*Rev. Latinoam. Psicopat. Fund.*, VII, 3, 102-112

# Why does psychiatry need to define "mental disorder"?

Claire Pouncey

Psychiatry's search for a single, comprehensive definition of "mental disorder" has generated a great deal of discussion (Fulford, 1989; Kendell, 1986; Kirmayer and Young, 1999; Lilienfeld and Marino, 1995; Moore, 1978; Papineau, 1994; Reznek, 1991; Spitzer and Endicott, 1978; Wakefield, 1992a; Wakefield, 1992b; Wakefield, 1993). The American Psychiatric Association's (APA) third edition of its *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III) defines "mental disorder" as

> a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is typically associated with either a painful symptom (distress) or impairment in one or more important areas of functioning (disability). (American Psychiatric Association, 1980)

This definition remained essentially unchanged in subsequent DSM revisions. Although the DSM specifies that "there is no assumption that each mental disorder is a discrete entity with sharp boundaries (discontinuity) between it and other mental disorders, as well as between it and No Mental Disorder" (American Psychiatric Association, 1980), and the text revision of the fourth edition of the *DSM* (DSM-IV-TR) reiterates that "no definition adequately specifies precise boundaries for the concept of 'mental disorder'" (American Psychiatric Association, 2000, xxx), this definition ostensibly has been used as a guiding principle for the DSM-IV (American Psychiatric Association, 1994, xxi). Furthermore, in 2002 the

APA's Nomenclature Work Group named as a research priority for DSM-V "defining 'mental disorder' ... in a way that allows it to be used as a criterion for deciding what is and is not a mental disorder" (Rounsaville et al., 2002), i.e. defining a boundary between disordered and nondisordered states in general. In contrast, the World Health Organization's tenth edition of its *International Classification of Diseases* (World Health Organization, 1992) does not define "mental disorder" at all, either to delineate the individual disorders from one another, or to demarcate the realm of normal from that of psychiatric illness.

**Possible reasons to define "Mental Disorder"**

Why does one classification emphasize the importance of defining "mental disorder" so strongly when the other disregards the question entirely? What concerns prompt us to search for a single definition of "mental disorder"? What is at stake in seeking such a definition or refraining from doing so?

*Clinical practice*. First, let us consider whether clinicians require a definition of "mental disorder" in their day-to-day practice. One scenario might be that clinicians need a definition in order to direct their practices. On this view, a patient presents to the psychiatrist with a problem, the psychiatrist evaluates that problem, diagnoses it, and provides treatment according to whether that diagnosis fits within psychiatry's purview, i.e, whether it meets with a general definition of mental disorder.



The problem with such a view is that the scenario does not reflect well what clinicians do. Patients usually present in some kind of distress; the psychiatrist attempts to alleviate that distress, regardless of whether the patient can be given a particular diagnosis, or whether the presenting complaints fit with a general definition of "mental disorder". No definition of "mental disorder" is likely to be sensitive enough to capture all the cases of distress that a psychiatrist might treat. The DSM recognizes a number of conditions that psychiatrists are likely to address, even though they do not constitute mental disorders even in the weakest sense of the term.[1] Furthermore, psychiatric treatments are nonspecific. That is, there are no treatments reserved exclusively for persons whose complaints meet criteria for being a mental disorder. The same psychotherapeutic and psychopharmacologic treatments, and even electroconvulsive therapy, are used

1. These include iatrogenic movement disorders, neuroleptic malignant syndrome, bereavement, borderline intellectual functioning, relational problems, academic and occupational problems, and abuse and neglect – the so-called "V codes (American Psychiatric Association, 2000).

for a host of different problems, only some of which may be mental disorders. There is no rule of psychiatric practice that makes providing a given treatment contingent upon the presence of "mental disorder" in some general sense. A definition of "mental disorder" is simply not a requirement for clinical practice.

*Research settings*. Perhaps we require a definition of "mental disorder" for research purposes. With funding as scarce as it is, one might suppose that in order to win monies for psychopathology research, one would need to tap into funds that are earmarked specifically for research into mental disorders. That is, one might expect that research into mental disorders proceeds from funds that are dedicated for mental disorders generally, and that one must have a way to demonstrate that a pathophysiologic process of interest is indeed a mental disorder before one can have access to such funds.

Despite the existence of specific funding *agencies* dedicated to funding research on mental disorders, psychopathology research does not depend upon proving that a condition of interest meets a precise definition of mental disorder. Even the United States' National Institute of Mental Health does not have a single, unequivocal definition of "mental disorder" o "mental health" that it uses to decide whether a particular study lies within its domain. Rather, investigations in psychopathology study specific disorders as they present in particular cohorts of persons, for instance schizophrenia (Sullivan et al., 2003), obsessive compulsive disorder (Szaszko et al., 2004), or binge eating disorder (Appolinario et al., 2003). In each of these cases, the investigators started with a particular hypothesis about a *particular* disorder; they did not pose hypotheses about mental disorders generally. Consequently, there is no need to define "mental disorder" for research purposes.[2]



*Administrative settings*. Both public and private policy-making seem to require a definition of "mental disorder" as well. In the United States, hospitals

2. Research on mental disorders as a general category is quite rare compared to studies on the characterization and treatment of particular psychopathology. There *is* some empirical research on mental disorders generally, and more has been proposed. In the 1970s, Campell, Scadding, and Roberts surveyed clinicians to see if they generally agreed on the conditions that ought to be accepted as diseases or disorders, even though there was no general agreement about how to define "disease" or "disorder" (Campbell et al., 1979). This widely cited study influenced the APA's Nomenclature Work Group, which has suggested that a larger version of it be repeated among health care providers internationally, to see if there are conditions that are uncontroversially accepted as mental disorders. The Nomenclature Work Group also proposed an international survey of clinicians to see what definitions of "mental disorder" they use (Rounsaville et al., 2002). Such studies do not constitute a counterexample to my claim, because they presuppose rather than prove that a definition of "mental disorder" is needed.

and clinics code the illnesses they treat, as well as the procedures they use to do so. Third party payers, whether they are private insurance companies or national entitlement systems, require that illnesses be coded as well. Once again, however, these codes are for particular diagnoses, not the diagnosis of "mental disorder" generally. For example, mental health providers code specific mental disorders, such as social phobia or anorexia nervosa; third party payers have policies about how much to reimburse for bipolar disorder or schizophrenia; governments and private funding agencies dedicate research monies for Parkinson disease, autism, and obsessive-compulsive disorder. None of the provider, reimbursement, or funding policies under consideration applies to mental disorders in general.

*Classification*. The definition of mental disorder is most important with respect to classification. To some, such as the APA's Nomenclature Work Group, it appears that a definition of "mental disorder" is necessary in order to know whether a particular condition ought to be formally recognized as a mental disorder. Kendell (1975), Guze (1978), Panzetta (1974), and, most recently, Wakefield (1993; Wakefield and First, 2003) make the same claim. In these cases, a definition of the general conception of "mental disorder" is meant to have regulatory power, to provide a reason for including conditions in our formal classifications or excluding them from such classifications. In turn, these nosologic decisions are thought to define the purview of psychiatry, authorizing certain conditions for research and treatment by mental health professionals. As Wakefield puts it, the idea is that "[A classification] manual will be coherent and conceptually valid (i.e., valid in discriminating disorder from nondisorder) only if its construction is guided by an adequate definition of disorder" (Wakefield, 1993, 160). On this view, a classification of mental disorders requires an explicit and finite definition of "mental disorder" in order to decide definitively which conditions are normal, and which are abnormal and (hopefully) amenable to psychiatric treatment.



## Classification controversies

*The Moral Question*. However, even in formulating or revising a nosology, most of the time an explicit definition of "mental disorder" is not needed. Only where a condition is in some way controversial do we seek a definition of "mental disorder" that will justify calling that condition a disorder, or calling it a mental disorder specifically. These are usually moral questions, thorny problems that speak to societal values about appropriate attitudes, beliefs, and behaviors.

Moral problems are notoriously difficult for medicine to handle. The field of bioethics arose because of problems created by medicine's extreme difficulty

in confronting questions of value explicitly and productively. There is a tendency within medicine to seek the answers to evaluative questions in biomedical facts, so as to minimize the subjectivity of personal moral preferences, and to avoid lengthy and inchoate moral deliberation. In some cases a substitution of empirical fact for deliberations of value may work; in other cases, conceptual rather than empirical work is required, despite its indeterminacy and possible subjectivity. The difficulty is that conceptual work can always be disputed more easily than can empirical work, for which we have more, and better accepted, intersubjective standards. Since nonempirical conclusions cannot be verified or falsified by the physical, observable world, it is understandable that a profession interested in objectively confirmable conclusions would relegate evaluative and conceptual matters to other disciplines. Many authors, including the editors of the DSM, seek a definition of "mental disorder" that will provide an empirical fact of the matter, with "operationalized" criteria (Spitzer and Endicott, 1978), that can eliminate the subjectivity of moral reasoning in cases that are ethically or sociopolitically charged.

*Homosexuality*. For instance, the debate about the definition of "mental disorder" arose because of a dispute in the early 1970s about whether the DSM should continue to list homosexuality as a mental disorder. The second edition of the DSM (American Psychiatric Association, 1968) recognized homosexuality as a disorder, which generated public and professional controversy as the gay rights movement in the United States lobbied the APA to have homosexuality removed from the classification (Bayer, 1987). Robert Spitzer, the general editor of DSM-III, addressed the issue by proposing a definition of "mental disorder" that was intended to settle the controversy. The idea was that such a definition would provide "explicit guiding principles that would help to determine which conditions should be included in the nomenclature, which excluded, and how conditions included should be defined" (Spitzer and Endicott, 1978). According to one author, Spitzer's definition successfully provided neutral ground on which opponents on the question of homosexuality could agree (Bayer, 1987).

However, the acceptance of the definition of "mental disorder" did not persuade psychiatrists who considered homosexuality a "perversion". The debate about including homosexuality in the DSM addressed whether psychiatry should medically condone behavior that many persons considered immoral, as much as it addressed whether homosexuality fits a definition of disorder. Providing a definition of "mental disorder" to address the question was a way to disguise the homosexuality question as a scientific matter rather than a moral and political one. The moral question remained and continued to be debated, even after the APA agreed to remove homosexuality from the DSM.

*Binge Eating Disorder*. Note that we do not appeal to a definition of "mental disorder" when the condition in question does not ignite sociopolitical outrage or moral controversy. For instance, Binge Eating Disorder (BED) was first proposed in the 1950s, and its status as a discrete mental disorder has been debated since that time (Fairburn et al., 1993; Stunkard, 1959; Stunkard and Allison, 2003). Unlike homosexuality, BED is not evaluatively charged. Calling a pattern of eating behaviors a disorder does not express social disapproval of obesity, overeating, or bingeing in particular, but rather seems to be a neutral response to the distress that such behaviors or the resulting body habitus cause for the person who binges. Although binge eating behaviors are not condoned, they also are not socially reviled. Without the impetus to settle a moral and political disagreement, the participants in the BED debate never called for a definition of "mental disorder" to settle their dispute.

Thus, we call for a definition of "mental disorder" when we need it to resolve a moral question, rather than a more straightforward matter of psychopathology. When we ask whether homosexuality is a mental disorder we are also asking whether homosexual behaviors are morally permissible. When we ask whether BED is a mental disorder we are simply asking whether a particular form of psychopathology is present. In short, any insistence that we have a single definition of "mental disorder" asks that we have a way of settling questions about whether certain morally questionable behaviors can be condoned or explained away on scientific grounds, so that we do not need to confront the moral concerns.



However, we cannot avoid moral engagement by deferring to a definition of "mental disorder", operational or otherwise. Rather, the very definition of "disorder" is the venue of moral debate. For decades, scholars have disputed the definitions of "health", "disease", "illness", and "disorder" (Boorse, 1975; Boorse, 1977; Caplan et al., 1981; Caplan et al., 2004; D'Amico, 1995; Engelhardt, 1974; Engelhardt, 1985; Fulford, 1989; Hesslow, 1993; Kendell, 1975; Lennox, 1995; Margolis, 1981; Mordacci and Sobel, 1998; Reznek, 1987; Sedgwick, 1973). Although subtle distinctions have been drawn between these concepts, the overarching question addressed is whether the concepts of "health", "disease", and "disorder" can be defined in a manner that is free of human values. Authors who find that "disease" and "disorder" are value-laden terms are called "normativists"; those who find them to be purely descriptive terms are called "nonnormativists".

Boorse (1975) believes that "disease" can be defined without reference to values. He defines "disease" as the interruption of normal function – dysfunction – which he defines in terms of evolutionary biology. A function is "a standard causal contribution to a goal actually pursued by the organism"; a dysfunction or

disease then would be a failure of that normal function. Boorse provides a nonnormative account that can be used to identify disease states unambiguously, without incorporating social biases or prejudices. However, Boorse denies that his nonnormativist account of "disease" applies to mental disorders, which he finds to be inherently normative.

Wakefield develops Boorse's position to develop an account of "disorder" that authenticates mental illness as a proper focus of medical attention. He uses Boorse's notion of normal functioning as a point of departure, and argues that disorders, like diseases, are "harmful dysfunctions". Unlike Boorse, Wakefield thinks that "disorder" is value-laden: he adds the word "harmful" to specify which dysfunctions qualify as disorders. Like Boorse, however, Wakefield finds "dysfunction" to be a value-free term that applies generally in both medicine and psychiatry.

Other authors (Engelhardt, 1974; Fulford, 1989; Margolis, 1981; Reznek, 1987; Sedgwick, 1973) argue persuasively against Boorse and Wakefield that "dysfunction" is an inherently evaluative term. With Wakefield, these authors find that mental and physical disorders or diseases are qualitatively similar, but they believe that both mental and physical disorders are fundamentally evaluative. Disorders, on this value-laden view, are not things that exist in the world separate from human interests. As Lilienfeld and Marino argue, there is no state of nature that corresponds to the word "disorder" (Lilienfeld, and Marino, 1995), just as there is no single state that refers to "the normal". Rather, any distinction between disorder and nondisorder, between disease and health, between illness and wellness, and between dysfunction and function is based in underlying preferences about the states of affairs we value and disvalue.



We cannot find a value-free definition of "mental disorder" that can serve as the arbiter of social approbation. Boorse and Wakefield's "proper functions" are only proper in the sense that we tend to *like* that out hearts circulate blood, that our kidneys maintain electrolyte balance, and that our blood cells secrete cytokines. We usually have no opinion about the fact that our hearts also secrete atrial natriuretic peptide; and we tend to prefer that our kidneys *not* fill our bladders at inconvenient times, and that our blood cells *not* make us feel achy and feverish when we have infection. In general, we value physiologic processes that make us live and thrive; we disvalue failure of those processes, as well as natural processes that threaten our lives (e.g., most cancers), or that interfere with human flourishing. Dysfunctions, diseases, and disorders are states of affairs that we disvalue for these reasons.

Mental disorders are good examples of conditions that persons or societies disvalue because they interfere with human thriving. Depressive and anxiety states make the people who have them feel unwell, and they can decrease productivity

and social participation. Attention deficit disorder (ADD) and sleep disorders interfere with school and work performance. Schizophrenia leads to impaired cognitive, affective, and executive processing to the point that persons who have it are often disabled. Paraphilias violate moral norms, creating distress for some individuals (such as with compulsive sexual behavior) or for society (such as with pedophilia or voyeurism).

If "dysfunction", "disease", and "disorder" are all evaluative terms, then we should expect to be engaged in debates about values all the time. In fact, we do constantly weigh different norms against one another in medicine. Note that in the preceding examples we disvalue particular conditions for different reasons: individual suffering and disability, diminished social functioning, and violation of social etiquette have no single feature in common that make them "disordered", except that they are disvalued. But different kinds of norms are involved in different situations: depression and anxiety produce variations in individuals' comfort levels, ADD causes variations from the performance norms of a population, and paraphilias often violate moral norms. In each of these cases, there also can be a gradient of disvalue corresponding to greater or lesser degrees of dysfunction. Additionally, there may be disagreement about the disvalue of any given instance of mental disorder among different parties involved. We can expect that caregivers, physicians, patients, and agencies will disagree about whether or to what extent a given person is actually disordered.



Since we are engaged in debates about norms and values all the time, there is no reason not to acknowledge the moral facets of debates about the definition of "mental disorder". If we want to define "mental disorder" for nosological purposes, i.e., in order to make decisions about whether particular emotionally and morally charged conditions should be included in our official nosology, we need to 1) explicitly debate the values involved in considering whether those conditions are disorders, and 2) clearly acknowledge the social context in which these considerations become controversial. The task of defining "mental disorder" does not involve identifying a value-free state of affairs, because the task is always specific to a certain nosologic and social context.

## Conclusion

Despite the insistence of the APA both that the DSM needs a better definition of "mental disorder", and that it uses the one it published in DSM-III to make nosologic decisions, we have seen that psychiatric nosology only requires such a definition to resolve controversial, morally charged cases in as neutral a manner

as is possible. However, we have seen that the very question of how to define "mental disorder" is morally charged. Whether we compare mental disorders to diseases or dysfunctions, there is an unavoidable evaluative component to the very term. Hence, no single definition of "mental disorder" can be expected to do the work we want so badly for it to be able to do. Instead, we must take into consideration that any nosologic decision may be controversial. Using a definition of mental disorder to settle a nosologic question requires sensitivity to the social context in which the controversy arises, and explicit deliberation of the values involved in each case.

## References

AMERICAN PSYCHIATRIC ASSOCIATION. *Diagnostic and statistical manual of mental disorders*. Washington, DC: American Psychiatric Press, 1968.

____ *Diagnostic and statistical manual of mental disorders*. Washington, DC: American Psychiatric Press, 1980.

____ *Diagnostic and statistical manual of mental disorders*. Washington, DC: American Psychiatric Press, 1994.

____ *Diagnostic and statistical manual of mental disorders*. Washington, DC: American Psychiatric Press, 2000.

APPOLINARIO, J.C. et al. A randomized, double-blind, placebo-controlled study of sibutramine in the treatment of binge-eating disorder. *Archives of General Psychiatry*, v. 60, n. 11, p. 1109-16, 2003.

BAYER, R. *Homosexuality and American Psychiatry*: The Politics of Diagnosis. Princeton, NJ: Princeton University Press, 1987.

BOORSE, C. On the distinction between disease and illness. *Philosophy and Public Affairs*, v. 5, p. 49-68, 1975.

____ Health as a theoretical concept. *Philosophy of Science*, v. 44, p. 542-73, 1977.

CAMPBELL, E.J.M., SCADDING, J.G. and ROBERTS, R.S. The concept of disease. *British Medical Journal*, v. 2, p. 757-62, 1979.

CAPLAN, A.L. et al. (ed.). *Concepts of Health and Disease*: Interdisciplinary Perspectives. Reading, MA: Addison-Wesley Publishing Company, 1981.

D'AMICO, R. Is disease a natural kind? *Journal of Medicine and Philosophy*, v. 20, n. 5, p. 551-69, 1995.

ENGELHARDT, H.T., JR. The disease of masturbation: Values and the concept of disease. *Bulletin of the History of Medicine*, v. 48, p. 234-48, 1974.

____ Typologies of disease: Nosologies revisited. In: SCHAFFNER, K. (ed.). *Logic of Discovery and Diagnosis in Medicine*. Berkeley: University of California Press, 1985. p. 56-71.

FAIRBURN, C.G., WELCH, S.L. and HAY, P.J. The classification of recurrent overeating: The "binge eating disorder" proposal. *International Journal of Eating Disorders*, v. 13, n. 2, p. 155-59, 1993.

FULFORD, K.W.M. *Moral Theory and Medical Practice*. Cambridge: Cambridge University Press, 1989.

GUZE, S.B. Nature of psychiatric illness: why psychiatry is a branch of medicine. *Comprehensive Psychiatry*, v. 19, p. 295-307, 1978.

HESSLOW, G. Do we need a concept of disease? *Theoretical Medicine*, v. 14, p. 1-14, 1993.

KENDELL, R.E. The concept of disease and its implications for psychiatry. *British Journal of Psychiatry*, v. 127, p. 305-15, 1975.

____ What are mental disorders? In: FREEDMAN, A.M. et al. (ed.). *Issues in Psychiatric Classification*: Science, Practice and Social Policy. New York: Human Sciences Press, Inc., 1986, p. 23-45.

KIRMAYER, L.J. and YOUNG, A. Culture and context in the evolutionary concept of mental disorder. *Journal of Abnormal Psychology*, v. 108, p. 446-52, 1999.

LENNOX, J.G. Health as an objective value. *Journal of Medicine and Philosophy*, v. 20, n. 5, p. 499-511, 1995.

LILIENFELD, S.O. and MARINO, L. Mental disorder as a Roschian concept: a critique of Wakefield's "harmful dysfunction" analysis. *Journal of Abnormal Psychology*, v. 104, n. 3, p. 411-20, 1995.

MARGOLIS, J. The concept of disease. In: CAPLAN, A.L. et al. (ed.). *Concepts of Health and Disease*: Interdisciplinary Perspectives. Reading, MA: Addison-Wesley Publishing Company, 1981. p. 561-77.

MOORE, M.S. Discussion of the Spitzer-Endicott and Klein proposed definitions of mental disorder. In: SPITZER, R.L. and KLEIN, D.F. (ed.). *Critical issues in psychiatric diagnosis*. New York: Raven Press, 1978. p. 85-107.

MORDACCI, R. and SOBEL, R. Health, a comprehensive concept. *Hastings Center Report*, v. 28, n. 1, p. 34-7, 1998.

PANZETTA, A.F. Towards a scientific psychiatric nosology: conceptual and pragmatic issues. *Archives of General Psychiatry*, v. 30, p. 154-61, 1974.

PAPINEAU, D. Mental disorder, illness and biological function. In: GRIFFITHS, A.P. (ed.). *Philosophy, Psychology and Psychiatry.* New York: Cambridge University Press, 1994. p. 73-82.

REZNEK, L. *The Nature of Disease*. London: Routledge and Kegan Paul, 1987.

____ *The Philosophical Defence of Psychiatry*. New York: Routledge, 1991.

ROUNSAVILLE, B.J., ALARCON, R.D., ANDREWS, G., JACKSON, J.S., KENDELL, R.E. and KENDLER, K. Basic nomenclature issues for DSM-V. In: KUPFER, D. J. et al. (ed.). *A Research Agenda for DSM-V.* Washington, DC: American Psychiatric Press, 2002. p. 1-29.

SEDGWICK, P. Illness – mental and otherwise. *Hastings Center Studies*, v. 1, n. 3, p. 19-40, 1973.

SPITZER, R.L. and ENDICOTT, J. Medical and mental disorder: proposed definition and criteria. In: SPITZER, R. L. and KLEIN, D. F. (ed.). *Critical issues in psychiatric diagnosis*. New York: Raven Press, 1978. p. 15-39.

STUNKARD, A.J. Eating patterns and obesity. *Psychiatric Quarterly*, v. 33, p. 284-94, 1959.

____ and ALLISON, K.C. Binge eating disorder: disorder or marker? *International Journal of Eating Disorders*, v. 34, p. S107-S16, 2003.

SULLIVAN, P.F., KENDLER, K.S. and NEALE, M.C. Schizophrenia as a complex trait: Evidence from a meta-analysis of twin studies. *Archives of General Psychiatry*, v. 60, n. 12, p. 1187-92, 2003.



SZASZKO, P.R. et al. Brain structural abnormalities in psychotropic drug-naive pediatric patients with obsessive-compulsive disorder. *American Journal of Psychiatry*, v. 161, n. 6, p. 1049-56, 2004.

WAKEFIELD, J.C. Disorder as harmful dysfunction: A conceptual critique of DSM-III-R's definition of mental disorder. *Psychological Review*, v. 99, n. 2, p. 232-47, 1992a.

____ The concept of mental disorder: on the boundary between biological facts and social values. *American Psychologist*, v. 47, n. 3, p. 373-88, 1992b.

____ Limits of operationalization: a critique of Spitzer and Endicott's (1978) proposed operational criteria for mental disorder. Journal of Abnormal Psychology, v. 102, n. 1, p. 160-72, 1993.

____ and FIRST, M.B. Clarifying the distinction between disorder and nondisorder: confronting the overdiagnosis (false-positives) problem in DSM-V. In: PHILLIPS, K. A. et al. (ed.). *Advancing DSM*: Dilemmas in Psychiatric Diagnosis. Washington, DC: American Psychiatric Press, 2003. p. 23-55.

WORLD HEALTH ORGANIZATION. *ICD-10 Classification of Mental and Behavioural Disorders*: Clinical Descriptions and Diagnostic Guidelines. Geneva: World Health Organization, 1992.