**November 13, 2017**
**Lecture 8**

*Up to this point in the course…*

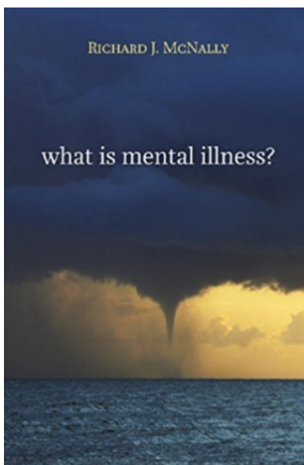
- *We considered the problem of how inevitable uncertainties of societies create inductive risks and how this creates an entry way for the roles of values in the scientific enterprise.*
- *Values also play a role in science, in what research to fund – there is no objective basis on what to fund.*
- *So, we make some form of value judgments and hopefully there are well-adjusted reasons for making those particular value judgements.*
- *Is there another way in which values in enter?*
- *Yes. However, we will look at something where the roles that values play (in such a situation) are quite different from what we previously saw.*
- *This is an issue that may affect ourselves, the people we know or societies in a large way – it is beginning to affect society at increasing rates*

Topics for today:

1. Psychiatry and Values
2. Defining Mental Disorder

## 1. Psychiatry and Values

Slide 1




- What is Mental Illness?
- By Richard J. McNally
- He is not a philosopher
- A psychiatrist
- Compare to Wakefield's writing, which is a philosophical piece
- Pick out characteristic features of what Wakefield does

Slide 2

- Half of Americans have been mentally ill at some point in their lives, and a quarter have been mentally ill in the last year.
  - Startling statistic
  - Half of the US population (similar numbers in Canada)
- In China and Nigeria, only 4-5% of people have been mentally ill in the last year.
  - Compared to US - one-fifth of mental illness occurrence

Slide 3

- Can you think of an explanation for this discrepancy?
    - China is quickly becoming an industrialized society
    - Not so different from US in many ways
    - So then what accounts for this discrepancy?
    - There is clearly a significant difference…
    - Suggestions from class:
        - Reporting
        - Stigmatization → could explain why some countries have low incidences
        - Diagnostic procedures → DSN; a large measure of defining what counts as a mental disorder in our society – not everyone employs this criteria for what counts as a mental illness – if you are using a different measure, of course you will be getting different numbers of how many people in a population are experiencing a disorder
        - Something about the way in which we define what a mental illness is, is going to play a huge role in understanding mental illness as a phenomena in society
        - Cultural factors play a role in it as well
        - There is a thought in scientific inquiry that science reveals to us what the world is really like; we are committing to the ideas that science establishes natural entities – tells us what kinds of things are really present in the world
        - The way in which we split up problems of science takes out the exact, correct kind of entities in the world…
        - Example: electrons – natural features
            - We got to identify the exact kind of things present in the world
            - Nothing about our own conceptualization of physics constructed this thing
        - The process of science just reveals to us the properties of those natural kinds
        - But not all features of scientific inquiry have this property of identifying these exact properties of the world
        - In some instances, we can develop concepts of describing the world, which are useful to getting us around the world but they may not identify what is exactly there
        - In the case of psychiatry, there are some instances where there is a clear phenomenon going on, as having behaviours or symptoms that we describe as distinct phenomena (which in the sense that their behaviour differs from how normal people behave)
        - What is "normal" by the way? → what does normal even mean?
        - We don't have a clear mechanism of what is going on in the person – we don't have a clear reason to say that someone has schizophrenia!
        - The presentation of someone with schizophrenia – we may not might think we identified a natural entity BUT we may think it is a concept that we engineered to pick out these classes of behaviour (but it doesn't pick out cases uniquely, which all have the same underlying biological mechanisms)
        - We are in philosophically-deep water (probably the deepest, said the professor)
            - It is important to look at

Slide 4

- We conjectured some reasons for why proportions of populations with mental disorders are distinct
- The problem seems to be particularly pronounced in the university student aged population
- Not just students at university – but individuals of that age
- Some evidence: social media have changed the social structure of the world in a way that affect these students of age
- We use social media at a disproportionally high rate

- This influences the kinds of social connections that people develop in the world
- As a result, it seems to influence the incline of certain mental disorders (depression and anxiety)
- Disclaimer: removing social media will not completely reduce these risks
- There are many other factor that contribute to these disorders

Slide 5

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**Using Many Social Media Platforms Linked With Depression, Anxiety Risk**

Nick Zagorski

Published online: January 17, 2017

**While time spent on social media is considered a risk factor for mental health problems, the more important factors may be related to which platforms are used and the user's online experiences.**

Research has suggested a link between spending extended time on social media and experiencing negative mental health outcomes. New evidence suggests that whether it's distracted attention from using multiple social media outlets or the emotional consequences of a negative online experience, it's the quality—not so much the quantity—of social media engagement that may affect mood and well-being.

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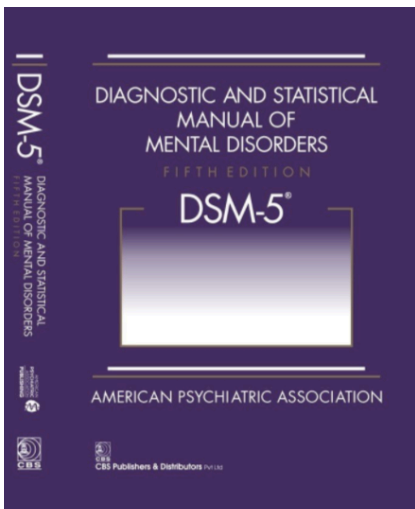
Slide 6

- To understand what might be going on, we need a definition of *mental disorder*
- How do we know that someone has this mental disorder?
- This is achieved through the DSM

Slide 7




- It is basic guiding idea – to pick out what are valid mental disorders
- This has changed many times; in the second version, homosexuality was treated as a personality disorder
- What has come and gone in the different DSM editions?
- What are they defining characteristic of a mental disorder?
- Some things now are regarded as normal function that were previously thought to be a mental disorder
- Anyways, how do we define normal?

Slide 8

- McNally: The first two versions of the DSM provided only brief, narrative descriptions of mental disorders, not explicit descriptions of symptoms and the number needed for a person to qualify for a diagnosis.

Slide 9

- DSM-II definition of inadequate personality disorder.
- “This behavior pattern is characterized by ineffectual responses to emotional, social, intellectual and physical demands. While the patient seems neither physically nor mentally deficient, he does manifest inadaptability, ineptness, poor judgment, social instability, and lack of physical and emotional stamina.”
    - Physiatrists at the time were supposed to use this definition to adjudicate whether or not if someone has this inadequate personality disorder
- How would you go about trying to determine whether or not someone had this disorder?
    - Do you know anyone that satisfies some elements of this description?
    - Yes and so does almost everyone in the room
    - Professor said: there is at some level of reading this, where it feels as if it describes you
    - Craig: DSM is more statistical; the definition above is vague
    - Determining if someone falls in this category is not straightforward
    - How much of each of these components does one need to have in order to be diagnosed?

Slide 10

- Point is: unclarity has consequences!
- Just like when we talked about formulating theses – you have to be adequately specific and explicit
- The definition above didn’t really accomplish anything
- You don’t want to be able to write just clearly but be able to carve out positions about the world – attitudes – which are precise so you can avoid problems that result from unclarity

Slide 11

- Example of the consequences of this unclarity that McNally provides us with:
- Rosenhan and seven other psychiatrically normal individuals got themselves admitted to inpatient psychiatric units at twelve different hospitals. Each complained of a single symptom: auditory hallucinations of a single word: “thud,” “hollow,” or “empty.” During the intake interview and their inpatient stay, averaging nineteen days, the pseudo patients behaved normally and complained of no further symptoms. One received a discharge diagnosis of schizophrenia, whereas the others received a discharge diagnosis of schizophrenia in remission.
    - DSM-2
    - These are people that have no schizophrenia
    - Had one symptom and was diagnosed

Slide 12

- Valid diagnostic criteria correctly identify those with the disorder and exclude those without the disorder.
    - How do we come up with criteria – to correctly pick out who has it or not?
- Validity, in turn, requires diagnostic reliability.
    - If two different doctors use the same criteria to diagnose something – then the criteria is characterized to be reliable
- If the diagnostic criteria for a disorder are reliable, then two clinicians who interview the same patient should arrive at the same diagnosis. If the diagnostic criteria are vague, rendering them subject to

**idiosyncratic interpretation** by different doctors, then they will be unreliable. The validity of a diagnosis presupposes its reliability.
  - As a result, one may come up with different diagnosis on someone who could have the disorder
  - In order to make a valid diagnostic criteria, there needs to be reliability
  - Different doctors, after being presented with the same patient with a particular set of symptoms, need to be able to agree when using the same criteria

Slide 13
- There are lots of ways to define something
- Strategy most often employed in psychiatric context is the idea of providing an operational definition
- An operational definition gives specific operations that can be performed to determine whether/to what extent a property obtains.
  - May not be familiar to you
- What is an operational definition of the weight of an object?
  - What kinds of operations in the world can we do to reveal to us the weight of the object?
  - Looking at a scale
  - Operational definition of my weight: my weight is the number that appears on a digital scale, when I step on it without holding myself up with anything else
  - Operational in a sense where a set of actions can be performed in the world, which tells you what the thing in question is (the thing in question is the numbers that happen on the scale, when you perform the operation)
  - Move from narrative descriptions of disorders towards operation definitions
  - Is there a better way?

Slide 14
- The weight of an object is the number that appears on a scale when you place the object on it.

Slide 15

Major Depressive Disorder 296.xx (F32.x and F33.x)

**A. Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.**

***Note:*** Do not include symptoms that are clearly attributable to another medical condition.

1. Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad, empty, hopeless) or observation made by others (e.g., appears tearful). (***Note:*** In children and adolescents, can be irritable mood.)
2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation.)
3. Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. (***Note:*** In children, consider failure to make expected weight gain.)
4. Insomnia or hypersomnia nearly every day.
5. Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down).
6. Fatigue or loss of energy nearly every day.
7. Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick).
8. Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others).
9. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

From DSN-V, for major depressive disorder (operational definition)
- When doctor diagnoses someone with this criteria (set out in this definition), it has been satisfied

- Need to have at least five of those symptoms
- #1: clearly operational (ways of going out in the world to see if criteria is satisfied)
- Look at a tape of someone talking… would you be able to agree if this criteria would be satisfied?
- Is there any room for interpretation?
- Perhaps we did a poll where we all make a judgement of someone talking, about whether or not they satisfy criteria #1 – do you think there would be **more** or **less** agreement between all of us than if we performed the same experiment and were asked if whether or not this person was emotionally ineffective?
    - There would be more agreement because more explicit and specific
    - Next week, we will try this experiment
    - Expectation: correlate more closely on this judgement than from the one in DSM-II
- You have major depressive disorder, if 5 or more of those criteria (doctor's should be correlate between them well) satisfy during the same 2-week period – which aren't deviations from other conditions

Slide 16

**B. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.**

**C. The episode is not attributable to the physiological effects of a substance or to another medical condition.**

*Note:* Criteria A-C represent a major depressive episode.

*Note:* Responses to a significant loss (e.g., bereavement, financial ruin, losses from a natural disaster, a serious medical illness or disability) may include the feelings of intense sadness, rumination about the loss, insomnia, poor appetite, and weight loss noted in Criterion A, which may resemble a depressive episode. Although such symptoms may be understandable or considered appropriate to the loss, the presence of a major depressive episode in addition to the normal response to a significant loss should also be carefully considered. This decision inevitably requires the exercise of clinical judgment based on the individual's history and the cultural norms for the expression of distress in the contest of loss.

**D. The occurrence of the major depressive episode is not better explained by schizoaffective disorder, schizophrenia, schizophreniform disorder, delusional disorder, or other specified and unspecified schizophrenia spectrum and other psychotic disorders.**

Additional causes that are added to the operational definitions

- B: if for whatever reason, the person satisfies five of these symptoms but were not causing distress or impairment in social life – then the person would not have the disorder in question
- C: the symptoms are not distributed to the effects of drugs or medical condition
- D: not better explained by other similar, related conditions

Slide 17

**E. There has never been a manic episode or a hypomanic episode.**

*Note:* This exclusion does not apply if all of the manic-like or hypomanic-like episodes are substance-induced or are attributable to the physiological effects of another medical condition.

*Specify:*

**With anxious distress**

**With mixed features**

**With melancholic features**

**With atypical features**

**With mood-congruent psychotic features**

**With mood-incongruent psychotic features**

**With catatonia.** Coding note: Use additional code 293.89 (F06.1).

**With peripartum onset**

**With seasonal pattern** (recurrent episode only)

2. Defining Mental Disorder

Discussion-based: looking at the different ways of defining mental disorders and how it lead to the adoption of the definitions we see now in DSM-5.

Slide 1

# The Concept of Mental Disorder

## *On the Boundary Between Biological Facts and Social Values*

Jerome C. Wakefield — *Columbia University School of Social Work and Institute for Health, Health Care Policy, and Aging Research, Rutgers University*

*Although the concept of mental disorder is fundamental to theory and practice in the mental health field, no agreed on and adequate analysis of this concept currently exists. I argue that a disorder is a harmful dysfunction, wherein* harmful *is a value term based on social norms, and* dysfunction *is a scientific term referring to the failure of a mental mechanism to perform a natural function for which it was designed by evolution. Thus, the concept of disorder combines value and scientific components. Six other accounts of disorder are evaluated, including the skeptical antipsychiatric view, the value approach, disorder as whatever professionals treat, two scientific approaches (statistical deviance and biological disadvantage), and the*

diagnosis involves the ability to distinguish disorder from normal reactions to stressful environments and from other nonpathological problems, such as the marital, parent-child, and occupational conflicts summarized in the V Code categories of the revised third edition of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-III-R*; American Psychiatric Association, 1987). At an institutional level, "mental disorder" demarcates the special responsibilities of mental health professionals from those of other professionals such as criminal justice lawyers, teachers, and social welfare workers. Thus jurisdictional disputes are often disputes about the application of the term *mental disorder*.

Paper by Jerome Wakefield

- Important figure in psychiatry
- What constitutes a mental disorder?
- Title: the concept of mental disorder
- Subtitle: on the boundary between biological facts and social values
- Preview: there a role for not just the biological basis for diseases (whether or not one has what should properly count as a mental disorder), but a value-type role, concerning to what extent the disorder in question produces harmful effects in the patient
  - Hardest paper assigned for the course
  - Professor will indicate the core arguments, which correlate the themes of the course

Slide 2

- W: "I argue that disorder lies on the boundary between the given natural world and the constructed social world; a disorder exists when the failure of a person's internal mechanisms to perform their functions as designed by nature impinges harmfully on the person's well-being as defined by social values and meanings."
- "The order that is disturbed when one has a disorder is thus simultaneously biological and social; neither alone is sufficient to justify the label disorder."
  - There is no such thing as mental disorder that has a purely biological basis
  - He arrives at this view by considering all the other available views in literature on how to think about what a mental disorder is – he thinks this is the most efficacious way to characterize what a mental disorder is
  - Now reflected in how we think about mental disorder is in the DSM-V

    - Many aspects of what Wakefield advocates are now identifiable in the DSM-V; we've seen this in the definition of major depressive disorder

Slide 3

- The concept of disorder is not the same as a theory of disorder. Physiological, behavioral, psychoanalytic, and other theories attempt to explain the causes and specify the underlying mechanisms of mental disorder, whereas the concept of disorder is the criterion used to identify the domain that all these theories are trying to explain.
    - Those are theories that attempt to explain *why* disorder is present
    - The game that Wakefield is engaging is different
        - Not to explain why mental disorders are present in individuals, but to provide what we mean when we say someone has a disorder
    - The two are related in various ways – but conceptually different

Slide 4

- Wakefield: there is no widely accepted account of disorder that adequately explains which conditions are disorders and which are not.
    - He considered each of the views and isolate why they don't work
    - Build up to an account that works by considering all of the views that don't work (in his POV)
- Task: develop such an account.

Slide 5

- Wakefield quotes Kendell: "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. "
    - This quote struck the professor in terms of what we learned in the course
    - What have we discussed so far?
        - Value-free ideal
        - This ideal is baked in to this view
        - Value-free ideal is maintained
        - People are committing to the idea that there are value judgments and then there are value-free scientific judgment (two distinct categories)
            - But we spent time to deny this: even within the context of scientific projects there are value judgements
        - Value-free ideal: science should be value-free (that is what good science is)
            - But this ideal is not good

Slide 6

- Wakefield proposes: "a hybrid account of disorder as harmful dysfunction, wherein dysfunction is a scientific and factual term based in evolutionary biology that refers to the failure of an internal mechanism to perform a natural function for which it was designed, and harmful is a value term referring to the consequences that occur to the person because of the dysfunction and are deemed negative by sociocultural standards."
    - This is where are headed – he wants to show why the deficiencies of previous accounts aren't inherited by the account that he advocates for
    - First bit of his proposal is about the role that science plays: telling us when something is not functioning correctly in the mind (in the context of mental disorder)
    - It is not just about dysfunction, but harm (a value term – referring to the consequence that occur to the person because of the dysfunction)

    - In order to have mental disorder, you need have dysfunction but a dysfunction that causes harm (negative social consequences)
- There is an interesting role that gets played by evolution in the background
- Concept of natural function is fraught
    - W gives compelling arguments
    - But going to pick on his argument in the way that natural function is characterized and utilized in the argument
    - Natural function of human?
    - What Wakefield tells us, you might think that is not adequate
- In the context of the brain, Wakefield makes a remark that the state of our understanding of the brain is like the state of the understanding of our other organs
- We do not have a good understanding of the brain
- Even if we had an unproblematic conception of what the natural function was… we do not know of all the mechanisms by which the brain is operated – so, what is the natural function even supposed to be?
- Just like climate change
- Values are stepping in to playing a role because the science by itself is inadequate to some regard to completely settle the question

Slide 7

Wakefield talks about SIX VIEWS THAT DON'T WORK

1) There is no such thing as mental disorder
    - Anti-psychiatry
2) Disorder is a pure value concept
    - Purely social, political concepts
3) Disorder is whatever professionals treat
4) Disorder is statistical deviance
5) Disorder is biological disadvantage
6) Disorder is unexpectable disability

The first five is what he rejects – gives wrong answers about things.

Sixth one is somewhat in agreement, but gives modifications to it (requirement that there has to be harm involved and not just dysfunction alone)

Slide 8

1) There is no such thing as mental disorder
    - "The skeptics typically claim that "mental disorder" is merely an evaluatory label that justifies the use of medical power ... to intervene in socially disapproved behavior."
    - There is no real thing happening in the world when talking about mental disorders
    - Just a label imposed on certain cases where people want to intervene in some particular behaviour

Slide 9

- Two types of argument in favor of the view:
    - Practical, ethical, and epistemic concerns about psychiatric diagnosis
        - When we say that there is mental disorder
        - Terrible argument
    - The concept of disorder can't carry over from concepts of physical disorder
        - More serious

Slide 10

- The first of these is easy to dismiss: just because something has undesirable consequences doesn't mean it isn't real.
    - That is like saying racism doesn’t exist because it has negative consequences in the world that it does exist
    - Not a good argument

Slide 11

- A specific version of the second argument:
- Szasz: physical disorder is a legitimate concept - a disorder consists of a physical lesion (lesions are understood as identifiable deviations in anatomical structure).
- Mental disorder is just an extension of the concept of physical disorder ... The same concept of disorder that applies to physical conditions should also apply to mental conditions.

Slide 12

- A specific version of the second argument: Szasz: mental disorder is typically not accompanied by any identifiable lesion of the brain or any other part of the body.
    - So we can’t identify what is going on in the physical structure of the brain that yield the mental disorder in questions
- An implicit assumption: no lesions will subsequently be found in the future to explain such conditions.
- Szasz concludes that the lesion concept of disorder that applies to physical conditions does not apply to mental conditions, and so there is no such thing as a mental disorders.

Slide 13

- Can you think of an objection to Szasz?
- Dualism? Physical realm is different and independent from the mental realm?
- Physical structure of brain doesn’t produce everything there is to know what is going on in your thoughts

Slide 14

- Wakefield's response to Szasz: If lesion is essentially a functional concept (characterized in terms how effects get produced), then mental conditions and physical conditions can literally be disorders for the very same reason, that is, their functional implications.
- Just as we can have lesions that affect our physical functioning, we can have lesions that affect our cognitive processes that produce harmful dysfunctions.
    - Concept of lesion has to be generalized here
    - Concept of lesion is no longer going to be: “I got a hole in my arm”
    - It is going to be a failure to function appropriately in cognitive processing
    - Relies on the idea that there is something that it is to have normal cognitive function (something that needs to be justified)

Slide 15

- 2) Disorder is a pure value concept
- What happens if we accept the skeptical conclusion that there is no scientific basis for the concept of mental disorder?
- Suppose we treat both mental and physical disorders as purely determined by values.
- That is what is suggested in this view

Slide 16

- Wakefield: The pure value account of disorder asserts that disorder is nothing (or almost nothing) but a value concept, so that social judgments of disorder are nothing but judgments of desirability according to social norms and ideals
  - Physical disorder of leg (it is broken)?
  - Is it just a value judgement?
  - Putting social value on the claim that your leg is broken
  - Nothing disordered about you having a broken leg
  - Nothing true about the world about your leg being broken being disordered
  - More plausible in the context of mental disorder
  - We don't understand schizophrenia
  - No scientific basis on it
  - When you say someone has schiz, coming down to value commitment about that person

Slide 17

- Wakefield has two arguments against this view:
- There are many undesirable conditions that are not classified as disorders.
  - Just because something is undesirable in the social sense, doesn't mean that we always classify it as disorder
- It does not explain how people can be mistaken about disorder and how people who share social norms and values can disagree about which conditions are disorders (this shows that facts have some role to play in determining what is a disorder).
  - It is possible to come up with similar sets of judgements about what the social norms are and come to different conclusions (about whether or not a particular feature of a person counts as a disorder); as a result, this is inadequate
  - W: This shows that facts have some role to play in determining what is a disorder (factual basis)

Slide 18

- 3) Disorder is whatever professionals treat
- What if we just say that disorder is simply any condition that health professionals treat?
- Physical disorders treated in normal hospital
- Mental disorder treated by mental health professionals

Slide 19

- Wakefield: Many concerns that are handled by health professionals clearly are not disorders (e.g. childbirth, unwanted pregnancy, circumcision, cosmetic surgery, and distresses due to the normal vicissitudes of life, marital conflicts, adolescent-parent conflict, and occupational problems).
- Not physical or mental disorders
- So, if we say it is whatever health professionals treats, then we account for all these things (but we don't want to say that these are disorders)

Slide 20

- 4) Disorder is statistical deviance
- What if we take disorder to be quantitative deviation from what is statistically normal?

Slide 21

- Wakefield: One basic problem with this view is that excellence in strength, intelligence, energy, talent, or any other area is just as statistically deviant as its opposite.

  - o In addition to whatever negative consequences you consider, you also include things that are regarded as positive
  - o Abnormally smart or talented – count them as things that one is lucky to have
- Moreover, there are many behaviors that are statistically deviant and undesirable but are not disorders; for example, such behavior can be criminal, discourteous, ignorant, morally repugnant, or disadvantageous.
  - o Even if you only include the negative characters (statistical), you still have undesirable features of people that are not disorders

Slide 22
- Wakefield: many conditions that are statistically normal in their context are still disorders (e.g. minor lung irritation from pollution (all of us – statistically normal), atherosclerosis, periodontal disease).
  - o Fails to count as disorders things that are statistically normal
  - o We have minor lung irritation from pollution
  - o Statistically normal to have it
  - o However, it is a disorder of the body not functioning normally

Slide 23
- 5) Disorder is biological disadvantage
  - o Distinct form his view

Slide 24
- Scadding, Kendell, and Boorse: use the evolutionary criterion of lowered survival or lowered reproductive fitness, as a purely scientific means for identifying disorders.
  - o We think we have a metric of biological fitness coming from the evolutional theory
  - o Here the aim of individuals is to survive and reproduce – if some condition that an individual experiences works to reduce the survival and reproducing rate – it was said that this counts as a disorder!

Slide 25
- Wakefield: A condition can reduce fertility without causing real harm; marginally lowered fertility is serious over the evolutionary time scale, but it may not affect an individual's well-being if the capacity for bearing some children remains intact.
- Moreover, some serious harms, such as chronic pain or loss of pleasure, might not reduce fertility or longevity at all.
  - o Chronic pain is certainly something that counts as a disorder (causes harm) – according to W
  - o But according to metric of biological disadvantage, this does not count as a disorder since it doesn’t affect one’s ability to survive or reproduce
  - o IF YOU ADOPT THIS **DISORDER IS BIOLOGICAL DISADVANTAGE** IDEA:
  - o In addition to being harmful for you, it will be harmful to subsequent generations
  - o But if you have disorder that results from just being in society (exposure like pollution) and not from genetic consequences (but from something that doesn’t affect your genes or biological information that’s being passed to next generations), then this view gets that case wrong…

Slide 25
- 6) Disorder is unexpectable disability (adopted in DSM III)
- W thinks this is closer to his view
- Minor changes though

Slide 26

- This is close to the view that Wakefield ultimately wants to defend.
- Identified and adopted in DSM-III
- To determine whether or not people had disorders

Slide 27

- W: "Dysfunction" and "negative consequences" (which can be taken to be equivalent to "harm") as two of the **necessary** conditions for disorder.
- Moreover, DSM-III-R (revision) explicitly states that a disorder must be "a manifestation of a behavioral, psychological, or biological dysfunction in the person"
- It is also required that a disorder must be associated with "present distress (a painful symptom) or disability (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" (p. xxii), and this list might be considered to be an operationalized approximation to the requirement that there must be harm.
    - Harm is the kind of concept which we also need to operationalize
    - This is ultimately where W finds fault with this articulation of what it is to be a mental disorder

Slide 28

- Wakefield has two objections:
    - One cannot simply define disorder in terms of dysfunction because dysfunction itself is a concept that requires analysis.
        - In order to have disorder, you need to have dysfunction (but not the most helpful thing if we don't know what we mean if something is dysfunction)
        - If this view needs to work, need an account of what means to be a dysfunction
    - Second, a central goal of DSM-III-R is to present reliable operationalized diagnostic criteria for specific disorders. The definition of disorder is aimed at providing a general framework for constructing such criteria. But dysfunction is not an operational concept, and for DSM-III-R's purposes, dysfunction must be translated into a more operational and reliable formula that captures the essential idea of dysfunction. (similarly for harm)
        - Need operationalization of the idea of dysfunction and operationalized view of what it is for something to be harmful
        - W wants to provide this in his view, in order to know what a harmful dysfunction and hence what a mental disorder actually is

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- DSM-III operationally defines disorder roughly as unexpectable distress or disability.
- But W says DSM gets it wrong on what it is to be disorder
- Wakefield objects to this operationalization.

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- Wakefield thinks disorder is harmful dysfunction (operationalized appropriately).

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- Wakefield: The concept of disorder must include a factual component so that disorders can be distinguished from a myriad (bunch) of other disvalued conditions. On the other hand, facts alone are not enough; disorder requires harm, which involves values.
    - What counts as harm?
    - Operationalization of harm is not going to be in terms of scientific harm, but in terms of value judgement about what we positively or negatively value

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- How should we analyze dysfunction?
- Wakefield: An obvious place to begin is 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 kinds of functions are relevant.
    - If you look at this part of the paper in detail...
    - Professor and Craig found issues with the position that he ultimately tries to identify
    - Side note: Unfulfilled function is another way of saying dysfunction
    - Problem is that not all functions are relevant
    - His example that he gives: only natural function of the parts of the body are supposed to count
    - Example: my nose functions in the role of holding my glasses up (but not a natural function)
    - Natural function of nose is to breathe… take in oxygen, etc.
    - What professor and Craig worries about is: whether or not this characterization of which functions count is **adequate**
    - If we don't know how the brain works fully, we don't have any way of telling the story about what natural function might look like
    - We only little of how the brain works and how the individual pieces of the brain add up to the complex experiences we have, at the level of which mental illness presents themselves
    - There is a real puzzle/challenge to motivate this harmful dysfunction view, because of what we are saying a dysfunction is (dysfunction = a failure to execute natural function)
    - What natural functions are, in this context, is hard to pin down
- (Only "natural" functions count, holding up my glasses is not a natural function of my nose, helping me breath is.)

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- Wakefield: natural functions are effects that explain the existence and structure of naturally occurring physical and mental mechanisms. Correspondingly, dysfunction is the failure of a mechanism to perform its natural function.
- He says, dysfunction is thus a purely factual scientific concept
- What might be a natural function of my eye, in this view: seeing
- What are the related mental mechanisms that get incorporated in the process of seeing?
- Is seeing a purely a physical process?
- Seeing begins by just the physical process of light impinging on your eye (physical process) and it takes that information and sends it to your brain – but then you have mental mechanism which aggregates that information and produces an experience (if it fails, what happens?)
- The fact that one needs glasses is due to physical properties
- In other contexts, you can fail to reconstruct the phenomena of seeing the room in front of you
    - W would probably say this is a mental dysfunction (cognitive level processes that we have some idea on what it is to function normally – by having an appropriate view of the room)
    - It is the mental mechanism failing (not to execute itself properly)
- Under what conditions is it right to say when something is not functioning appropriately?
- This idea of dysfunction in the context of mental disorder is supposed to be purely scientific
- Once we get a better picture of the brain, it will be more clear to us – we would be able to explain more clearly, in what instances there really are dysfunction

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- The resulting view from W's view:
- The following general concept of disorder results from the preceding analysis: A condition is a disorder if and only if (a) the condition causes some harm or deprivation of benefit to the person as judged by the

standards of the person's culture (the value criterion/value judgment), and (b) the condition results from the inability of some internal mechanism to perform its natural function, wherein a natural function is an effect that is part of the evolutionary explanation of the existence and structure of the mechanism (the explanatory criterion – based on scientific facts).

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- DOES THIS WORK?
- Does this capture what is meant when it is said that something is a disorder