CHAPTER 14

Taking Disorder Seriously

A Critique of Psychiatric Criteria for Mental Disorders from the Harmful-Dysfunction Perspective

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Psychiatry, clinical psychology, clinical social work, and the other mental health professions—for convenience, I collectively refer to these professions here as "psychiatry"—claim to address mental problems that are disorders in the medical sense. This is the rationale for placing these professions within the broader medical professions and providing them with the unique support that the medical professions receive, such as reimbursement for treatment by medical insurance and research funding targeted at health research. Not only is the concept of mental disorder at the foundation of psychiatry as a medical discipline; it is also at the heart of scholarly and public disputes about which mental conditions should be classified as pathological and which as normal suffering or problems of living, and it has ramifications not just for psychiatric diagnosis but also for research, policy, and prevention/screening efforts.

To say that mental disorder is the *primary* or *essential* target of psychiatry is not to deny that psychiatry is mandated to intervene in various other domains of problematic mental conditions. Some of these other conditions are indicated in DSM as nondisordered conditions that are commonly the target of psychiatric intervention (DSM's "V Codes"). These include, for example, problems in selecting a career, relationship problems, normal grief, and other such problems in living. The same distinction exists in physical medicine; for example, fertility, pregnancy, and childbirth pain are all normal conditions that are often the target of medical intervention. Both physical and mental medicine are mandated to extend the application of their knowledge and skills beyond prevention and treatment of disorder to include such tasks as (1) reduction of mental suffering and social role impairment from normal mental states (e.g., grief); (2) control and treatment of normal but socially undesirable trait variations (e.g., lack of assertiveness, higher-than-average fear of public speaking, less-than-average social skill) in individuals whose traits do not fit our social templates, when such normal variation becomes so disadvantageous that it blocks access to our culture's distinctive opportunities and thus is an issue of "psychological justice" (Wakefield, 1988a, 1988b); and (3) enhancement of individuals' normal mental function in "cosmetically" desirable ways

that serve the personal happiness of the individual (e.g., relationship skills, resilience training, leadership training).

I ignore these other domains of intervention here because they are not part of the primary rationale for the existence of the mental health professions as medical professions. As the appellation "mental health professions" would suggest, whatever else one might ask of psychiatry, its essential and defining concern is mental disorder.

Note also that the equation that for convenience I assume here between "mental health" and "absence of mental disorder" has been questioned by "positive psychiatrists" (e.g., Vaillant, 2003), as well as by an expansive World Health Organization (WHO) definition of health that includes social and economic well-being. The "positive psychiatrists" argue that health includes a domain of superlative functioning that goes beyond lack of disorder and includes possession of high levels of (for example) mental fitness and resilience, virtues like courage, and positive feelings such as happiness. However, for present purposes, I work within the framework of the traditional notion that health is a lack of disorder. The question of whether there exists an additional domain of positive mental health requires its own extended answer, to be provided elsewhere (for an initial foray, but in Italian, see Wakefield, 2005b). Even if there is such a domain, that additional target for the mental health professions would not greatly influence my argument about the concept of disorder. And, admittedly, I am prima facie skeptical of expansive claims about the domain of positive mental health, which I suspect are being used to smuggle into the medical category what mostly consist of nonmedical and culturally loaded value judgments about what constitutes a good life.

Given the centrality of the concept of disorder to psychiatry, it is important to ask this question: When are mental conditions justifiably considered mental disorders rather than other kinds of negative mental conditions, such as problems in living, bad relationships, socially disadvantageous traits, or traits that simply make one unhappy? To answer this question requires an answer to the prior question: What is the meaning of the term "mental disorder"? The credibility and even the coherence of psychiatry as a medical discipline depend on there being a persuasive answer to this question.

I approach this question via a conceptual analysis that asks: What do we generally mean when we say that a problematic mental condition—such as adolescent antisocial behavior, a child's defiant behavior toward a parent, intense sadness, intense worry, intense shyness, failure to learn to read, or heavy use of illicit drugs—is not merely a form of normal (albeit undesirable and painful) human functioning, but indicative of psychiatric disorder? Given the surprising degree of agreement about which such conditions are mental disorders, it can be presumed that such judgments are guided by, and must be explained by, a shared conceptual structure represented in the minds of those making the judgments.

Among existing attempts to analyze the concept "mental disorder," a basic division is between value-based and scientific approaches. As Kendell (1986) put it, "The most fundamental issue, and also the most contentious one, is whether disease and illness are normative concepts based on value judgments, or whether they are value-free scientific terms; in other words, whether they are biomedical terms or sociopolitical ones" (p. 25). I have proposed a hybrid account, the "harmful-dysfunction" (HD) analysis of the concept of mental disorder (Wakefield, 1992a, 1992b, 1993, 1996, 1997, 1999a, 1999b). According to this analysis, a disorder is a "harmful dysfunction"—where "harmful" is a value-based term, referring to conditions judged negative by sociocultural standards, and "dysfunction" is a scientific factual term, referring to failure of biologically designed functioning. In modern science, "dysfunction," I argue, is ultimately anchored in evolutionary biology and refers to the failure of an internal mechanism to perform one of its naturally selected functions.

In this chapter, while commenting on some other approaches, I focus on exploring the considerable explanatory power of the HD analysis for understanding the distinction between mental disorder and other problematic mental conditions. I also illustrate the implications of the analysis for assessing the validity of DSM diagnostic criteria.

A few other initial caveats should be stated before I examine some past and present

attempts to define mental disorder. First, I am concerned here with understanding what makes a mental condition a mental *disorder* in the medical sense. I sidestep the perplexing (but, I think, not as conceptually interesting) question: What makes a specific medical disorder a *mental* disorder rather than a physical disorder? (But see Wakefield, 2007.)

There are many further questions about the conceptual foundations of nosology and diagnosis, other than the distinction between disorder and nondisorder, that I do not address here. I believe that most such questions—for example, how to define a specific form of disorder; how to distinguish one disorder from another; the proper role in a classification system of superordinate categories (e.g., "anxiety disorders," "externalizing disorders"); and the dimensional versus categorical structure of disorder indicators and etiological variables—cannot be productively addressed until the more fundamental distinction between disorder and nondisorder is clarified.

I focus on the term "disorder" to identify psychiatry's primary domain as a medical discipline because it covers all forms of pathology, including traumatic injuries and diseases. Some writers emphasize other terms, such as "illness" or "disease" to specify the overall set of pathological conditions relevant to medicine, and "mental illness" or "mental disease" to specify the overall set of pathological conditions that are the special concern of psychiatry. But these other terms have connotations that are too specific as generic terms for medical conditions. For example, are broken bones and snake phobias "illnesses," and are physical poisonings and posttraumatic stress disorder (PTSD) "diseases"? They are surely all disorders.

Contrary to an impression I have occasionally encountered, the use of the generic medical term "disorder" to refer to the entire set of mental pathological conditions that are the primary target of psychiatry did not start with DSM at all, but rather has a long history. To take some random examples, "disorder" was already the term of choice for mental pathology in various entries of Samuel Johnson's *Dictionary*, published in 1755. In the second issue, in October 1844, of the *American Journal of Insanity* (later to morph into the *American Journal of Psychiatry*), the editor, A. Brigham, published an essay on "The Definition of Insanity" that began: "By Insanity is generally understood some disorder of the faculties of the mind" (p. 97). The bibliography included a book by Dr. Henry Johnson, titled *On the Arrangement and Nomenclature of Mental Disorders*, published just the year before (1843). Of course, the use of the term "disorder" leaves open precisely what kind of "order" is supposed to be failing in medical pathology. "Disorder" can be used generically for failure of many types of order, as in "civic disorder." I argue below that in medicine, it is the order derived from the biologically designed functioning of the mind and body that is claimed to fail in attributions of mental and physical disorder. The only other candidate seems to be the order imposed by social values (Spitzer, 1999), and that approach, I argue, does not offer a coherent account of our diagnostic judgments and intuitions.

A mental disorder may be considered a disorder of mental mechanisms and thus conceptually analogous to disorders of other kinds of mechanisms. Consequently, the problem is to define "disorder" in the general sense used in medicine and then apply it to the domain of mental mechanisms. The domain of "mental mechanisms" is not defined in some Cartesian metaphysical way, but simply as whatever hypothesized brain mechanisms underlie certain capacities we label "mental," such as thought, emotion, perception, speech, appetitive behavior, and so on. What deeper property, if any, unites these processes under the category "mental"—such as perhaps the involvement of representational structures—is left unaddressed here.

Because the analysis here ultimately concerns the general concept of disorder as applied to both mental and physical conditions, examples from both mental and physical domains are used to test the analysis. I use "internal mechanism" as a general term to refer to physical structures and organs as well as to mental structures and dispositions, such as motivational, cognitive, affective, and perceptual mechanisms.

The fact that mental disorders are medical disorders in a conceptual sense does *not* necessarily mean that mental disorders must be physiological brain disorders. Mental functions can fail because of problems with functioning at the representational ("soft-

ware") level rather than the physiological ("hardware") level.

I do not assume that there is a precise or crisp boundary between disorder and nondisorder. It is assumed that "mental disorder," like most concepts, has areas of indeterminacy, ambiguity, fuzziness, and vagueness, and that a successful analysis should reflect and explain such aspects of our judgments. One must distinguish the problem of drawing boundaries between disorder and nondisorder along continua from the question of whether there is a meaningful distinction between clear cases of disorder and nondisorder. For example, there is no sharp boundary between being a child and being an adult, but there are lots of clear cases of being a child and of being an adult. No doubt, boundary setting sometimes in part involves values, and is very sensitive to current social views and knowledge. So, for example, the place where the boundary between childhood and adulthood is drawn in different domains (voting, religious services, drivers' licenses, drinking age, potential military service, etc.) does not necessarily represent a natural boundary, but may reflect, within the fuzziness of a continuous dimension, a choice based on broader goals and values. But all this boundary setting is built upon the foundation of a real distinction between clear cases of children and adults. The problem with current diagnostic criteria, I argue, is not with boundary setting but with clear cases of nondisorders being misclassified as disorders.

Lastly, it should be emphasized that the question of whether a condition is a disorder is not the same as the question of whether it should be treated or would benefit from being treated (Spitzer, 1998). Some disorders should not be treated, and some nondisorders should be treated. Perhaps, for example, intense normal grief is best ameliorated at times, just as is childbirth pain. But there are costs to misdiagnosing such normal conditions as disorders: If an individual is believed to be disordered, this belief shapes perceived prognosis and treatment choice, and does not offer the individual fully informed consent in light of the true nature of the condition and the full range of reasonable options for addressing it. Diagnosis of disorder can bias treatment choice toward medication and toward attempts to "fix" the individual rather than change the environment. It also tends to eliminate the option of watchful waiting as an alternative, relative to a diagnosis of an intense normal reaction to environmental circumstances. I focus here on the concept of disorder, and this question is relevant to, but not identical to, such practical questions as whether or how a condition should be treated.

The False-Positives Problem in DSM

From the perspective of DSM-V, one of the main motives for clarifying the concept of mental disorder is to help improve the ability to draw the distinction between mental disorders and nondisordered problems of living. The distinction needs clarification because the label "mental disorder," it has been widely argued, is often incorrectly applied to many other kinds of undesirable but nondisordered conditions.

The issue of whether the conceptual boundary of disorder has been overextended to include nondisordered problems of living is not new, but it has evolved into a new form. In the 1960s and 1970s, there were vehement criticisms of psychiatry from both professional and nonprofessional sources who argued that there is no such thing as "mental disorder" at all in the literal medical sense of disorder. Psychiatric diagnosis was claimed to be just a matter of medically labeling nondisordered but socially disvalued conditions for purposes of social control. It was argued that psychiatrists could not reliably distinguish disorder from nondisorder or one purported disorder from another, thus proving the invalidity of their diagnostic concepts.

There are many reasons why the antipsychiatric movement is no longer a potent force, but one reason is that with the publication of DSM-III (American Psychiatric Association, 1980), many of the antipsychiatrists' criticisms were squarely and systematically addressed by the psychiatric community. DSM-III provided a definition of mental disorder that attempted to distinguish mental disorders in the medical sense from social deviance and other kinds of personal and social problems. Moreover, common nondisordered conditions that may warrant psychiatric attention were distinguished from disorders

and listed separately in a section called "V Codes for Conditions Not Attributable to a Mental Disorder That Are a Focus of Attention or Treatment." Most importantly, DSM-III offered operationalized theory-neutral definitions of each disorder that improved reliability and contributed to valid differentiation of disorders from nondisorders and of one disorder from another. These innovations—along with other developments, such as the growing evidence of a biological basis and effective pharmacological treatment for some disorders—have pretty much put the antipsychiatric critiques to rest. The claim that the concept of mental disorder is incoherent or that mental disorders do not exist is rarely heard these days except in postmodernist or radical behaviorist treatises, and it is certainly not a major concern in public discourse about psychiatry.

Psychiatry now faces a new set of challenges regarding its basic concept of mental disorder, and I would argue that a comparably systematic assault on these challenges should be undertaken in the process of constructing DSM-V. The new challenges again come both from within the mental health professions and from the lay public. Their focus is not on whether mental disorders exist at all, but rather on whether mental health professionals, when using DSM criteria, are overdiagnosing disorders so as to invalidly pathologize many other kinds of human problems. This new challenge contains an echo of the old antipsychiatric concerns about social control and mislabeling of nondisordered conditions as disorders. However, it is much more subtle and targeted, and it is not inherently antagonistic to the broader goals and conceptual approach of psychiatry. The new challenge consists of a diverse set of objections to the labeling of specific conditions as disorders on a category-by-category basis. The claim is not so much that whole categories are bogus, as that overly inclusive criteria mix normal conditions with true disorders in heterogeneous disorder categories that confuse the nature and prognosis of conditions, give rise to faulty epidemiological prevalence estimates and treatment outcome research, and lead to misdiagnosis that undermines informed treatment decisions.

I refer to the problem of psychiatric criteria that potentially classify nondisorders as disorders as the "false-positives" problem. To the degree that diagnostic criteria successfully identify all and only disordered individuals as disordered, the criteria are referred to as "conceptually valid" criteria (Wakefield, 1992a, 1992b).

Conceptual validity has proven difficult to attain with diagnostic criteria that are framed in terms of symptoms, such as DSM's typical criteria. The reason is simply that the symptoms of many mental disorders can occur as normal responses to certain kinds of environments. For example, deep sadness can indicate major depressive disorder, or it can indicate a normal reaction to loss. Intense anxiety can be a symptom of generalized anxiety disorder, or it can be a normal response to an unusually stressful set of circumstances. Adolescent antisocial behavior can represent a dysfunction, such as an inability to empathize with others' needs, an inability to function according to social rules, or an inability to inhibit impulses, and thus can indicate conduct disorder; or such behavior can represent the consequences of a rational decision to join a gang and go along with gang antisocial activities as a way to protect oneself in a dangerous neighborhood. Although excessive alcohol intake is a manifestation of dependence, it can also represent a transient youthful attempt to be exuberantly excessive that involves neither addiction nor abuse. (Some of these examples are developed in greater detail later in this chapter.) In these and many other instances, criteria that rely exclusively on symptoms to identify disorders are in danger of also encompassing potentially large numbers of normal conditions with the same "symptoms" as the disorders.

It should be noted that even those disordered conditions that do not fall under standard diagnostic criteria for a given disorder may still be diagnosed as a disorder under DSM's "wastebasket" categories of diagnosis "not otherwise specified" (NOS; e.g., mood disorder NOS). For example, even subthreshold conditions that do not satisfy diagnostic criteria can nonetheless be classified as disorders via the corresponding NOS category. In contrast, there is no mechanism within DSM allowing the classification of a condition that does satisfy the diagnostic criteria, but that the clinician judges is not a disorder, to be classified as a normal re-

action rather than a disorder. The primary response to false positives should be to adjust diagnostic criteria to reflect the distinction between disorder and nondisorder more validly (Spitzer & Wakefield, 1999). The critique of psychiatric diagnostic criteria based on the HD analysis attempts to accomplish the first step toward such revisions.

Why Psychiatry Can't Escape the Analysis of the Concept of Mental Disorder

The DSM and ICD diagnostic criteria are currently the primary arbiters of what is disordered versus nondisordered in most clinical practice and research. But they are clearly not conceptually final arbiters. The criteria are regularly revised to make them more valid in indicating disorder and to eliminate false positives; such revisions implicitly acknowledge that "errors" in the criteria are possible. Moreover, both the popular press and critics within the mental health professions challenge the validity of the criteria in picking out mental disorder, and these disputes do not seem entirely arbitrary, but rather often seem to appeal to an underlying shared notion of disorder. Indeed, professionals often classify conditions using the NOS category, which requires a sense of what is and is not a disorder independent of specific diagnostic criteria.

Granting the common observation that there is no "gold-standard" laboratory test or physiological indicator for mental disorders and that current criteria are fallible, we might still ask: Why must we grapple with the elusive concept of disorder itself when there are so many empirical techniques for identifying disorders? The reality is that all of the tests commonly used to distinguish disorder from nondisorder rest on implicit assumptions about the concept of disorder; otherwise, it is not clear whether the test is distinguishing disorder from nondisorder, one disorder from another disorder, or one nondisordered condition from another. Common tests of validity—such as statistical deviance, family history/genetic loading, predictive validity, Kendell's (1975; Kendell & Brockington, 1980) discontinuity of distribution, factor-analytic validity, construct validity, syndromal co-occurrence of symptoms, response to medication, the Robins and Guze (1970) criteria, Meehl's (1995; Meehl & Yonce, 1994, 1996) taxometric analysis, and all other such guides—can identify a valid construct and separate one such construct from another. But whether the distinguished constructs are disorders or nondisorders goes beyond the test's capabilities. Every such test is equally satisfied by myriad normal as well as disordered conditions. Even the currently popular (in the United States) use of role impairment does not inherently distinguish disorder from nondisorder (and for this reason is generally avoided by ICD) because there are many normal conditions, ranging from sleep and fatigue to grief and terror, that not only impair routine role functioning but are biologically designed to do so. It only *seems* as though these various kinds of empirical criteria provide a stand-alone standard for disorder because they are used within a context in which disorders (in some background conceptual sense) are already implicitly and independently inferred to exist, and the aim is simply to distinguish among disorders. This essential background assumption itself depends on the concept of disorder being deployed prior to and independently of the specific empirical test. Thus there is no substitute for the concept of mental disorder as the ultimate standard. None of our empirical approaches work without a basis in a conceptual analysis of disorder.

A further reason why we must rely on the concept of disorder is the lack of definitive etiological understanding of mental disorder and the consequent theoretical fragmentation of psychiatry. This fragmentation provided the impetus for the decision to provide theory-neutral criteria in DSM and ICD for diagnosing disorders. Etiological theory (e.g., the return of the repressed, irrational ideas, serotonin deficit) would generally provide ways to distinguish disorder from nondisorder in a more developed science. The need to rely for now on theory-neutral criteria means that the concept of disorder itself, which is to some extent shared by various theories, offers the best way of judging whether a theory-neutral diagnostic criteria set picks out disorders rather than normal conditions (i.e., is conceptually valid [Wakefield, 1992a]). Theory-neutral criteria work to the extent that they adhere to an implicit

understanding of disorder versus nondisorder that is shared across most theoretical perspectives and constitutes a provisional basis for shared identification of disorders for research purposes.

Disorder as Social Evaluation and Sanctioned Seeking of Help

I start by considering two pre-DSM-III attempts to define disorder. The first of these was the behaviorist account. Psychologists were heavily under the sway of behaviorism at the time of the DSM-III revolution, and consequently had little to offer psychiatrists by way of a conceptually sound definition of mental disorder. They saw all behavior as learned via the same normal principles of stimulus and response, and thus they could delineate no theoretically deep difference between the conditions labeled mental disorders and those labeled normal. Instead, they suggested that the difference lay in social evaluations that led to treatment—in effect, asserting that disorder is whatever we decide disorder should be. Starting with Eysenck's (1960) classic analysis and critique of medicalization, behaviorists argued against any deep theoretical difference between disorder and nondisorder. Oddly enough, this placed behaviorists logically in the same camp as antipsychiatrists who argued that diagnosis was essentially about social evaluation and social control.

Here are some excerpts regarding the concept of disorder from the seminal behaviorist account by Ullman and Krasner (1975):

> The central idea of this book is that the behaviors traditionally called abnormal are no different, either quantitatively or qualitatively, in their development and maintenance from other behaviors. . . . In general conversation the word "abnormal" is used to signify that something is unexpected, irregular, and different from the normal or predictable state of affairs. (p. 2) Abnormality was defined as behavior violating interpersonal expectations in a manner that sanctions intervention of mental health practitioners. (p. 9) The principal argument of this book is that abnormal behavior is no different from normal behavior in its development, its maintenance, or the manner in which it may be changed. The difference between normal and abnormal behavior is not intrinsic; rather it lies in a societal reaction. (p. 32) "Sick" and "healthy" labels for behavior represent *social evaluations*. (p. 33; original emphasis)

This value-based account of mental disorder places social evaluation—and consequently sanctions for treatment—at the heart of the concept. This definition seems tailor-made to allow mental health professionals to treat and receive reimbursement for all negatively evaluated conditions for which people may want help.

Ullman and Krasner (1975) offered a quite cogent criterion for a successful definition of disorder—that it be a necessary and sufficient criterion for explaining what people do in fact judge to be disordered: "A definition of abnormality should have certain characteristics. . . . The definition of "abnormal" should include all the people who are indeed abnormal and none of the people who are not. To the extent that abnormal people are not so designated and normal people are, the definition leads to error" (p. 11). Yet they never seriously tested their definition against this simple criterion, and the definition they did offer fails their test miserably. For one thing, myriad behaviors are socially evaluated as negative (from lack of courtesy to incompatible marriages), and people may even think it useful to seek help for these, but people do not label them as mental disorders or even as abnormal behaviors (in the relevant, functional sense of abnormality—statistical abnormality in and of itself is clearly not a pertinent definition of mental disorder; see Wakefield, 1992a). Regarding service use, professional services for a condition may not be available in a given locale or time period, and for a variety of reasons people may not be inclined to utilize such services for certain disordered conditions when they do exist; yet the condition can be a disorder nonetheless.

Disorder as Symptom–Course Syndrome

A common view throughout psychiatry is that disorders are, at least initially pending identification of their etiology, definable by syndromes. A "syndrome" in this sense is simply a condition consisting of some co-

occurring symptoms that may also have a typical course. Psychiatrists have talked a lot about syndromal definitions of mental disorder, by which they mean the identification of a disorder by its symptoms and course. Some specific disorders may have a syndromal structure that enables one to recognize that disorder and to distinguish it from other disorders. Unfortunately, the reasonable idea of using syndromal criteria to pick out a specific disorder once a disordered condition is recognized to exist has gotten confused with the unreasonable idea of defining the very concept of a condition as a psychiatric disorder—that is, differentiating normality and pathology—in terms of possessing syndromal structure. But this makes no sense; the fact that a condition contains certain phenomena (or "symptoms") that regularly tend to co-occur, and that the condition tends to have a somewhat predictable course, says nothing in and of itself about whether the condition is a disorder.

This view has had enormous influence, To take a random example, in explaining the "dependence syndrome" concept of alcoholism that he helped to define and that has reshaped DSM and ICD definitions of substance use disorders, Edwards (1986) says: "The meaning to be given to the term 'syndrome' deserves some attention. . . . [W]hat is essentially implied is a co-occurrence, with some coherence" (p. 172).

In 1972, a highly influential article was published by a group of psychiatric researchers at Washington University in St. Louis (Feighner et al., 1972). This was a report of newly formulated operational diagnostic criteria for mental disorders. The Feighner et al. publication became the precursor of DSM-III's approach to diagnosis. A couple of years later, three authors of this paper published an influential book on psychiatric diagnosis that elaborated on the Feighner et al. criteria and ushered in the DSM era. To explain how they delineated disorders, the authors (Woodruff, Goodwin, & Guze, 1974) stated:

> When the term "disease" is used, this is what is meant: a disease is a cluster of symptoms and/or signs with a more or less predictable course. Symptoms are what patients tell you; signs are what you see. The cluster may be associated with physical abnormality or may not. The central point is that it results in consultation with a physician who specializes in recognizing, preventing, and, sometimes, curing diseases. (p. x)

Although one finds many statements like this in the literature, from a conceptual perspective it makes no sense to characterize disorder in terms of possession of syndromal structure; the fact that a condition is characterizable as a syndrome is neither sufficient (there are many normal syndromes) nor necessary (there can be single-symptom disorders of unpredictable course) for characterizing it as a disorder. The definition is thus absurd even if we leave aside the seeming implication of the last sentence that by definition a disorder is a condition that results in consultation with a physician: Were there no disorders before there were physicians? If we get rid of physicians, do we get rid of disorders?

Even Ullman and Krasner (1975) saw the main problem with this sort of pure syndromal symptom-cluster-and-course approach to disorder: Namely, it encompasses myriad normal conditions. Ironically, however, the syndromal definition was not all that different from their own approach, and both suffered from the same sorts of deficiencies. They said of the syndromal definition: "By this definition, disease is whatever the physician deals with. . . . [Does] a college student, whose status has a "natural history" (including a cure known as graduation) . . . qualify as having a disease? Do fatigue, irritability, and dislike of psychology texts qualify as symptoms and/or signs? And is the use of the campus counseling center a necessary part of the syndrome?" (p. 13). Despite the chiding, the only change in the definition they suggested was adding maladjustment in cultural context as a necessary part of the concept of disorder (p. 12). Yet, clearly, one can reconstruct the same objections after adding that requirement. For example, if having difficulty in college, as described in Ullman and Krasner's counterexample to the syndromal definition, is unacceptable and maladaptive within one's (let's suppose) academically driven cultural context, does that make such problems a mental disorder?

Although the identification of syndromes is of scientific importance, the notion that one can use the syndrome notion to define

the concept of disorder is a ground-level confusion, albeit one repeated by many associated with DSM. It is true that disorders are often recognized as specific disorders via syndromes and often are syndromally defined prior to etiological knowledge, in both physical and mental medicine. But syndromal diagnosis in psychiatry and in medicine more generally still involves the classification of conditions *as disorders*. Thus there is an implicit step prior to the syndromal definition, in which the particular syndrome is inferred to indicate a disorder. This necessary step in using a syndromal approach to disorder is entirely ignored in psychiatric accounts, leaving the disorder status of the syndrome unexplained.

If the HD analysis is correct about the meaning of disorder, then during the syndromal phase of classification of disorders, there must be an implicit inference that the syndromally defined pattern is due to a dysfunction. Syndromal definitions do gradually get replaced by etiological definitions on the basis of accumulating scientific knowledge about the nature of the involved dysfunctions. But prior to that knowledge, the conditions are already classified as disorders (often for millennia) on the basis of their syndromal manifestations. The reason this can occur is that on the basis of the symptom syndrome and circumstantial evidence, but without actual knowledge of etiology, it is inferred (fallibly, but often correctly) that there is a dysfunction underlying the particular syndrome (see the discussion below of the "epistemological objection" to the HD analysis).

Without such an inference to dysfunction, *any* pattern, normal or abnormal, could constitute a "syndrome." Normal shortness is a problematic "syndrome," as is relative stupidity or foolhardiness or lack of athletic ability, and so on. How do we distinguish the problematic syndromal patterns that are disorders from the problematic syndromal patterns that are not disorders? For that matter, however one defines the threshold for having a syndrome, there are probably counterexamples of disorders that do not manifest themselves as syndromes of co-occurring symptoms and predictable course, so how does one encompass them within the syndromal definition unless the definition is itself vacuous and the criterion circular? The most adequate answer to these questions, I believe, is that we consider a problematic syndromally (or nonsyndromally)-defined condition to be a disorder when we believe that the condition is caused by a dysfunction in the sense identified by the HD analysis. Without this additional implicit requirement, the syndromal approach offers no cogent distinction between disorder and nondisorder.

Strengths and Weaknesses of DSM-IV's Definition of Mental Disorder

To understand the potential sources of DSM-IV's false positives, it is useful to start by examining its own definition of mental disorder, which reads in DSM-IV-TR as follows:

> In DSM-IV, each of the mental disorders is conceptualized as a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (e.g., a painful symptom) or disability (i.e., impairment in one or more important areas of functioning) or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom. In addition, this syndrome or pattern must not be merely an expectable and culturally sanctioned response to a particular event, for example, the death of a loved one. Whatever its original cause, it must currently be considered a manifestation of a behavioral, psychological, or biological dysfunction in the individual. Neither deviant behavior (e.g., political, religious, or sexual) nor conflicts that are primarily between the individual and society are mental disorders unless the deviance or conflict is a symptom of a dysfunction in the individual, as described above. (American Psychiatric Association, 2000, p. xxxi)

This definition of mental disorder is derived from an extended analysis of the concept of mental disorder provided by Spitzer and Endicott (1978). The analysis and critique of DSM-IV's definition of mental disorder has been pursued in several articles (Wakefield, 1992a, 1992b, 1993, 1996, 1997), and that material is not repeated here. Rather, on the basis of that work, I summarize a few major strengths and weaknesses of the definition as a prelude to proposing a revised analysis.

Regarding strengths, the definition makes four points. First, disorder is something in the individual; it is not simply a bad relationship or poor role performance. Second, the internal condition, which must be inferred to exist from manifest symptoms, is a dysfunction; that is, something must have gone wrong with the way that the internal mechanism normally functions (Klein, 1978; Spitzer & Endicott, 1978). Many problematic internal states, such as ignorance, lack of skill, lack of talent, sadness due to a loss, and foolhardiness, are not disorders in the medical sense because they are not dysfunctions. As noted, in the case of mental disorders, the dysfunctional mechanism must be a cognitive, motivational, behavioral, emotional, or other psychological mechanism. ("Mechanism" is used here without any mechanistic implications about the nature of the mind, but simply as a term commonly used in the evolutionary literature to refer to any inner process or structure.)

Third, a dysfunction of some internal mechanism is not enough by itself to imply disorder. Many things that go wrong with various mental and physical mechanisms do not deserve to be called disorders because they do not have sufficiently negative implications for the individual's overall well-being. The difference between dysfunctions that can be classified as disorders and dysfunctions that cannot be classified as disorders thus lies in whether the dysfunction causes significant harm to the person.

Finally, a strength is that the definition cautions that the distress or disability must come about due to a dysfunction and cannot be due only to social deviance, disapproval by others, or conflict with society or with others. This requirement is meant to preclude the misuse of psychiatry for sheer social control purposes, as occurred in Soviet psychiatry.

Regarding the definition's weaknesses, first, the use of the phrase "clinically significant" is circular in a definition of disorder because the decision as to whether or not a syndrome or pattern is clinically significant depends on whether it is considered a disorder. Second, the list of possible harmful effects, which has grown through successive editions of DSM, has become unwieldy. Clauses have been added to take care of specific problem categories, so the list has an ad hoc quality. There is the sense that it is only a matter of time until yet further clauses must be added. The fact is that any significant harm directly caused by a dysfunction will qualify the dysfunction as a disorder.

There are also problems with defining the concept of "disability" as "impaired function." If this includes impaired function of an internal mechanism, it leads to counterexamples because, for example, a specific gene can be impaired and dysfunctional without causing a disorder. There is also a general problem of distinguishing normal variation in ability from pathological disability; for example, inability to excel at sports is not necessarily a disability. The notion of disability seems itself to depend on a prior understanding of function and dysfunction (Wakefield, 1993).

The most serious problem, however—and the one underlying most of the other quibbles above—is that there is no explanation or analysis of the critical concept "dysfunction." Any definition of "disorder" in terms of the closely related concept "dysfunction" is inadequate unless "dysfunction" gets some independent analysis. DSM-IV's definition does require that a disorder cannot be an expectable or socially sanctioned response to events, and this is perhaps the closest it comes to attempting to offer an explication of dysfunction. However, "dysfunction" diverges from both "unexpectable" and "culturally unsanctioned" functioning. Much culturally unsanctioned functioning is not necessarily disordered, ranging from bad manners and petty crime to defiance of social conventions or civil disobedience based on high moral principles (ranging from Vietnam War protesters in the United States to the prototypical case of the inappropriate diagnosis of the Soviet dissidents). Moreover, normal reactions to external stresses (e.g., grief, terror) can be unexpectable (in a statistical sense) and harmful, and nondysfunctional internal conditions (e.g., illiteracy, greediness, or slovenliness) can be unexpectable and harmful, yet not disorders. Conversely, some conditions that are dysfunctions can be quite expectable in context, such as PTSD after a severe trauma. Indeed, most of the conditions included in the V Code chapter of DSM-IV (e.g., family or occupational conflict) are unexpectable and harmful, but are not disorders. Thus

the definition does not adequately operationalize "dysfunction."

Although the DSM definition of disorder has some limitations, the false positives to be found in the DSM are not due primarily to a faulty definition of disorder. This is because the strengths of the definition, and in particular the reference to dysfunction, would be enough (if followed up rigorously and properly elaborated) to eliminate many false positives. Rather, the definition's key requirement of dysfunction remains unelaborated—and, when elaborated by the HD analysis, it turns out that criteria sets do not meet the criteria for disorder set by the definition. This disparity between the definition and the criteria sets is the source of most of the false positives (Wakefield, 1997).

Clinical Significance

Beyond the definition of mental disorder, the most notable attempt in DSM-IV to make general progress on the false-positives problem has been the development of a clinical significance criterion (CSC) for use in evaluating mental disorder—basically transferring the clinical significance feature from the definition of mental disorder to the criteria sets for specific disorders. The CSC proposed in DSM-IV required that the symptoms cause either clinically significant distress or impairment in social, occupational, or other important areas of functioning. (Note that such impairment in role functioning as socially defined is not in and of itself equivalent to "dysfunction" in the sense of a failure of a biologically shaped function; many normal states, such as grief and sleep, impair role functioning in this sense.) The CSC aims to set an impairment/distress threshold for diagnosis, so as to eliminate false positives where there is minimal harm to the individual, and in a few instances it does improve validity. However, requiring "clinically significant" distress or role impairment as a criterion for distinguishing disorder from nondisorder is circular because the amount of distress or impairment varies greatly with both normal and disordered negative conditions. Thus, as a criterion for disorder, to say that distress or impairment is "clinically significant" in this context can only mean that the distress or impairment is significant enough to imply the existence of a disorder—a tautologous criterion. The phrase offers no real guidance in deciding whether the level of impairment is or is not sufficient to imply disorder.

Furthermore, the CSC does not deal with a large number of potential false positives—specifically, those where there may be harm but no dysfunction. For example, the normal child in a threatening environment whose aggressive behavior meets the criteria for conduct disorder, and the normal child threatened by a school bully who meets the selective mutism criteria by virtue of not speaking at school because of fear, do both experience distress and significant impairment in functioning as part of their normal reactions and so are not excluded from diagnosis by the CSC. Although there is obviously a thorny issue lurking here about the point at which motivations become so intense and rigid as to be pathological, it seems clear that in some cases such motivations (e.g., the motivation to avoid talking so as to avoid being beaten up by a bully) can be perfectly normal, even though they impair performance and are distressful. Thus clinical significance by itself does not imply disorder.

Another problem with the CSC is the potential for yielding false-negative misdiagnoses when it is indiscriminately added to criteria sets because it requires such specific forms of harm. For example, DSM-IV's requirement that a pattern of substance use must cause clinically significant impairment or distress before dependence can be diagnosed could yield large numbers of false negatives. It is not uncommon to encounter individuals whose health is threatened by drug addiction (and who surely have a disorder), but who are not distressed and who can carry on successful role functioning. The proverbial successful stockbroker with a cocaine addiction may be an instance, as may be many people who use tobacco. The problem in many of these cases is that distress and role impairment are not the only kinds of harms that can be caused by dysfunctions. However, in principle, the latter kinds of problems with the CSC could be addressed simply by requiring "significant harm."

Perhaps the most problematic aspect of the CSC is that it reflects a misunderstanding of the main problem underlying false positives, and thus a misdirection of effort. The CSC

is based on the assumption that the way to ensure that a condition is pathological is to ensure that it causes sufficient distress or impairment in social or role functioning—an assumption at odds with broader diagnostic practice in medicine. Moreover, DSM-based false positives are most often due not to a failure of symptoms to reach a threshold of harmfulness, but to a failure of symptomatic criteria to indicate the presence of an underlying dysfunction. Thus ratcheting up the level of harm such as distress or impairment is not sufficient for distinguishing disorder from nondisorder. There are two good indicators of this failure in DSM itself. The first is that the most obvious potential false positive in the manual—uncomplicated bereavement as distinguished from major depressive disorder—must be dealt with in an additional special exclusion clause and is not eliminated by the CSC in the criteria set because normal grief can be just as distressful and role-impairing as pathological depression, even though it is not caused by a dysfunction. The second indicator is that although the CSC is added to the criteria for conduct disorder (see above), DSM still adds a textual note that adolescents may satisfy the criteria and still not be disordered because their antisocial behavior may not be due to a dysfunction but to a normal reaction to a problematic environment. Clearly, the CSC does not address the dysfunction problem. Both distress and role impairment can result from normal or disordered emotions and behaviors. Wakefield and Spitzer (2002b) suggest that the issue of false positives in diagnosis is better approached by examining the context of the particular symptoms and adjusting the details of the diagnostic criteria.

The HD Analysis of the Concept of Mental Disorder

The HD analysis departs from three observations. First, the concept of "disorder" has been around in physical medicine and applied to some mental conditions for millennia and is broadly understood in a shared way by laypeople and professionals. Second, a central goal of an analysis of "mental disorder" is to clarify and reveal the degree of legitimacy in psychiatry's claims to be a truly medical discipline rather than, as antipsychiatrists and others have claimed, a social control institution masquerading as a medical discipline. Third, there are strong widely held intuitions that diagnosis can be misapplied and even abused when applied for social control purposes to mental conditions socially considered negative (as in the case of the Soviet dissidents), and thus it appears that there is more to the concept of mental disorder than just social values.

The approach to defining "mental disorder" that is suggested by the first observation is a conceptual analysis of the existing meaning of "disorder" as it is generally understood in medicine and society in general, with a focus on whether and how this concept applies to the mental domain. The challenge is to forge an analysis that is consistent with this shared meaning. The claim of psychiatry to be a medical discipline depends on there being genuine mental disorders in the same sense of "disorder" that is used in physical medicine, so the analysis must in fact rise to the challenge of providing an analysis of the generic concept of disorder in order to establish that mental conditions can fall under it. Any proposal to define "mental disorder" in a way unique to psychiatry that does not fall under the broader medical concept of disorder would fail to address the issue of the medical nature of psychiatry. Finally, the possibility that even an entire culture may be mistaken about disorder, as well as the fact that there are many negative conditions not considered medical disorders, suggests that the concept has at least some factual or objective component that is more than simply a value judgment. The challenge here is to explain the nature of this factual component. The HD analysis is aimed at addressing these challenges.

The Value Component of "Disorder"

As traditional value-based accounts suggest, a condition is a mental disorder only if it is harmful according to social values and thus at least potentially warrants medical attention. Medicine in general, and psychiatry in particular, are irrevocably value-based professions. "Harm" is construed broadly here to include all negative conditions.

Both lay and professional classificatory behaviors demonstrate that the concept of

mental disorder contains a value component. For example, inability to learn to read due to a dysfunction in the corpus callosum (I am assuming that this theory of some forms of dyslexia is correct) is harmful in literate societies but not harmful in preliterate societies, where reading is not a skill that is taught or valued, and thus this dysfunction is not a disorder in those societies. Most people have what physicians call "benign anomalies"—that is, minor malformations that are the result of genetic or developmental errors but that cause no significant problem—and such anomalies are not considered disorders. For example, benign angiomas are small blood vessels whose growth has gone awry, leading them to connect to the skin; however, because they are not harmful, they are not considered disorders. The requirement that there be harm also accounts for why simple albinism, heart position reversal, and fused toes are not generally considered disorders, even though each results from an abnormal breakdown in the way some mechanism is designed to function. Purely scientific accounts of "disorder," even those based on evolutionary function as in the analysis below (e.g., Boorse, 1975, 1976), fail to address this value component.

In the DSM and ICD diagnostic criteria, the symptoms and clinical significance requirement generally ensure that the condition causes harm and is negatively valued. The dispute remains about whether "mental disorder" is purely evaluative or contains a significant factual component that can discriminate a potential domain of negative conditions that are disorders from those that are nondisorders. Many negative conditions are not disorders, and many of them contain symptoms and are clinically significant in that they cause distress or role impairment (e.g., grief). The distinction between disorders and nondisorders thus seems to depend on some further criterion.

The Factual Component of "Disorder" as Failure of Naturally Selected Functions

Contrary to those who maintain that a mental disorder is simply a socially disapproved mental condition (e.g., Houts, 2001; Sedgwick, 1982), "mental disorder" as commonly used is just one category of the many negative mental conditions that can afflict a person. We need an additional factual component to distinguish disorders from the many other negative mental conditions not considered disorders, such as ignorance, lack of skill, lack of talent, low intelligence, illiteracy, criminality, bad manners, foolishness, and moral weakness.

Indeed, both professionals and laypersons distinguish between quite similar negative conditions as disorders versus nondisorders. For example, illiteracy is not in itself considered a disorder, even though it is disvalued and harmful in Western society, but a similar condition that is believed to be due to lack of ability to learn to read because of some internal neurological flaw or psychological inhibition is considered a disorder. Male inclinations to aggressiveness and to sexual infidelity are considered negative but are not generally considered disorders because they are seen as the result of natural functioning, although similar compulsive motivational conditions are seen as disorders. Grief is seen as normal, whereas similarly intense sadness not triggered by real loss is seen as disordered. A purely value-based account of "disorder" does not explain such distinctions among negative conditions.

Moreover, we often adjust our views of disorder according to cross-cultural evidence that may go against our values. For example, U.S. culture does not value polygamy, but Americans judge that it is not a failure of natural functioning and thus not a disorder, partly on the basis of cross-cultural data.

The challenge, then, is to elucidate the factual component. Based on common usage in the literature, I call this factual component a "dysfunction." What, then, is a dysfunction? An obvious place to begin is with the supposition that a dysfunction implies an unfulfilled function—that is, a failure of some mechanism in the organism to perform its function. However, not all uses of "function" and "dysfunction" are relevant. The medically relevant sense of "dysfunction" is clearly *not* the colloquial sense in which the term refers to an individual's failure to perform well in a social role or in a given environment, as in assertions like "I'm in a dysfunctional relationship" or "Discomfort with hierarchical power structures is dysfunctional in today's corporate environment." These kinds of problems need not be

individual disorders. A disorder is different from a failure to function in a socially or personally preferred manner, precisely because a dysfunction exists only when something has gone wrong with functioning, so that a mechanism cannot perform as it is naturally (i.e., independently of human intentions) supposed to perform.

Presumably, then, the functions that are relevant are "natural" or "biological" functions. Such functions are frequently attributed to inferred mental mechanisms that may remain to be identified, and failures are labeled dysfunctions. For example, a natural function of the perceptual apparatus is to convey roughly accurate information about the immediate environment, so gross hallucinations indicate dysfunction. Some cognitive mechanisms have the function of providing a person with the capacity for a degree of rationality as expressed in deductive, inductive, and means–end reasoning, so it is a dysfunction when the capacity for such reasoning breaks down, as in severe psychotic states.

The function of a mechanism is important because of its distinctive form of explanatory power; the existence and structure of the mechanism is explained by reference to the mechanism's effects. For example, the heart's effect of pumping the blood is also part of the heart's explanation, in that one can legitimately answer a question like "Why do we have hearts?" or "Why do hearts exist?" with "Because hearts pump the blood." The effect of pumping the blood also enters into explanations of the detailed structure and activity of the heart. Talk of "design" and "purpose" in the case of naturally occurring mechanisms is just a metaphorical way of referring to this unique explanatory property that the effects of a mechanism explain the mechanism. So "natural function" can be analyzed as follows: A natural function of an organ or other mechanism is an effect of the organ or mechanism that enters into an explanation of the existence, structure, or activity of the organ or mechanism. A "dysfunction" exists when an internal mechanism is unable to perform one of its natural functions. (This is only a first approximation to a full analysis; there are additional issues in the analysis of "function" that cannot be dealt with here. See Wakefield, 2000a, 2000b, 2005a.)

The analysis above applies equally well to the natural functions of mental mechanisms. Like artifacts and organs, mental mechanisms, such as cognitive, linguistic, perceptual, affective, and motivational mechanisms, have such strikingly beneficial effects and depend on such complex and harmonious interactions that the effects cannot be entirely accidental. Thus functional explanations of mental mechanisms are sometimes justified by what we know about how people manage to survive and reproduce. For example, a function of linguistic mechanisms is to provide a capacity for communication; a function of the fear response is to avoid danger; and a function of tiredness is to bring about rest and sleep. These functional explanations yield ascriptions of dysfunctions when respective mechanisms fail to perform their functions, as in aphasia, phobia, and insomnia.

"Dysfunction" is thus a purely factual scientific concept. However, discovering what in fact is natural or dysfunctional (and thus what is disordered) may be difficult and may be subject to scientific controversy—especially with respect to mental mechanisms, about which we are still largely ignorant. This ignorance is part of the reason for the high degree of confusion and controversy concerning which conditions are really mental disorders. However, functional explanations can be plausible and useful even when little is known about the actual nature of a mechanism or even about the nature of a function. For example, we know little about the mechanisms underlying sleep, and little about the functions of sleep, but circumstantial evidence persuades us that sleep is a normal, biologically designed phenomenon and not (despite the fact that it incapacitates us for roughly one-third of our lives) a disorder; the circumstantial evidence enables us to distinguish some normal versus disordered conditions related to sleep, despite our ignorance.

Obviously, one can go wrong in such explanatory attempts; what seems nonaccidental may turn out to be accidental. Moreover, cultural preconceptions may easily influence one's judgment about what is biologically natural. But often one is right, and one is making a factual claim that can be defeated by evidence. Functional explanatory hypotheses communicate complex knowledge that

may not be so easily and efficiently communicated in any other way.

Today, evolutionary theory provides a better explanation of how a mechanism's effects can explain the mechanism's presence and structure. In brief, those mechanisms with effects on the organism that contributed to the organism's reproductive success over enough generations thereby increased in frequency, and hence were "naturally selected" and exist in today's organisms. Thus an explanation of a mechanism in terms of its natural function may be considered a roundabout way of referring to a causal explanation in terms of natural selection. Since natural selection is the only known means by which an effect can explain a naturally occurring mechanism that provides it, evolutionary explanations presumably underlie all correct ascriptions of natural functions. Consequently, an evolutionary approach to mental functioning (Wakefield, 1999b, 2005a) is central to an understanding of psychopathology.

One might object that what goes wrong in disorders is sometimes a social function that has nothing to do with natural, universal categories. For example, reading disorders seem to be failures of a social function because there is nothing natural or designed about reading. However, illiteracy involves the very same kind of harm as reading disorder, but it is not considered a disorder. Inability to read is only considered indicative of disorder when circumstances suggest that the reason for the inability lies in a failure of some brain or psychological mechanism to perform its natural function. There are many failures of individuals to fulfill social functions, and they are not considered disorders unless they are attributed to a failed natural function.

If one looks down the list of disorders in DSM, it is apparent that by and large it is a list of the various ways that something can go wrong with what appear to be designed features of the mind. Very roughly, psychotic disorders involve failures of thought processes to work as designed; anxiety disorders involve failures of anxiety- and fear-generating mechanisms to work as designed; depressive disorders involve failures of mechanisms regulating sadness and responses to loss; disruptive behavior disorders of children involve failures of socialization processes and processes underlying conscience and social cooperation; sleep disorders involve failures of sleep processes to function properly; sexual dysfunctions involve failures of various mechanism involved in sexual motivation and response; eating disorders involve failures of appetitive mechanisms; and so on. There is a certain amount of nonsense in DSM, and criteria are often overly inclusive. However, the vast majority of categories are inspired by conditions that even a layperson would correctly recognize as failures of designed functioning.

It is clear that we need not know either the natural function of a response (or set of responses) or the specific nature of the mechanisms underlying the response to judge from circumstantial evidence that the response is likely to be a designed feature of the mind and its failure a dysfunction. Take, for example, sleep. We scientifically understand neither the precise functions of sleep nor the mechanisms that trigger and regulate sleep; yet almost everyone recognizes sleep as a natural response that must be the effect of some set of mechanisms that were partly selected because they yield sleep. Of course, this could turn out to be incorrect, however unlikely it may seem. Moreover, although there is certainly a large fuzzy area, we do recognize that a certain degree of deviation in sleep pattern toward either insomnia or hypersomnia, if not for obvious temporary normal reasons (e.g., noise, exhaustion), probably indicates a disorder.

When we distinguish normal grief from pathological depression, or normal delinquent behavior from conduct disorder, or normal criminality from antisocial personality disorder, or normal unhappiness from adjustment disorder, or illiteracy from reading disorder, we are implicitly using the "failure-of-designed-function" criterion. All of these conditions—normal and abnormal—are disvalued and harmful conditions, and the effects of the normal and pathological conditions can be quite similar behaviorally; yet some are considered pathological and some not. The natural-function criterion explains these distinctions.

It bears emphasis that even biological conditions that are harmful in the current environment are not considered disorders if they are considered designed features. For example, the taste preference for fat is not

considered a disorder, even though in today's food-rich environment it may kill you, because it is considered a designed feature that helped our ancestors to obtain needed calories in a previous food-scarce environment. Higher average male aggressiveness is not considered a mass disorder of men even though in today's society it is arguably harmful because it is considered the way men are designed (of course, there are aggressiveness disorders; here as elsewhere, individuals may have disordered responses of designed features).

In sum, a mental disorder is a harmful mental dysfunction. If the HD analysis is correct, then a society's categories of mental disorder offer two pieces of information. First, they indicate a value judgment that the society considers the condition negative or harmful. Second, they make the factual claim that the harm is due to a failure of the mind to work as designed. This claim may be correct or incorrect, but in any event it reveals what the society thinks about the natural or designed working of the human mind.

The Epistemological Objection

One of the most common objections to the HD analysis is that we just don't know the evolutionary history of the features of the human mind. The argument is that because the HD analysis holds that whether one has a disorder depends on facts about internal mechanisms and their evolutionary history, and we are largely ignorant of these facts, the analysis therefore implies that it is impossible to know at this time whether conditions are disorders or nondisorders. This might be called the "epistemological" objection because it concerns limits in our ability to know about and recognize disorders, rather than the logic of the analysis of disorder itself.

The epistemological objection is based on the assumption that to know that there is a dysfunction, one must know the dysfunctional mechanisms and their evolutionary history. This assumption is false. To know that a dysfunction exists, one need only have sufficient indirect evidence—for example, surface evidence that indicates or correlates with the existence of internal dysfunction—to infer that some mechanism is failing to perform as designed. This is all that the definition of "dysfunction" I have given earlier actually implies.

What does follow from my account, then, is that to attribute disorder, *either* one has to know about the mechanisms and evolution, *or* one has to have indirect evidence allowing one to judge that there is a dysfunction without knowing the internal or evolutionary details. At present, the latter, indirect method is used in most cases to judge when there is a disorder. In particular, for most DSM-IV categories, the indirect method is enough to enable us to make plausible judgments about whether problematic conditions stem from dysfunctions and are thus disorders. We do not have to know the details of evolution or of internal mechanisms to know, for example, that typical cases of thought disorder, drug dependence, mood disorders, sexual dysfunction, anxiety disorders, and so on, are failures of some mechanisms to perform their designed functions; it is obvious from surface features. This is what makes a symptom-based diagnostic system possible, to the extent that it is possible (see Wakefield, 1996, for a discussion of the limits of DSM-IV's symptom-based criteria in picking out dysfunctions, and DSM-IV's resulting overinclusiveness). My claim is that in routinely distinguishing normal suffering from mental disorder, people are implicitly making the sort of distinction specified in the HD analysis. If the distinction is ignored, then conceptual confusion is likely to follow.

Let me use an analogy from artifact functions to illustrate the logic of such indirect evidence. When my automobile does not work, there can be various explanations. The problem could be due to a variety of circumstances that do not indicate that there is anything wrong with the car itself; for example, the gas tank could be empty, the ignition might not turn the engine on because the car's transmission is not in "park," there could be objects blocking the wheels, and so on. However, if such circumstantial causes are eliminated, then I can often reasonably infer that the problem is due to the fact that some internal mechanism is malfunctioning—that is, is not doing what it was designed to do.

Suppose that I am in a state of great ignorance about the mechanisms that make up my car and how they are designed, and have

no idea what mechanism is malfunctioning. The epistemological objection suggests that I would not be justified in inferring an automobile malfunction, and that such judgments must be deferred until I learn about the parts of my automobile and their design. But we know that in the case of the automobile, something is wrong with this objection. I know almost nothing about the design of automobiles, but I am perfectly capable of recognizing many cases of automotive malfunction, and regularly discriminate such cases from proper automotive functioning. How do I perform this feat, which the objection claims to be impossible?

Although I do not understand a car's internal parts and have no idea of the history or details of their design or their immediate functions, some functions of those parts are obvious because of the clearly nonaccidental benefits that accrue from them. For example, it cannot be accidental that cars take people from place to place with great ease and efficiency; it cannot be accidental that lights allow people to drive cars safely at night; it cannot be accidental that the gas gauge generally indicates the amount of gas in the car; and so on. For complex reasons, these sorts of beneficial, designed phenomena are often recognizable, and their failures can often be recognized as malfunctions, even if one does not know how the underlying mechanisms work or even what they are. Thus I know that something is wrong with the car's internal mechanisms when the car will not move after I have filled it with gas, turned on the engine, put it into gear, and eliminated other circumstantial causes as noted above; when the lights do not go on after I turn the light switch to "on"; or when the gas gauge stays on "empty" no matter how much gas I put in the tank. Even if I do not know about pistons or their immediate designed functions in engine performance, I do know that when my car is backfiring and unable to go over 35 miles per hour, something is wrong with some mechanism. Once I conclude from the observation of nonaccidental surface features that unknown internal mechanisms must be designed to accomplish certain surface functions, I can often infer the existence of internal malfunctions from observations of the failures of those surface functions. These inferences can certainly go wrong and lead to false conclusions. But they often lead to correct conclusions, and they are the same sort of inferences that were at the foundation of physical medicine until a few hundred years ago, when knowledge of internal mechanisms and disorder etiologies exploded. Until then, the judgment that, for example, blindness or paralysis were disorders involved the same kinds of inferences without any knowledge of internal mechanisms.

The HD analysis implies that exploration of mental mechanisms and their functions and dysfunctions is essential if we are to understand mental disorders fully and treat them effectively in the long run. The HD analysis thus provides a useful framework for understanding psychiatric research; we want to identify the specific dysfunctions in the specific internal mechanisms that correspond to each mental disorder. But while we are waiting for such knowledge, the HD analysis explains why we can often make the valid judgments we do, and it illuminates the indirect evidence on which such judgments are based.

Implications of the HD Analysis for Validity of Diagnostic Criteria

One of the disadvantages of pure social-constructivist and antipsychiatric views of mental disorder is that, in rejecting the very notion of mental disorder as a coherent medical-scientific concept, they offer us no place to stand from which to critique current diagnostic criteria and to improve their validity. In contrast, the HD analysis allows us to identify criteria that are too broad and that incorrectly include normal reactions under the "disorder" category. Here are some brief examples of problematic criteria.[1]

Major Depressive Disorder

The DSM-IV criteria for major depressive disorder contain an exclusion for uncomplicated bereavement (up to 2 months of symptoms after loss of a loved one are allowed as normal), but no exclusions for equally normal reactions to other major losses, such as a terminal medical diagnosis in oneself or a loved one, separation from one's spouse, the end of an intense love affair, or loss of one's job and retirement fund. Reactions to such

losses may satisfy DSM-IV diagnostic criteria but are not necessarily disorders. If one's reaction to such a loss includes, for example, just 2 weeks of depressed mood, diminished pleasure in usual activities, insomnia, fatigue, and diminished ability to concentrate on work tasks, then one's reaction satisfies DSM-IV criteria for major depressive disorder, even though such a reaction need not imply pathology any more than it does in bereavement. Clearly, the essential requirement that there be a dysfunction in a depressive disorder—perhaps one in which loss response mechanisms are not responding proportionately to loss as designed—is not adequately captured by DSM-IV criteria (Horwitz & Wakefield, 2007; Wakefield, Schmitz, First, & Horwitz, 2007).

Note that the argument here is *not* that "reactive" depressions are not disorders; the "disorder–nondisorder" distinction should not be confused with the traditional "reactive–endogenous" distinction. Some reactive depressions represent proportionate, designed responses to environmental events that do not involve any internal dysfunction, and are not disorders. But other reactions to loss can be of such disproportionate intensity or duration, or can involve such extreme symptoms (e.g., suicidal behavior or severe psychomotor retardation) out of the list of possible symptoms allowable by DSM-IV, as to imply the probability of a breakdown in the designed, adaptive functioning of loss response mechanisms. Thus many reactive depressions that fall under DSM-IV criteria are indeed disorders. This point is recognized by DSM-IV in the concept of "complicated" or disordered bereavement, and the same logic holds for other "complicated" loss reactions. In such cases, the triggering environmental event interacting with other characteristics of the individual or environment causes enduring harmful dysfunction in an internal mechanism, yielding a disorder. So the argument here is not that reactive depression is not a disorder, but rather that among reactive depressions to a variety of losses, some are disorders and some are not, and DSM-IV criteria do not adequately distinguish the disordered ("complicated") reactions from the normal ("uncomplicated") ones.

Because of these flaws, the epidemiological data on prevalence of depression can be misleading, yielding potentially inflated estimates of the social and economic costs of depression. Based on international epidemiological studies using symptom-based criteria, the WHO has publicized the apparently immense costs of depression. However, the claimed enormity of this burden relative to other serious diseases, and the consequent influence on priorities, may result in part from the failure to distinguish depressive disorders from intense normal sadness. The epidemiological studies encompass everyone who meets symptom criteria—a group that, due to the possible confounding of normal sadness with disorder, may be heterogeneous to a greater degree than clinical patients would indicate, yielding an invalid overall estimation of disease burden. Unraveling these confusions could lead to a more optimal distribution of the WHO's health resources.

Conduct Disorder

The DSM-IV diagnostic criteria for conduct disorder allow adolescents who are responding with antisocial behavior to peer pressure, threatening environment, or abuses at home to be diagnosed with this disorder. For example, if a girl, attempting to avoid escalating sexual abuse by her stepfather, lies to her parents about her whereabouts and often stays out late at night despite their prohibitions—and then, tired during the day, often skips school, and her academic functioning is consequently impaired—she can be diagnosed as having conduct disorder. Rebellious kids or kids who fall in with the wrong crowd, skip school, and repetitively engage in shoplifting and vandalism also qualify for diagnosis. Regrettably, Tom Sawyer and Huck Finn fare no better diagnostically under DSM-IV criteria (Richters & Cicchetti, 1993). Such conditions are not necessarily disorders, as laypersons and professionals agree (Pottick, Kirk, Hsieh, & Tian, 2007; Wakefield, Kirk, Pottick, Tian, & Hsieh, 2006; Wakefield, Pottick, & Kirk, 2002).

However, in an acknowledgment of such problems, this statement is included in the "Specific Culture, Age, and Gender Features" section of the DSM-IV-TR text for conduct disorder: "Consistent with the DSM-IV definition of mental disorder, the Conduct Disorder diagnosis should be applied only when the behavior in question is symptomatic of an

underlying dysfunction within the individual and not simply a reaction to the immediate social context" (American Psychiatric Association, 2000, p. 96). If these ideas had been incorporated into the diagnostic criteria, many false positives could have been eliminated. Unfortunately, in epidemiological and research contexts, such textual nuances are likely to be ignored.

The problem evident with the diagnostic criteria for conduct disorder is that because they rely on specific socially disapproved behaviors and eliminate traditional psychopathy indicators (such as lack of empathy and failure to develop moral conscience), the criteria do not adequately distinguish criminality and normal delinquency from genuine mental disorder. The same problem afflicts the criteria for antisocial personality disorder (see below).

Separation Anxiety Disorder

Separation anxiety disorder is diagnosed in children on the basis of symptoms indicating age-inappropriate, excessive anxiety concerning separation from home or from those to whom a child is attached, lasting at least 4 weeks. The symptoms (e.g., excessive distress when separation occurs, worry that some event will lead to separation, refusal to go to school because of fear of separation, reluctance to be alone or without a major attachment figure) are just the sorts of things children experience when they have a normal, intense separation anxiety response. The criteria do not distinguish between a true disorder, in which separation responses are triggered inappropriately, and normal responses to perceived threats to a child's primary bond (due to an unreliable caregiver or other serious disruptions). For example, in a study of children of military personnel at three bases that happened to occur at the time of Operation Desert Storm—when many parents of the children were in fact leaving for the Middle East, and when children knew other children with parents who had been killed or injured—the level of separation anxiety was high enough among many of the children for them to qualify as having separation anxiety disorder according to DSM standards. In fact, however, they were responding with a normal-range separation response to an unusual environment in which they had realistic concerns that their parents would not come back (A. M. Brannan, personal communication, 1998).

Paraphilias (and "Sexual Predator" Laws)

In some states in the United States, a repeat sexual offender who is considered to have a mental disorder in the form of a sexual paraphilia that places his actions out of his control, and who may therefore be a threat to children or adults in the community through repetition of his criminal acts, may be classified as a "sexual predator" and detained through civil commitment after a hearing, even after the individual has fully served a prison term for a sexual crime. In such hearings, the diagnosis of mental disorder is crucial to continued detention of the individual. Often judgments about the presence of a paraphilia are made even when the proposed category is not specifically included in DSM; the DSM's residual category of sexual disorders NOS is used in such cases. However, conditions that are socially disapproved and that lead to illegal actions are not the same as mental disorders, yet may be cited in such hearings. For example, a man who has sexual relations with several underage females may be acting illegally and immorally, but it is unlikely that in virtue of those sexual acts alone he has a mental disorder. Attraction to teenage and even preteen females by males seems common across cultures; has evolutionary roots, in all likelihood; and indeed emerges in such facts as that during certain periods in some countries, a large proportion of prostitutes were (and sometimes still are) preteens.

Social Phobia

Whereas social phobia is a real disorder in which people can sometimes be incapable of engaging in the most routine social interactions, the current diagnostic criteria allow diagnosis when someone is, say, intensely anxious about public speaking in front of strangers. But it remains unclear whether such fear is really a failure of normal functioning or rather an expression of normal-range danger signals that were adaptive in the past, when failure in such situations could lead to ejection from the group and a

consequent threat to survival. This diagnosis seems potentially an expression of North American society's high need for people who can engage in occupations that require communicating to large groups (Wakefield, Horwitz, & Schmitz, 2005a, 2005b).

Adjustment Disorder

Adjustment disorder is defined in terms of a reaction to an identifiable stressor that either (1) causes marked distress that is in excess of what would be expected from exposure to the stressor; or (2) significantly impairs academic, occupational, or social functioning. The first clause allows the top third, say, of the normal distribution of reactivity to stress to be diagnosed as disordered, and it does not take into account the contextual factors that may provide good reasons for one person to react more intensely than others. The second criterion classifies as disordered any normal reaction to adversity that temporarily impairs functioning (e.g., one does not want to socialize, or one does not feel up to going to work). Here, too, the criteria contain an exclusion for bereavement but not for other equally normal reactions to misfortune.

Antisocial Personality Disorder

The criteria for antisocial personality disorder fail to distinguish some instances of sheer criminal behavior from this disorder. Traditionally, this distinction was made by requiring that an antisocial mental disorder must involve a dysfunction in one of the mechanisms that usually inhibit such behavior, such as those providing the capacity for guilt, anxiety, remorse, learning from mistakes, or capacity for loyalty. DSM-III and DSM-III-R (American Psychiatric Association, 1987) criteria failed to make this distinction adequately. Allen Frances, the Chairperson of the Task Force on DSM-IV, said the following in 1980 about DSM-III criteria for antisocial personality disorder:

> The DSM-III diagnostic criteria specifying antisocial personality are indeed clear and reliable . . . but they may have missed the most important clinical point. Using criteria comparable to those in DSM-III, approximately 80% of all criminals are diagnosed as antisocial. . . . It would seem to be more useful to have criteria that distinguish those criminals who are capable of loyalty, anxiety, and guilt from those who are not. . . . There was also considerable concern that the DSM-III criteria would be too easily and universally attained by individuals growing up in rough and deprived areas. (Frances, 1980, p. 1053)

The DSM-III criteria about which Frances wrote were as follows. In addition to having shown evidence of conduct disorder before age 15, an adult must meet four or more of the following criteria: inconsistent work (e.g., 6 months of unemployment in 5 years); irresponsible parenting; breaking the law (e.g., selling drugs, repeated arrests); lack of an enduring sexual relationship (e.g., two divorces or separations, 10 or more sexual partners in a year); irritability and aggressiveness; failure to honor financial obligations; impulsivity (e.g., moving without a prearranged job); deceitfulness; and recklessness (e.g., driving while intoxicated). Frances was surely right that these are invalid criteria for picking out those who have antisocial personality disorder from nondisordered criminals and others, for a host of face validity reasons.

DSM-IV criteria for antisocial personality disorder are essentially the same as in DSM-III, except for the following changes: DSM-IV combines the work and finance criteria into one "either–or" criterion; removes the criteria related to parenting and an enduring sexual relationship; has an additional "lack of remorse" criterion (added in DSM-III-R); and requires three instead of four of the resulting seven criteria for diagnosis. These changes fail to address the main problem with the criteria—namely, that they do not distinguish between career criminals and persons with a mental disorder. The criminal certainly meets the illegal activity criterion and may well meet the work/finance criterion (criminal activity is not "work" as intended in this criterion); the deceit criterion (criminal careers often involve substantial deceit); and one or more of the impulsivity, irritability/aggressiveness, or recklessness criteria (by the very nature of criminal activity). The "remorse" criterion was added as a concession to the traditional approach to validity, but because only three criteria are necessary for diagnosis, the inclusion of a seventh "remorse" criterion does nothing to prevent false positives on the basis of three

out of the other six criteria. It thus appears that DSM-IV again "missed the most important clinical point." These flaws in the criteria for antisocial personality disorder are particularly of concern, not only because they create the possibility that psychiatrically normal criminals could mount a psychiatric defense—but, more importantly, because laws recently enacted in Great Britain allow detention beyond the jail term meted out in criminal proceedings of those offenders with antisocial personality disorder. Such laws make the overinclusiveness of the criteria potentially a tool of social control under a medical label.

Personality Disorder

Nor has DSM-IV fixed a more fundamental problem with its general definition of personality disorder, which guides the application of the frequently used personality disorder NOS category and provides the rationale for the more specific categories (Wakefield, 1989, 2006, 2008). The definition requires a pattern of inner experience and behavior that is (1) inflexible and pervasive across situations; (2) stable and of long duration and early onset (i.e., started at least as early as adolescence or early adulthood); (3) deviates markedly from the expectations of the person's culture; and, (4) causes significant distress or impairment. The first two of these criteria just describe what it is for a pattern of behavior to be considered a personality trait, whether normal or pathological. So a personality disorder is essentially defined as a personality trait that causes distress or impairment and is not what is expected in one's culture. The problem with this definition is that it covers a vast range of normal personality variations. For example, in our culture, a person of below-average intelligence may experience distress and will deviate from normative expectations; people who are foolish, selfish, nonconformist, or irreverent, and people who are creative and who experience distress or impairment from their creative birth pangs and deviate from social expectations in the pursuit of their muse, may all qualify as having personality disorders according to these criteria. Even the Soviet dissidents mentioned earlier in this chapter would probably have qualified for such a diagnosis because they inflexibly protested tyranny and thus deviated from what their society expected, experiencing distress and social impairment as a result. Closer to home, it has been noted that Martin Luther King—who, in heroically fighting for racial justice, persisted in violating the expectations of his local Southern culture and as a result sustained great distress and even death—would have to be considered to have a personality disorder, according to DSM-IV (Kalat, 1996, p. 597).

Disorder of Written Expression

An op-ed piece on DSM-IV in the *New York Times* by Stuart Kirk and Herb Kutchins (1994), which the *Times* titled "Is Bad Writing a Mental Disorder?", used disorder of written expression from the category of learning disorders as an example of the "nonsense" that is in the manual. Because DSM-IV criteria for this and other learning disorders require only that a child's achievement level be substantially below average, it is true that the criteria do not distinguish very bad penmanship from disorder. Clearly, a distinction is needed here: Bad penmanship is not a disorder in itself, but bad penmanship caused by a dysfunction in one of the mechanisms that enable children to learn to write is a disorder. (Kirk and Kutchins acknowledged that this distinction could be made.) This sort of distinction has been common in the learning disorders community for decades, and it requires that before diagnosing a child with a learning disorder, one must attempt to eliminate possible "normal" causes of the lack of achievement, such as family distractions, lack of motivation, or inability to understand the language of instruction. Because DSM-IV criteria fail to make this distinction, there is no adequate answer to Kirk and Kutchins's embarrassing question. In actuality, the problem is not with the category of disorder of written expression but with the invalid DSM-IV criteria. The danger is that when DSM-IV puts forward criteria that are open to such ridicule, the legitimate distinction can easily get lost. In the case of the learning disorders, this distinction is critical not only for diagnosis, but for the integrity and public support of special education programs.

The DSM-IV disorders usually first diagnosed in infancy, childhood, or adolescence

present several further examples of failure to address known problems. These disorders have been at the center of some of the most embarrassing public allegations about diagnostic invalidity—including charges that some normal children who do not keep up in school are classified as having learning disorders and inappropriately receive costly special education resources; that some normal but rambunctious children are diagnosed as having attention-deficit/hyperactivity disorder and are drugged into submission; and that some normal children who are difficult for their parents to handle are hospitalized under the diagnosis of oppositional defiant disorder. Given the special vulnerabilities of children, it is here, if anywhere, that the diagnostic expertise of the mental health professions should display itself by providing ways to distinguish such false positives from true disorders.

Substance Abuse

DSM-IV substance abuse roughly requires any one of four criteria: poor role performance at work or at home due to substance use; substance use in hazardous circumstances, such as driving under the influence of alcohol; recurrent substance-related legal problems; or social or interpersonal problems due to substance use, such as arguments with family members about this use. These criteria are not only face-invalid as indicators of disorder; they are also inconsistent with DSM-IV's own definition of mental disorder, which asserts that "symptoms" must not be due to conflict with society. Arrests for illegal activity and disapproval of family members are exactly the kinds of social conflicts that are insufficient for diagnosis of disorder according to DSM-IV's definition. It is remarkable that DSM-IV allows arguments with one's spouse about alcohol or drug use to be sufficient by itself for being diagnosed with substance abuse. In other words, if you drink or smoke marijuana, your spouse can now give you a mental disorder simply by arguing with you about it, and can cure you by becoming more tolerant! Given that parents are likely to argue with their children about even minor experiments with alcohol or drugs, this criterion is dangerously overinclusive indeed. Being arrested more than once for driving while under the influence of alcohol or for possession of marijuana is also sufficient for diagnosis, making one's diagnostic status depend on the diligence of the local police force and the vagaries of local drug laws. As to the "hazardousness" criterion, it is clear that very large numbers of people drive under the influence of alcohol for all kinds of foolish reasons, and that they need not have a mental disorder to do so.

Substance Dependence

The DSM-IV diagnosis of substance dependence is based on three or more symptoms from among those indicating either physiological dependence (tolerance or withdrawal) or psychological dependence (takes more than was intended; desires to cut down; great deal of time spent on getting, taking, and recovering from substance use; other activities reduced because of time spent on substance use; and use of substance is continued despite health risks). The problem is that DSM-IV's operationalization of psychological dependence consists of criteria that essentially operationalize the broader notion of "intense desire" or "strong preference," not the narrower class of pathological psychological addictions. Yet intense desires or strong preferences in themselves, whether for substances or for anything else, do not imply disorder. Consequently, it would appear that many persons who avidly use substances but who are not truly dependent on them would be misdiagnosed as disordered by these criteria. This flaw in the criteria could fuel the suspicion that the inclusiveness of the criteria reflect social disapproval and social goals of controlling substance use, rather than the logic of disorder.

This problem yielded public embarrassment for DSM-IV when the criteria for substance dependence were held up for public ridicule by defenders of the tobacco companies in debates about whether smokers suffer from a true addictive mental disorder. While it is clearly the case that many smokers are literally addicted, the tobacco companies scored easy points by arguing that if the DSM-IV criteria for substance dependence were applied to other domains of voluntary behavior, they would identify large numbers of preferred activities as psychological addictions and disorders. For example, an in-

dividual at risk for heart disease who desires and intends to cut fat intake down to 10% of calories in accordance with dietary guidelines, but makes it only to 20% because of his or her enjoyment of the taste of fat in foods, logically satisfies DSM-IV criteria for psychological substance dependence but would not seem to be disordered. Or a person who goes to bed without flossing his or her teeth more often than intended despite the health consequences, and wishes he or she would floss more often, satisfies the same criteria but is not disordered. Of course, these individuals are not technically diagnosable as having substance dependence—for the purpose of diagnosis, DSM-IV-TR defines "substance" as "a drug of abuse, a medication, or a toxin" (American Psychiatric Association, 2000, p. 191)—but the tobacco companies still had a point. The concept of psychological dependence should have the same logic, whether the object of desire is substance use or some other activity (and, in fact, the addition of gambling and other such behaviors as potential addictions or dependence conditions is under active discussion). Thus the fact that the hypothesized individuals' desires for eating fat and not flossing, respectively, are not considered disordered, whereas individuals who have exactly the same kind of relationship to their cigarette smoking are classified as disordered by DSM-IV, indicates the overinclusive nature of DSM-IV's operationalization of psychological substance dependence. DSM-IV criteria for substance dependence appear to overpathologize drug use by presupposing that all nondisordered desires are wholly ruled by reason; the criteria thus fail to distinguish truly disordered dependence from intense enjoyment, strong preference, and other nondisordered modes of drug use.

Bipolar II Disorder

The criteria for the new (to DSM-IV) category of bipolar II disorder require that at some point in life the individual must have suffered a major depressive episode and a hypomanic episode; a hypomanic episode is essentially a mild, short-lived (at least 4 days), and nonimpairing manic episode. Because of the mildness of the hypomanic symptoms, this category may be subject to many false positives. For example, a period of intense romantic involvement may satisfy the criteria for hypomanic episode if it lasts at least 4 days, and if the lover experiences an elevated, expansive mood during which he or she is three or more of the following: sexually indiscreet, distractible, physically active, talkative, high in self-esteem, lacking sleep, and having thoughts racing. If the lover is spurned and goes into a depressed tailspin for 2 weeks that satisfies the criteria for major depressive episode (or if the lover previously had a spell of sadness due to some serious loss that spuriously qualifies for disorder status under the criteria for major depressive disorder—see above), then he or she will qualify for a diagnosis of bipolar II disorder, even if no disorder is really present. Another common source of false positives for hypomania is the presence of "irritability" for several days due to lengthy marital spats. This failure of validity is potentially an especially serious problem for epidemiologists; even with the much more stringent DSM criteria for manic episode, epidemiological surveys using lay-administered structured interviews have gotten a very large proportion of false positives, partly because of misclassification of normal variations in mood as manic episodes (R. Kessler, personal communication, 1998). None of this is to say that bipolar II disorder is not a legitimate category, but only that DSM-IV criteria do not validly identify it.

Acute Stress Disorder

The recently added category of acute stress disorder seems to pathologize normal-range stress responses. If a terrible event (e.g., threatened death or injury, rape) causes fear, helplessness, or horror (as it typically might), and one has stress response symptoms (e.g., feels in a daze and "out of it," thinks about the event, reacts to reminders of the event) for more than 2 *days*, then one is considered to qualify for this diagnosis. Moreover, the criteria are written in such a way that the more extreme dissociative symptoms need only be present while one is actually experiencing the event; they need not continue after the event itself. After the event, one must only be distressed by reminders of the event or keep processing thoughts about the event, try to avoid those reminders, and remain anxious and impaired in function-

ing for 2 days. After such an event, it would seem odd *not* to have such a reaction. There is no doubt that some acute stress responses are so severe and harmful as to be disorders, but the DSM-IV criteria do not distinguish these genuine disorders from intense, normal stress reactions.

These examples, important as they are, are meant to be only illustrative, not exhaustive. Similar problems exist in many other categories throughout the manual.

Conclusion

Careful attention to the concept of mental disorder underlying psychiatry suggests that, contrary to various critics' claims, there is indeed a coherent medical concept of mental disorder in which "disorder" is used precisely as it is in physical medicine. Once this concept is made explicit, it offers a "place to stand" in evaluating whether current symptom-based DSM and ICD diagnostic criteria are accomplishing their goal of identifying psychiatric disorders as opposed to normal problematic mental conditions. This concept appears to be one that is intuitively understood by both the lay public and mental health professionals (Wakefield et al., 2002, 2006). Thus it is possible that those who must argue cases based on expert judgments of mental disorder have opportunities to develop new pathways for examination and cross-examination that can both support and challenge such judgments, independently of what the official diagnostic criteria indicate. Although the HD analysis has been cited in several law review articles, the broader conceptual implications of this analysis for law and psychiatry largely remain to be explored.

Note

1. Some of these examples as well as some passages are revised versions of material that has appeared elsewhere. I thank the American Psychological Association (Wakefield, 1996), the American Psychiatric Press (Wakefield & First, 2003), and Elsevier B.V. (Wakefield, 1997) for permission to use those passages.

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