorder instead of disease are considered. The analysis of these reasons clarifies the distinction between the general definition of disorder and its implicit, technical meaning which arises from concrete use in DSM disorders. The characteristics and limits of this technical meaning are discussed and contrasted to alternative definitions, like Wakefield's harmful/dysfunction analysis.*

*It is shown that Wakefield's analysis faces internal theoretical problems in addition to practical limits for its acceptance in the DSM-V. In particular, it is shown that: a) the term dysfunction is not purely factual but intrinsically normative/evaluative; b) it is difficult to clarify what dysfunctions are in the psychiatric context (the dysfunctional mechanism involved being unknown in most cases and the use of evolutionary theory being even more problematic); c) the use of conceptual analysis and commonsense intuition to define dysfunctions leaves unsatisfied empiricists; d) it is unlikely that the authors of the DSM-V will accept Wakefield's suggestion to revise the diagnostic criteria of any single DSM disorder in accordance with his analysis, because this is an excessively extensive change and also because this would probably reduce DSM reliability.*

*In conclusion, it is pointed up in which sense DSM mental disorders have to be conceived as constructs, and that this undermines the realistic search for a clear-cut demarcation criterion between what is disorder and what is not.*

**Key words:** classification, nosology, nosography, phenomenology, conceptualization, theoretical construct, mental dysfunction.

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#### **INTRODUCTION**

In view of the publication of the DSM-V researchers were solicited to contribute to the discussion on possible changes (Kupfer et al., 2002). Among the basic nomenclature problems to be addressed in view of the DSM-V, the first under discussion was "how to define mental disorder" (Rounsaville et al.,

2002). According to Rounsaville et al. (2002, p.3) "the most contentious issue is whether *disease, illness, and disorder* are scientific biomedical terms or are sociopolitical terms that necessarily involve a value judgment". In effect, this is one fundamental philosophical problem underlying discussions on diagnostic

systems. It should be stressed that a discussion on the definition of mental disorders can be focused at various levels of abstraction.

At the most general level, which considers different approaches in different cultural contexts, a culture or society may formulate a psychiatric condition in seven general ways (Fabrega 2005, p.224):

- 1) medical/naturalistic phenomenon;
- 2) spiritual/religious phenomenon;
- 3) malevolent/villainous phenomenon;
- 4) nonauthentic or malingered/fictive phenomenon;
- 5) phenomenon attributed to external unwarrantable attack;
- 6) phenomenon attributed to a warrantable punishment for wrongdoing;
- 7) a phenomenon resulting from faulty habits or moral predicaments.

At an intermediate level, internal to the Western culture, there are different general views about what constitute a disease (in its general sense, which enclose mental disorders). Under the influence of the work of Albert et al. (1988), these general views may be grouped as follows:

- 1) nominalism: a disease is what a profession or society labels as such;
- 2) social idealism: deviation from the social ideal of health;
- 3) statistical: deviation from the statistical norms;
- 4) realism: lesion and/or dysfunction of a biological organ or system.

At the same level is Rounsaville et al.'s (2002) work, which considers:

- 1) sociopolitical;
- 2) biomedical;
- 3) combined biomedical and sociopolitical;
- 4) ostensive types of definition of "disease or disorder".

The present paper will start focusing on a third level, internal to psychopathology, trying to answer to questions such as the followings:

- a) Why the DSM authors decided to use the term "disorder"?

- b) Once introduced has the term disorder acquired a specific, technical meaning?
- c) Why the DSM-V Agenda considers the general definition of mental disorder in need of revision?
- d) May new definitions solve current problems?
- e) Are new definitions in accordance with the theoretical basic principles of the DSM?

After having discussed these questions at this third level, the reader will be driven to their implication for the upper level. Accordingly, the final part of the paper will focus on some philosophical problems arising when a strict criterion sharply discriminating mental disorder from non disordered conditions is proposed; in this context, the relativity of such a distinction will be highlighted.

### **THE CONSTRUCTION OF MENTAL "DISORDER" AS A TECHNICAL TERM**

In order to understand why the DSM-III used the term "disorder" the nosological debate of the early Seventies should be considered. In particular, studies such as the famous *United States-United Kingdom Diagnostic Project* (Kendell et al., 1971) introduced the fundamental problem of diagnostic low inter-rater reliability. If different clinicians labelled the same patients with different diagnoses, then the minimal basis for any scientific activity (namely, the use of technical words to mean the same things/phenomena) was at risk.

Accordingly, nosographers worked on improving reliability and, following some of Hempel's suggestions (Hempel 1965; Schwartz and Wiggins 1986), they introduced in the classification operative diagnostic criteria aimed to provide a framework for comparison of data gathered in different centres and to promote communication between investigators (Feighner et al., 1972). It should be stressed that the study of Feighner et al., which can be considered as the most direct forerunner of the DSM-III, used the words *illness*, *diagnostic category*, *disorder*, *clinical picture*, *syndrome*, *psychiatric condition* as synonyms.

According to Klerman (1984) the DSM-III resulted from the felicitous union between the group of St. Louis (the authors of Feighner's criteria) and the psychometric and statistical skills of Spitzer and Endicott in New York. In the transition from Feighner's criteria to DSM-III diagnoses, an apparently little but relevant change was the use of the term "disorder" instead of illness or syndrome. This reflected a significant change in basic philosophical assumptions which, in turn, depended from changed needs. Feighner's criteria were mainly focused on improving reliability and admitting research data as the only ones allowed to guide diagnostic decisions. This project was conceived within a neo-kraepelinian frame that considered mental pathologies in accordance with medical pathologies. This explains why they used synonymously words such as illness, syndrome and disorder (and also the reason why they considered laboratory tests and family aggregation among their diagnostic criteria).

Compared to Feighner's criteria, the DSM-III had to be more careful because among its primary goals there was its acceptability among clinicians working in all mental settings and believing in different theoretical views about the etiology of psychopathological conditions. Accordingly, a descriptive, "atheoretical" approach was adopted together with operative diagnostic criteria. As a consequence, it is likely that the term "disorder" was used instead of illness or disease because they risked to be felt as too much medical-oriented, linked to a biological theory about etiology. On the contrary, the term disorder was enough general and "atheoretical" to be widely accepted. Indeed, the DSM-III adopted a general definition of "mental disorder" as a clinically significant behavioural or psychological syndrome or pattern that occurs in an individual and that is associated with present distress or disability, and which reflects a psychological or biological dysfunction in the individual (American Psychiatric Association, 1980). By

using general terms such as "syndrome or pattern" and "behavioural or psychological", avoiding to define what is meant with "clinically significant" and, according to Rounsaville et al. (2002, p.3), failing "to define or explain the crucial term *dysfunction*", the DSM renounced to specify exactly what a mental disorder was. Nevertheless, this was the price it had to pay in order to be widely accepted, and it indubitably realised it.

At this point, the next question to consider is: despite its non-specific general definition, can we ascribe to the term "disorder" a specific, technical meaning? Here we need to shift from the explicit aforementioned definition to the implicit meaning of mental disorders as it emerges from their concrete use. An analysis of the current crisis of the DSM classification system (Aragona, 2006) focused on the following specific characteristics of mental disorders as they are used in the DSM:

1) *Descriptive approach*. According to the atheoretical model, the great majority of DSM mental disorders are based on the phenomenal description of clinical manifestations (symptoms or behaviours). Thus, mental disorders usually differ from illnesses or diseases because within the biomedical context these last two concepts are usually based on etiopathogenesis while disorders (like syndromes) are based on phenomenal descriptions.

2) *Use of explicit "operative" diagnostic criteria*. Any DSM mental disorder is characterized by a defined set of diagnostic criteria, each with a clear, explicit definition of its satisfaction criteria. Once the clinician has controlled that the patient's characteristics effectively fit with those enlisted in the diagnostic criteria, the diagnosis becomes automatic. This characteristic discriminates mental disorders from classical typologies in which the diagnostic act largely relied on the subjective judgment of the clinician that was requested to decide how much the concrete case was similar to the ideal typology. In the case of typologies, the clinicians had to judge if the concrete patient was enough similar to the

ideal type described in the psychiatric manual, while in the case of DSM disorders, the physician can only decide if the enlisted phenomena are present or not. In fact, the diagnostic rules are not under his power, considering that the authors of the DSM have decided them *a-priori* and the clinician is only expected to apply them.

3) *Lack of a hierarchical ordering of symptoms.* With the exclusion of rare exceptions,<sup>1</sup> DSM mental disorders do not consider qualitative differences among symptoms. Indeed, all the symptoms listed in the symptomatological criterion (usually named A) are equivalent. This point traces a distinction from classical psychopathological syndromes, which were based on Bleuler's qualitative hierarchical distinction of fundamental from accessory symptoms (Vella and Aragona, 2000).

4) *Use of polythetic criteria with quantitative diagnostic thresholds.* With the exception of a few DSM-III monothetic disorders, the vast majority of DSM-III disorders and all the disorders of DSM-III-R and subsequent versions were defined polythetically. In short, polythetic definitions are based on a list of characteristics all of which are possessed by some members of the category, but none of which is possessed by every member of the class. In the diagnostic field, there is a list of symptoms possessed by some patients with a given disorder, none of which is fundamental. Hence, polythetic diagnostic criteria are linked to the above mentioned lack of hierarchical distinctions among symptoms and to the requirement of a quantitative diagnostic threshold (presence of a minimal number of symptoms, independently from their quality). As an example, the symptomatological criterion of the DSM mental disorders is often formalized as "X (or more) of the following Y symptoms have to be present".

In conclusion, the general DSM definition of disorder is a category "all-embracing", with no clear correspondence with either the concept of disease or the concept of syndrome

in medical classification (Jablensky 1999). On the contrary, the concept of disorder as it emerges from the way it was effectively used in the single DSM disorders is specific, and here its distinction from the concept of disease, typology and psychopathological syndrome is clear-cut.

### **SHOULD THE GENERAL DSM DEFINITION OF "MENTAL DISORDER" BE CHANGED?**

The previous paragraph showed that the strategy of the DSM-III to define the term *mental disorder* generically while using stringent diagnostic criteria was successful: both main goals of wide acceptability and increased reliability were achieved. What has it changed in the meanwhile? Why the authors of the DSM-V Agenda consider the general definition of mental disorder unsatisfactory and in need of revision? What are the current diagnostic problems that such a change in the definition should resolve?

Rounsaville et al. (2002, p.3) talk of "rising public concern about what is sometimes seen as the progressive medicalization of all problem behaviors and relationships" and accordingly they regard as "desirable that DSM-V should, if at all possible, include a definition of *mental disorder* that can be used as a criterion for assessing potential candidates for inclusion in the classification, and deletions from it". This last remark is in line with Wakefield's (1992) early critique to the DSM-III-R concept of mental disorder which failed to validly distinguish disorders from non-disorders. Thus, the current diagnostic problem that a new clear general concept of mental disorder should help to solve is that of overdiagnosis.

This problem arose from the evaluation of the results of two major epidemiological studies; namely, the Epidemiologic Catchment Area (ECA; Robins and Regier, 1991) that used DSM-III diagnoses and the National Comorbidity Survey (NCS; Kessler et al., 1994) that used DSM-III-R disorders. Both surveys reported prevalence rates for psychiatric disorders that many critics considered

much too high (for example, about 30% of interviewed met criteria for at least one mental disorder). This higher-than-expected prevalence, rather than producing new pressure for greater mental health funding to respond to the discovered unmet need, led critics to attack the DSM system itself, accused to be overly inclusive (Wakefield and Spitzer 2002, pp.31-32).

As a consequence, the DSM-IV Task Force decided to add a clinical significance criterion to the definitions of many disorders in the DSM-IV (namely half of all Axis I and Axis II disorders). When additional criteria of clinical significance were applied *post hoc* to the ECA and NCS data, prevalence rates of overall mental and substance use disorders showed approximately a 30% drop (Narrow et al., 2002). However, this prevalence reduction was still considered unsatisfactory, because only partially successful in eliminating false positives (Kendell 2002, p.5) and because adding a significance criterion *ad hoc* was considered likely to eliminate some true cases of mental disorder, rising false negatives rates (Wakefield and Spitzer 2002, p.37).

Moreover, it was argued that the elimination of mild disorders from the DSM-V was a serious risk, because mild disorders are often along a continuum of progression from a mild to a more severe form of psychopathology, and because effective treatment of mild disorders might prevent a substantial proportion of future serious disorders (Kessler et al., 2003). Finally, it was stressed that lowering the prevalence rates is not what counts in redefining disorders, because this should be done “in a way that is conceptually coherent and valid” (Wakefield and Spitzer 2002, p.33).

Accordingly, Wakefield and Spitzer (2002, p.33) “proceed on the assumption that progress in diagnostic validity can be made only if there is a clear understanding of the relationships between disorder and the concepts of dysfunction, disability and distress”. While objections to the clinical significance criterion based on its expected

effect on false positives and false negatives are practical ones, which can be empirically tested, on the other side the last remark that what is needed is a coherent and valid redefinition of mental disorders is a theoretical claim that needs to be addressed at the level of conceptual analysis.

Having rejected the clinical significance criterion as well as other *ad hoc*, case by case strategies to address the overdiagnosis problem, Wakefield and First (2003) suggested to adopt Wakefield’s harmful-dysfunction analysis to reformulate the DSM general definition of mental disorders. The next paragraph will focus on this proposal.

#### **WAKEFIELD’S HARMFUL/DYSFUNCTION ANALYSIS**

Wakefield (1992) proposed to consider a mental disorder as a harmful dysfunction, where “harm” is a normative concept anchored in social values and “dysfunction” is intended to be a factual concept referred to the failure of a mechanism to perform its natural function. Additionally, the dysfunction is a derangement in a naturally selected mechanism whose existence or structure has to be explained *via* its evolutionary history. This definition is the expression of a two-stage picture of mental disorders, which claims that dysfunctions are the purely factual basis of the diagnosis, and that a normative evaluation of its consequences must follow in order to decide if such a dysfunction is (or is not) a disorder.

In order to be accepted as the basic definition of mental disorder in the DSM-V, the harmful-dysfunction definition should prove:

- a) to be unmoved by philosophical critiques on its conceptual plausibility;
- b) to be supported from available research data;
- c) to be in accordance with the DSM requirements;
- d) to be of concrete aid in the solution of the overdiagnosis problem, without worsening prior well-established DSM achievements.

Let us start from the philosophical point. As seen, Wakefield’s analysis is based on a two-stage picture grounded on the idea that purely

normative and purely factual components can be sharply distinguished. No doubt that feeling sick, asking for a doctor, doing something that the society disvalues as “crazy” are relevant factors in the definition of what counts as mental disorder, and that many authors would agree that they are intrinsically normative.<sup>2</sup> What is more difficult to accept is the idea that dysfunctions are “purely factual”.

A first critique on this point is that a term like dysfunction is intrinsically normative: it is already operating an intrinsic idea that a putative mechanism does not work properly as it ought to, and that this different way to function is evaluated as negative (as a bad way to function). Moreover, a second critique considers the way Wakefield presents dysfunctions; for example, Fulford and Thornton (2007, p.161) stress that “by liberally employing terms like “failure”, Wakefield shows that his definition of dysfunction also has an underlying value side as well as the fact side he presents us with. [...] Wakefield is able to present his definition of “dysfunction” fact-side up, while all the time it is the hidden value-side that is doing the (logical) work”.

Besides these critiques on the intrinsic values involved in the concept of dysfunction, a major problem for Wakefield is to define exactly what he really means with “dysfunctions”; here, philosophical and empirical concerns merge together. The general DSM-IV-TR definition of mental disorder was able to escape this problem, because in that context the term dysfunction could be defined generically leaving the atheoretical criteria untouched. This is not the case of Wakefield’s dysfunctions: having made mental dysfunctions the necessary requirement for the diagnosis of mental disorder, their use must rely on a clear knowledge and definition of what they are. Wakefield’s definition is weak on this point for two reasons: first, in most cases the dysfunctional mechanism involved is not known. Accordingly, “the problem is that too

little is known about the cerebral mechanisms underlying basic psychological functions [...] for it to be possible in most cases to do more than infer the probable presence of a biological dysfunction” (Rounsaville et al., 2002, pp.5-6). Wakefield tries to escape this obvious limit suggesting that the only relevant dysfunctional mechanisms are those possessed “in virtue of how human beings are designed by evolution” (Wakefield and First, 2003, p.36), but this use of evolutionary theory is even more problematic. First of all, it was stressed that “the phylogenetic trajectory of human cognition is difficult, if not impossible, to ascertain” (McNally 2001). Moreover, it was noted that this definition of dysfunction (as a failure of an organ or mechanism to perform the natural function for which it had been designed by natural selection):

“implies the existence of purpose-driven evolutionary processes resulting in pre-ordained, fixed structures and functions, presumably located within the human brain. This view ignores the fact that natural selection is an opportunistic process, not guided by purpose or design, and that its general outcome is an increasing inter-individual variability [...] Lastly, the assumption that neural systems within the human brain perform fixed cognitive or emotional functions pre-ordained by natural selection ignores two widely accepted pieces of evidence from evolutionary biology and neuroscience: first, that some highly specialized human cognitive functions (e.g. reading or writing) evolve by piggy-backing on earlier, more primitive adaptive mechanisms, and are therefore neutral vis-à-vis reproductive fitness; and secondly, that the individual brain is a neural plasticity machine, in the sense that it constructs its own internal cognitive architecture in post-natal development, in an activity-dependent manner, interacting with its environment. Thus, the thresholds of vulnerability to dysfunction of any causes vary individually to an extent that would make the discernment of a breakdown in a “natural function” implausible” (Jablensky, 2007, pp.157-158).

In a similar way, it was stressed that many mental functions are not direct evolutionary adaptations, but rather by-products of adaptations which are, per se, adaptively neutral (Lilienfeld and Marino, 1995), and that “natural function may not be actual function. The

existence of many traits may be explained not by the increased fitness they confer but by evolutionary conservatism. [...] some physical and psychological human traits may best be explained by the fact that they conferred some adaptive advantage on an evolutionary ancestor of ours rather than on us” (Gold and Kirmayer, 2007, p.165).

Hence, if evolutionary theory is not enough to enucleate dysfunctions, how should it be done? Wakefield clearly stresses that our ignorance of the details of evolution is not an impediment because we all have a folk intuition that makes it “obvious from surface features” when underlying mechanisms are functional or dysfunctional (Wakefield, 1997a, p.256). Namely it is this idea, that we should be able to say when someone’s psychological functions are not working properly as designed just on the base of commonsense evaluation of surface features, that Murphy (2006, p.45) directly rejects: “It is not a priori that all causes of mental disorder are failures to perform an evolved function, nor that we can figure this out via knowledge of folk psychology”.

Accordingly, Wakefield is in trouble when an accurate determination of what are properly mental dysfunctions is requested, since for the majority of mental disorders neither the mechanisms underlying the supposed dysfunctions nor their evolutionary pathways are sufficiently known. Thus, he gives only a general draft of it while he uses commonsense intuition as the final arbiter of what really counts as dysfunctional. Critics easily attacked his view on this point, claiming that conceptual analysis and commonsense intuition should be rejected as a source of authority (Murphy, 2006, p.61) and asking for an empirically based analysis of what a disorder is.

Having considered some of Wakefield’s harmful/dysfunction analysis shortcomings, we turn now to the effect it could be expected on the process of making the DSM-V. The first point to be considered now is the relationship between this analysis and the

atheoretical requirement of the DSM. Wakefield (1997b, p.644) seems to renounce to ask for the abandonment of this position in favour of a theoretically oriented classification based on evolutionary theory. On the contrary, he claims that his etiological assumption about the dysfunction of an internal mechanism “is not theory-laden in a sense that would undermine DSM-IV’s theory neutrality”, thus trying to let his analysis accepted into the atheoretical frame of the DSM. How is it possible? Let us consider one typical Wakefield’s example: “Conduct Disorder must be caused by an internal dysfunction of some mechanism involved in socialization, empathy, or other prosocial behaviour” (Wakefield 1997b, p.644). Here there are two possible alternative interpretations: at one side, if taken in its stronger sense, the etiological assumption should refer to the dysfunction of a precise mechanism. This would imply the rejection of the DSM atheoretical requirement together with even stronger consequences: if we describe a precise mechanism, then we know it, and in a diagnostic context this means that we know the physiopathology of the pathological condition under investigation.

In turn, if we know its physiopathology we do not need anymore to found the determination of this pathological condition on descriptive psychopathology. As a consequence, we would have no more a disorder (descriptively-based) but a disease (based on the physiopathology that underlines symptoms).

However, Wakefield’s analysis cannot help in this task because, as seen above, he admits that the actual mechanisms of his dysfunctions are unknown and no precise causal mechanism is described. Accordingly, only the other possibility remains; namely, to refer to dysfunctional mechanisms in a weaker sense, without any definite indication of the specific mechanism involved (dysfunctions as inferred, hypothesized entities). In this case talking of the failure of a mechanism involved in socialization and empathy means nothing more than Conduct Disorder is characterized by difficulties in socializing and feeling empathy.

This formulation respects the DSM-IV theory neutrality but it is suspect that dysfunctions are nothing more than a different way to say the same things, thus their utility being in question.

Another point to be considered is about possible effects of Wakefield's suggestions on reliability. In order to solve the overdiagnosis problem he recommended to introduce environmental qualifiers in diagnostic criteria (Wakefield 1997b). For example, in major depression a criterion might be: "the symptoms are not simply a proportional and appropriate response to negative life circumstances or events" (Wakefield and Spitzer 2002). Could a similar criterion be adopted without decreasing DSM reliability? The answer is not, the introduction of rules aimed to exclude symptoms caused by a normal reaction to environmental stressors would surely decrease reliability, because it would be very difficult to find clear and consensual definition/description of what is exactly to be intended as *normal reaction*, *proportional and appropriate response* and so on. Moreover, reliability would also be seriously jeopardized due to Wakefield's evolutionary approach:

"To establish that a condition is a *disorder* in the sense of Wakefield's analysis, we would have to establish, or at least have a consensus about, whether it arose because of or at least involved "failure of a natural mechanism to function as designed in evolution". But as opposed to what? Behavioral scientists working in an evolutionary theoretic framework have suggested that failure of function in Wakefield's sense as a pathway to harmful conditions can be contrasted with, for instance, evolutionary design/current environmental mismatch, or maladaptive learning. If these are the kinds of intended contrasts, we need to wait until the science has been done to establish which types or sub-types of problems are "genuine disorders" in the sense of Wakefield's analysis, and which are not. And in the meantime, during what might be a long wait, we would need *another name* for the problems, not *disorders* (which in this scenario we are interpreting in Wakefield's sense), but perhaps, for instance, *mental health problems*, the criteria for which would have to be reliable enough for us to do

meaningful, generalizable research. We would be back where we are with (another) change of name" (Bolton, 2007, pp.164-165).

In sum, reliability would decrease, and Wakefield himself appears to be conscious of this (at least in the case of his rules aimed to exclude symptoms caused by a normal reaction to environmental stressors). Coherently, he claims that "reliability purchased at the cost of validity is no bargain" and he declares himself ready to sacrifice at least part of DSM achievements on reliability: "increases in validity are not only compatible with but sometimes require decreases in reliability" (Wakefield 1997b, p.646). This position has many merits; indeed it is clear and, above all, it is the result of a serious analysis of one of the main problems of the DSM (namely, that the excessive focus of the DSM on reliability led to a simplistic definition of symptoms which are often insufficient as valid indicators of disorder). Nevertheless, would the authors of the DSM-V agree to introduce new criteria if they are likely to reduce reliability? It is a shared view that DSM-III success was *mainly* due to its ability to improve reliability. Thus, it can be easily predicted that the authors of the DSM-V will be very cautious on the risk of decreasing reliability.

Finally, the last point to be considered is that of the practical effects of the adoption of Wakefield's suggestions. Despite his claim for the substitution of the DSM-IV general definition of mental disorders with his harmful-dysfunction definition, Wakefield appears conscious that this would have limited practical effects unless it is accompanied with consequential changes of the various diagnostic criteria: "false positives can occur if the criteria sets for specific disorders do not conform to the requirements of the definition" (Wakefield and First, 2003, p.33).

Accordingly, his harmful-dysfunction definition of disorder should "provide guidance on how to construct diagnostic criteria sets for individual disorders" (Wakefield and First, 2003, p.24). This coherent consequence from the general definition of disorder to the changes

of diagnostic criteria for specific disorders is among the major strengths of Wakefield's proposal, tracing a distinction from *ad hoc* adoption of exclusion clauses aimed at single known cases of overdiagnosis. However, how changes in individual disorders should be done? And, would the authors of the DSM-V be inclined to accept this kind of changes? Practically, added criteria should indicate how disproportionate a response is to environmental triggers; alternatively, they should signal when a reaction occurs without appropriate eliciting stimuli or, on the contrary, when a normal response does not occur despite the occurrence of the specific circumstances under which such a response was waited; finally, when possible they should identify what is supposed to be going wrong in the involved mechanism (Wakefield and First, 2003). Suitable examples are "the symptoms are not simply a proportional and appropriate response to negative life circumstances or events" (Wakefield and Spitzer 2002, p.38) or "antisocial behavior does not necessarily indicate Conduct Disorder if it is simply the result of peer pressure or a rational decision in a threatening or deprived environment" (Wakefield 1997b, p.644). It is undeniable that by stressing this point Wakefield has the merit of having solicited a reflection on contextual judgments that any good clinicians should consider in his anamnesis.

However, how might it be made operative in order to be accepted for DSM-V criteria? Who must decide what should be intended for disproportionate? When should a response to a living situation be considered exaggerated, and who decides what is exaggerated? Who knows when stimuli are appropriated? How many specific circumstances are known that in normal conditions invariably elicit a given response? Are rational decisions always synonymous of normal decisions? All this questions involve clinicians' subjective choices that are at the antipodes of the DSM operative diagnostic criteria (as seen above, expressly designed to increase reliability by

reducing the role of the subjective judgment of the single evaluator). It should be stressed that in view of the DSM-V researchers were alerted that changes in diagnostic criteria have many possible disadvantages that need to be considered (Rounsaville et al., 2002, pp.10-11). Thus, it is likely that this conservative approach will refuse to accept too many small changes (at least one for any specific disorder, if Wakefield's suggestion must be followed coherently), especially if they are too subjective and as a consequence they risk to decrease reliability.

Accordingly, the authors of the DSM-V could more easily accept to introduce only the general Wakefield's definition of disorder (as a harmful dysfunction) in the introduction of the DSM-V (something in the same direction was already done for the DSM-IV, albeit partially). This general change would be easier because it would change only the generic definition of disorder, without any change of the single diagnostic criteria (which are the core of the DSM system). However, as discussed above this strategy would have no effect on the overdiagnosis problem, thus failing to solve one of the main current classification problems.

## DISCUSSION

The present paper considered one of the basic nomenclature problems that were regarded as in need of discussion in view of the DSM-V, namely "how to define mental disorder" (Rounsaville et al., 2002).

In the first part of the script it was shown that the DSM concept of mental disorder is two-faced. At one side, in the introduction of the diagnostic manual there is a generic definition of disorder, which slightly changed in subsequent versions but without increasing its specificity. It was argued that, intentionally or not, the very fact that this general definition was non-specific helped the DSM-III in one of its primary aims: namely, wide acceptability among clinicians working in all mental settings, independently from their views on the etiology of mental disorders (a more defined concept of mental disorder was at risk to unmask

etiological beliefs and thus to be more difficult to be accepted). On the other side, it was shown that in the DSM-III the term “disorder” acquired a specific, technical meaning, implicitly arising from its concrete use (from the way the single mental disorders were categorized by means of operative diagnostic criteria).

Accordingly, the specific definition of mental disorder might be conceived as “a categorial concept based on the description of some mental phenomena which are (usually without qualitative differences or hierarchies among them) explicitly enlisted in polythetic operative diagnostic criteria”. Onset, course, time frequency of the symptoms and exclusion rules for other disorders are among the other criteria considered in the operative “diagnostic mechanism” whose final principal goal was to significantly increase diagnostic reliability.

Another point of interest that emerged from the analysis of mental disorders was that their specific concept was markedly different from other categorial concepts such as diseases, typologies and classic psychopathological syndromes. In fact, medical diseases “are now defined at a more fundamental level than their syndrome and are distinguished from one another by fairly well-established differences in pathology or etiology” (Kendell and Jablensky 2003, p.9), while usual mental disorders (e.g. schizophrenia and bipolar disorder) are descriptive concepts that officially say nothing about possible mechanisms underlying symptoms.

Moreover, classical typologies were, according to Jaspers’ work on *Idealtypes*, mainly diagnosed through a subjective decision following the comparison of the concrete clinical case to the ideal typology.

On the contrary, operative diagnostic criteria were designed to mechanically guide the clinicians to the diagnosis (in this last case the physician was only allowed to decide if the enlisted phenomena were present or not, the diagnostic rules being not under his power but a-priori decided by the authors of the DSM).

Finally, classic psychopathological syndromes were based on qualitative distinctions of fundamental from accessory symptoms, while disorders are a kind of syndrome whose symptoms are not hierarchically differentiated (in the case of disorders the approach is quantitative and polythetic, being essentially based on diagnostic thresholds).

In the last paragraphs it was shown that one of the main problems soliciting for a conceptual revision of the definition of mental disorder was the pragmatic problem of overdiagnosis. Wakefield’s harmful-dysfunction definition was then considered and the first point that needs to be addressed now is that his characterization of a “mental disorder” is very different from that emerged from the above discussed historically-grounded conceptual analysis of mental disorders as technical terms specifically linked to the DSM nosography. Wakefield swings ambiguously between a very general meaning of disorder as “a broader term that covers both traumatic injuries and diseases/illnesses, thus being closer to the overall concept of medical pathology” (Wakefield, 2007, p.150) and a restricted meaning based on the necessary requirement of a dysfunction plus a negative judgment on the harmful effects of having that dysfunction. In the first case the term is used generically as equivalent to medical pathology and it cannot escape the critique of Jablenski (2007) that medical doctors practice medicine and treat illnesses without neither using nor needing an overarching and universal definition of disorder. In the second case the requirement, if taken seriously, is so strict that it would provide (as Wakefield intended to) a demarcation criterion to sharply divide “real” disorders from problems in living that involve “a normal though problematic reaction to stressful environmental conditions” (Wakefield, 2007, p.153).

Here the question is: do we really need a rigid demarcation criterion? And also, what kind of entity would be a mental disorder if Wakefield’s proposal has to be followed? Wakefield is very critical with the authors of

the DSM, but he shares with their neokraepelinian view a common obsession, namely that of reducing psychiatry to a branch of medicine. When this means that psychiatry (like medicine) must be founded on the scientific method, there is nothing to disagree about it. The problems arise when this position is not only a methodological one, but in addition it takes for granted that it must add a positive content (in this case the claim that mental disorders *must* be dysfunctions). As a consequence of this position, it might be asked:

First, if mental disorders are characterized on the basis of a dysfunction (that is, in medicine, on a physiopathological level), what kind of difference would remain between the concept of “disorder” and that of “disease” (which, as seen above, is a medical diagnostic category based on the knowledge of its etiology and/or physiopathology)? Why should we still need a concept of disorder if it can be completely reduced to that of disease? Second, clinical psychiatrists do not treat only psycho-organic diseases, but also syndromes in which a dysfunction is unknown and those in which the sickness is related to living problems. Possible consequences of such a rigid demarcation criterion could be:

a) the paradoxical situation that if a classical psychiatric disorder is not found to be based on any known dysfunction, it is *ipso facto* a non-psychiatric condition. Today, this would involve all the classical “endogenous psychoses”, which are diagnosed only on the basis of descriptive features, as well as many other psychiatric disorders enlisted in the DSM. Should they be deleted from any psychiatric classification?

b) alternatively, psychiatrists could continue to consider useful to diagnose these conditions; hence, this would lead to the restriction of the term mental disorder to the cases meeting the harmful/dysfunction requirement and the *ex novo* creation of a new name for those clinical conditions that still need a psychiatric treatment but cannot fulfil Wakefield’s restrict criteria (“We would be

back where we are with (another) change of name”, notes Bolton (2007, p.165));

c) finally, a third possibility would be the self-confinement of clinical psychiatry into a smaller field of action, reducing its activities to a sort of clinical neuropsychology (focusing only to symptoms due to brain and cognitive lesions/dysfunctions), leaving out the cure for the most part of current psychiatric problems to other disciplines (for instance, psychology).<sup>3</sup>

Psychiatrists could reasonably ask: Why should we scotomize living problems if they are responsible of psychic sufferance that can be successfully treated? Bearing in mind that Wakefield claims that his harmful/dysfunction analysis should be accepted because it is a solution for the overdiagnosis problem, a point of general interest is whether psychiatry should consider the overdiagnosis problem as an internal, theoretical problem, or rather as an external bias (due to the interests of the American insurance companies to reimburse less treatments by simply denying to many subjects in therapy the status of mental sufferer).

In any case, in the present work it was shown that Wakefield’s suggestion will be probably discarded for pragmatic reasons (unwanted decrease of reliability and need of too much changes in the diagnostic criteria of any single DSM disorder); hence, genuine or not, the overdiagnosis problem is unlikely to be solved by using Wakefield’s analysis simply because the authors of the DSM-V probably will not accept to reformulate any diagnostic criteria set in accordance with his suggestion.

Another point of philosophical relevance arising from a comparison of the different concepts of “disorder” discussed herein is the following: the harmful dysfunction analysis is proposed as a hybrid position (partly factual and partly normative) although as Fulford and Thornton (2007) clearly show, it is the concept of dysfunction which is at the basis of Wakefield’s concept of disorder.

Having asserted the factual status of his concept of dysfunction, and in turn the dysfunction being the core of his concept of

disorder, Wakefield appears to assert an objectivist position on mental disorders. On the contrary, the historical reconstruction of the emergence of the concept of mental disorder as a technical implicit term specific of the DSM points in a very different direction; from this last perspective the concept of disorder emerges in a particular place (North America), in a particular era (the second half of the Twentieth Century), in a particular cultural milieu (the encounter of neokraepelinian and neo-empiricist psychiatrists) and in reply to particular challenges (above all the unreliability of psychiatric nosography and related discredit: see on this Aragona, 2006). From this point of view, thus, mental disorders are constructions (although seeing a concept as constructed does not mean necessarily that it was invented and that it has nothing to do with nature and reality but simply that our “worldmaking” activity is involved as a relevant factor). Hence, the contrast is between objectivist and constructivist accounts of the meaning of “mental disorder”.

However, it should be noted that the objectivist position cannot avoid implicit constructivism when proposes (as Wakefield does) to actively change the DSM diagnostic criteria in order to decrease the prevalence of mental disorders in epidemiological studies (a pragmatic need, indeed). In this context it is paradigmatic the following quotation of one of the most important supporters of the harmful-dysfunctional analysis (co-author of a significant paper on this position (Wakefield and First, 2003) and, above all, one of the most influential persons in the DSM-V board):

“Given that there are certainly at least some cases of individuals whose lives have been ruined by an inability to control their sexual impulses, the issue is not whether compulsive sexual behaviour can ever be considered a disorder, but instead how to tailor the criteria set for compulsive sexual behaviour disorder so that it falls within the definition of mental disorder [...] Thus, the aforementioned harmful dysfunction analysis should not just be applied in the construction of

criteria sets for new disorders, but should be used to guide revisions of the existing criteria sets as well” (First, 2007, p.159).

Intended to support Wakefield’s proposal, this writing clearly shows that mental disorders are constructed in accordance to theoretical positions in order to overcome practical problems and to pursue concrete goals. Therefore, the construction of mental disorders being implicitly admitted even by the supporters of the harmful/dysfunction analysis, an objectivist question like “what really is a mental disorder?” appears to be senseless. By the same token even the question that implicitly underlies the overinclusion problem, that is “what (who) is normal and what (who) is mentally disordered?” should be reconsidered, being significantly influenced by what is conceived as normal and what is thought to be a mental pathology in our society and in our era. Researchers aware of the relativity of this distinction would be less prone to look for a unique a-historical definition of disorder and would probably agree that in the diagnostic activity what is decisive in order to say that someone is in a pathological condition is clinical significance.

In turn, clinical significance will widely vary in relation to social and scientific factors (treatment availability included), and we should not expect to find a unique and definitive definition of clinical significance, valid in any case, in any culture and in any period of time.<sup>4</sup>

Accordingly, clinical significance cannot be a solution in the search of a demarcation criterion; it means nothing *in se*, being only another way to express the mere fact that clinicians have to judge whether a subject is healthy and does not need any treatment or pathological and in need of treatment.

Factors that influence this technical (but still subjective) judgment may be *a parte objecti* (patient’s features of uttered experiences or behaviours) and *a parte subjecti* (clinician’s ideas/knowledge and emotional reaction to patient’s characteristics), as well as technical (e.g. treatment availability), social and cultural influences. Therefore, much work on the

general categories that drive/bias this clinical judgment would be appreciated.

### Endnotes

(1) For example, the criteria for major depression place two symptoms, depressed mood and loss of interests or pleasure, at a different level of importance, even if neither is necessary for the diagnosis.

(2) Although someone could question whether a sentence like “I feel sick” could also be seen as a fact, thus challenging also the idea of “purely normative” characteristics.

(3) It should be noted that psychiatry and psychology are now intertwined and strictly collaborate in the treatment of psychic problems. On the contrary, in the hypothesis discussed herein they would divorce, focusing on two completely separate kinds of entity (psychiatric disorders and living difficulties). Some clinicians will probably find this demarcation unsound, given the usual interplay between mental functions and living and environmental conditions.

(4) On this particular point there are no obvious differences with Wakefield who writes: “a dysfunction only qualifies as a disorder if it causes harm over the threshold of clinical significance, and judgements that a condition is negative or harmful are irretrievably culturally relative” (Wakefield, 2006). However, its assumption that basic dysfunctions are always the same and that the thing that varies is only the judgment on its harmfulness (Wakefield, 2007) does not consider at all that culture often shapes the form of the disorder itself, not only the reaction to it. Further ethnopsychiatric studies are needed to consider in more detail Wakefield’s shortcomings on this point.

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