1 *DSM* in the Light of HDA (and Conversely)

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> According to both the *DSM* definition of mental disorder and my "harmful dysfunction analysis" (HDA) of the concept of disorder, a disorder is an internal dysfunction (meaning a failure of a biologically designed function) that causes harm (as socially evaluated).
>
> —Wakefield (2009, 87)

Introduction

Wakefield's "harmful dysfunction analysis" (HDA) has met with well-deserved success since his seminal 1992 paper. This analysis, according to which there are two main components in the concept of disorder—a harmful and a dysfunctional component—provides us with a means of clarifying the distinction between the normal and the pathological in the mental health field, and of testing the conceptual validity of any diagnostic label. The HDA has proved to be useful in a number of debates, including the one on the recurrent lack of consideration given to the clinical context in many diagnoses (and more specifically the controversial recent decision to eliminate the exclusion of bereavement from the diagnosis of major depressive disorder) and the increasing tendency to pathologize certain natural emotions (e.g., sadness, anxiety) or deviant behaviors (e.g., alcohol use, paraphilias, crime). This approach developed by a philosopher has even managed to convince a number of influential psychiatrists of the American psychiatric institution, among them Robert Spitzer, chair of the third edition of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-III*), and Michael First, the editor of Text and Criteria for the *DSM-IV*.

In this chapter, I propose a brief account of the complex historical intertwining of the *DSM* and the HDA. In his work, Jerome Wakefield constantly refers to the *DSM*. From his first presentation of the HDA in 1992 onward, the American classification of mental disorders has played a central role in the philosophical defense of the HDA. Conversely, HDA appears to support, from a philosophical point of view, the general methodological strategy adopted by the *DSM* since 1980.

I do not intend here to "deconstruct" the HDA by means of a historiographical argument: I acknowledge that the philosophical relevance of the HDA should be considered solely in the light of conceptual arguments. Yet, in view of certain historical considerations, I wish to point out some important differences between the HDA and the *DSM*.

I. Wakefield, an Early Advocate of the *DSM-III*

Wakefield's ambition to capture the essence of the pathological phenomenon can be found early in his work, several years before the official birth of the HDA. It can be traced back to two papers published in 1987 and 1988, interestingly at the time of a debate on the *DSM-III*.

What was at stake? In 1983, three years after the publication of the *DSM-III*, a debate arose in the *American Psychologist* between psychologist Marcie Kaplan and two important architects of the *DSM-III*, namely, Robert Spitzer (chair) and Janet Williams (text editor). With supporting examples, Kaplan (1983) criticized the *DSM-III* for introducing some sexual biases in the diagnostic criteria, which had the faulty consequence of perpetuating sex difference in treatment rates for mental illness. Williams and Spitzer (1983) replied to this accusation by claiming that the *DSM-III* Task Force took all appropriate measures to immunize the classification against all kind of biases, especially sexual biases.

A few years later, Jerome Wakefield (who had defended a social work thesis at Berkeley on "psychosexual disorders" in 1984 and had then worked on the history of concepts of sexual disorder as a postdoctoral fellow at the Pembroke Center for Teaching and Research on Women at Brown University) took part in this particular debate and published two papers, one in the *American Psychologist* and the other in the *Journal of Sex Research*. In these two papers, Wakefield adopts a balanced standpoint that puts him in a conciliatory position in the debate: although he does agree with Kaplan on the existence of potentially damaging sexual biases in many accepted diagnostic labels, he nevertheless takes the defense of the *DSM-III* by arguing that the third edition has efficiently managed to neutralize such biases. His demonstration focuses on the diagnosis of primary orgasmic dysfunction (POD) promoted during the 1970s by the two famous pioneers of American sexology, William H. Masters and Virginia E. Johnson. Wakefield criticizes their influential definition of POD for tending to overpathologize the lack of orgasm in women. The mistake, according to him, lies in the very term of "dysfunction" in the definition, which is much too indeterminate and does not have the same meaning when it applies to women as opposed to men. Indeed, Wakefield demonstrates that a necessary condition for characterizing a condition as pathological in men (e.g., in "ejaculatory incompetence") is the lack of orgasmic "ability." But when it comes to women, the mere absence of orgasm during intercourse is judged sufficient to consider it pathological. This is precisely the case in the definition of POD

by Masters and Johnson: their fixation on the many psychosocial factors that impede women's sexuality in North American society has played an important emancipating role, but it led them paradoxically to consider that the mere lack of orgasm in women would in itself be indicative of a pathological condition. Despite its appellation, the diagnosis of "primary orgasmic dysfunction" simply neglects to take into account the very common possibility that a woman may not achieve orgasm during intercourse not because she is ill and has an internal dysfunction but just because she has a poor sexual experience and/or inadequate stimulation.

Does the *DSM-III* rush into the same mistake? Wakefield argues that it does not, thanks to the diagnosis of "inhibited female orgasm" provided in the psychosexual dysfunctions section of the classification. Even if the definition does not refer to the notion of "dysfunction," the term "inhibited" implicitly assumes in the *DSM-III* that the condition is characterized by some internal dysfunction whenever orgasm is not achieved despite sexual stimulation that was adequate "in focus, intensity, and duration" (American Psychiatric Association 1980, 279). The clinical evaluation of this contextual consideration does certainly present many difficulties. Wakefield nevertheless concludes that its appraisal in diagnostic criteria constitutes "substantial progress in diagnostic logic" (Wakefield 1987, 464).

Wakefield reiterated his defense of the *DSM-III* a year later, in 1988. In a paper entitled "Female Primary Orgasmic Dysfunction: Masters and Johnson versus *DSM-III-R* on Diagnosis and Incidence," he emphasizes with even more conviction the contrast between the two approaches and praises the DSM-III for its decision to narrow down the criteria for this specific psychosexual disorder. Wakefield also insists in this paper on the beneficial role that a good conceptual analysis may have in settling many diagnostic quarrels: "My argument is aimed at depathologizing women by highlighting the conceptual flaws in current diagnostic practices" (Wakefield 1988, 364). He then cites three authors—Szasz, Scheff, and Foucault—who have been influential in the past decades for denouncing the misuses of psychiatric labels. But Wakefield immediately differentiates himself from these three skeptical authors: "The critical point is that I accept the legitimacy and coherence of the traditional concept of mental disorder. Roughly and intuitively, a mental disorder, like any other disorder, is a harmful deviation from the way the organism is naturally designed to function" (Wakefield 1988, 364). This quotation encapsulates what can be considered the very first account of the HDA in Wakefield's philosophical career—but not yet with the evolutionary perspective that will be decisive in the 1992 seminal paper. The author insists on the importance of such a "functional conception of disorder" and provides two arguments that he will frequently mobilize in his subsequent work. First, he claims that this account provides a "traditional and reasonable standard" (Wakefield 1988, 364): it does not depart from the long-established use of the concept (the term "traditional" is used twice in the same passage), and it also depends on rational consideration, at least on

commonsense intuition. Second, Wakefield is confident that this definition of a mental disorder, despite its roughness and incompleteness, can be fruitful in the psychiatric debate: "No matter how vague or problematic, there is an intuitive functional concept of disorder underlying our judgments, and diagnostic criteria must remain consistent with this conception if they are to be legitimate criteria" (Wakefield 1988, 365).

The reference to the notion of dysfunction is quite useful "no matter how vague and problematic" it is. And the proof of the pudding is in the eating, for this appeal is sufficient here to conclude that the *DSM-III-R* criteria for inhibited female orgasm are "logically superior" (Wakefield 1988, 365) to those developed by Masters and Johnson for POD.

II. *DSM* and the Concept of Mental Disorder

2.1 The Uncanny Familiarity between *DSM* and HDA

Wakefield's most quoted paper is certainly "The Concept of Mental Disorder: On the Boundary between Biological Facts and Social Values" (hereafter CMD), published in 1992 in the *American Psychologist*. This is a philosophical paper in a pure analytical vein, in the wake of Hempel, Putnam, and Searle (of whom Wakefield was a student at Berkeley). It is grounded in the methodological framework of conceptual analysis, which relies on widely shared judgments in order to reveal the ultimate components of a concept (see Aucouturier and Demazeux 2013; Lemoine 2013). Wakefield has never conceded that historical consideration could undermine the credibility of a sound conceptual analysis. This is why he strongly disagrees with Michel Foucault (whom he met when the French philosopher was staying at Berkeley) and Thomas Scheff, since they both attempted "to discredit mental disorder through analysis of the historical processes that led up to the adoption of the concept … or of the sociological processes that influence diagnosis" (Wakefield 1992a, 374). Wakefield, on the contrary, insists on the possibility that a conceptual analysis can be correct even if the concept in question is often misused in practice.

In the CMD paper, Wakefield discusses several definitions of mental disorder and defends the strengths and advantages of his own account. He begins by successively commenting on six alternative proposals, all considered by him to be flawed, albeit for different reasons. The six approaches (respectively, the skeptical antipsychiatric view, the value approach, the disorder as whatever professionals treat, the statistical deviance, the biological disadvantage, and the *DSM*'s definition as "unexpectable distress or disability") are obviously ranked according to their relative closeness to the HDA. In particular, the *DSM-III-R*'s definition—which Wakefield introduces emphatically as the "most influential recent definition of mental disorder" (Wakefield 1992a, 379)—is considered the closest approach to the HDA. Wakefield deliberately makes a connection

between the two definitions: "The definition in *DSM-III-R* is inspired by an overall view of disorder very much like the harmful dysfunction approach I propose" (Wakefield 1992a, 380). While the *DSM* definition is thought to be faulty because it concedes too much to the statistical deviance approach, it still relies on the sound intuition that a disorder is essentially a *harmful dysfunction*.

This uncanny familiarity between the *DSM* and the HDA is explored in greater depth in two papers published respectively in 1992 and 1993: "Disorder as Harmful Dysfunction: A Conceptual Critique *of DSM-III-R*'s Definition of Mental Disorder" (hereafter DHD), published in *Psychological Review*, and "Limits of Operationalization: A Critique of Spitzer and Endicott's (1978) Proposed Operational Criteria for Mental Disorder" (hereafter LO), published in the *Abnormal Journal of Psychology*.

In the DHD, Wakefield offers a very detailed critical examination of the official definition of mental disorder provided by the *DSM-III-R* as "unexpectable distress or disability." In the LO, he carefully analyzes and criticizes a previous attempt by Spitzer and Endicott, in 1978. Although this long operational definition never played an official role, it has directly influenced the *DSM* definition. So Wakefield is right to investigate the conceptual strategy put forward by Spitzer back in 1978, because it clearly helps to highlight some implicit assumptions that are still present in the *DSM*. Yet it is quite regretful that he does not push his historical investigation a little bit further: if he went back to the very first definitional attempts by Spitzer in 1973 and by Spitzer and Wilson in 1975, he would had discovered that at the time, there was no hint of any "functional conception" of disorder.

Let's consider the historical sequence of the four attempts where Spitzer was directly involved:

(1) Spitzer's definition provided in the *DSM-II* position statement published in December 1973 on the occasion of the exclusion of homosexuality from the classification,

(2) Spitzer and Wilson's (1975) "elaboration and expansion" of the 1973 definition,

(3) Spitzer and Endicott's long operational definition in 1978, and

(4) finally, the *DSM-III* (American Psychiatric Association 1980) and *DSM-III-R* (American Psychiatric Association 1987) definitions.[1]

Why is it important to trace back this historical sequence? As we shall see, it sheds new light on two important points: (a) the functional account was completely absent from the first two attempts, and (b) it gained a more important—but ambiguous and not decisive—role in the subsequent attempts.

2.2 Mental Disorder before the Rise of the Function Debate

Unlike Wakefield, who starts his investigation with the account of the *DSM-III-R* and goes back to the 1978 attempt to see if it was already relying of the same intuitions,

I provide a chronological reconstruction that highlights the progressive refinement of the four different definitional attempts by Spitzer and his colleagues. In this regard, it is important to note that Spitzer's very first attempt to provide a general definition of mental disorder was made in the middle of the controversy that arose in 1972–1973 around homosexuality (Spitzer and Endicott 1978, 15). The rationale for removing homosexuality from the *DSM-II* is based on a 4-point statement (American Psychiatric Association 1973, 2) that highlights the absence of scientific consensus on the issue among experts. But Spitzer goes further. He justifies the exclusion of homosexuality by saying that this condition, contrary to all the other conditions listed in the official classification, does not fulfill the two general criteria for a mental disorder, namely, "subjective distress" and "generalized impairment." The historian Hannah Decker has reported Spitzer's strong emphasis on the "subjective distress" criterion (Decker 2013, 155). In any case, these two criteria will remain central in all the subsequent attempts.

Of note is the fact that the only occurrences of "function" or "functioning" in this important text are explicitly said to be evaluative and dependent on cultural norms. For instance, it would be misleading to interpret Spitzer's statement that a "significant proportion of homosexuals are apparently satisfied with their sexual orientation, show no significant signs of manifest psychopathology … and are able to *function* quite effectively" (American Psychiatric Association 1973, 2, my emphasis), as a hint toward a natural model of normal functioning. The same can be said of the few examples that Spitzer provides of other nonoptimal functioning (i.e., celibacy, revolutionary behavior, religious fanaticism, vegetarianism, male chauvinism). This evaluative appreciation of "functioning" is also obvious in a 1974 interview. To a journalist who asks him, "What about the failure to function heterosexually? Is this not a dysfunction and sufficient reason for categorising homosexuality as a disorder?" Spitzer answers,

> No it is not. First of all, many homosexuals can function heterosexually but prefer to function homosexually (in varying degrees). Second, no one would claim that a heterosexual who was unable to function homosexually and had no desire to do so had a homosexual dysfunction. Therefore, homosexuals who have no desire to function heterosexually should not be categorised as suffering from a heterosexual dysfunction. (Spitzer 1974, 17)

In no way can one interpret the term "dysfunction" in this citation as denoting the impairment of a natural function.[2] Homosexuals "function" differently but neither more nor less than do heterosexuals. In Spitzer's mind, it is merely a question of preference. This interpretation explains why Spitzer is prompt to refuse the possibility that the notion of dysfunction may be relevant to resolve the homosexuality controversy. This particular point will also be important to correctly appreciate the introduction of the notion of "organismic dysfunction" in later approaches.

For now, consider the Spitzer and Wilson (1975) definition. It includes three main criteria that we can summarize as follows: (1) a demarcation criterion (between

psychiatric and nonpsychiatric disorders), (2) three central defining conditions of a mental disorder, and (3) a criterion of clinical distinctness.

The whole definition embraces what the authors call a "narrow approach" (or European approach) that they contrast with the "broad approach" prevalent in the United States (Spitzer and Wilson 1975, 4). Whereas the broad approach tends to consider any "significant deviation from an ideal state of positive mental health" as the manifestation of a pathological condition, the new approach tries explicitly to be more restrictive. The difficulty, for sure, is to determine how restrictive the narrow approach should be, and this is why some explicit clinical criteria for the definition of mental disorder are needed. Early on, Spitzer felt that the two criteria of "subjective distress" and "generalized impairment" were fundamental but insufficient if one wanted the definition to account for conditions as commonly accepted in the psychiatric tradition as fetishism, exhibitionism, or necrophilia.[3] Retrospectively, Spitzer conceded, "As we considered the many conditions traditionally included in the nomenclature, we realized that although the definition of mental disorder proposed at the time of the controversy regarding homosexuality was suitable for almost all of them, a broader definition seemed necessary" (Spitzer and Endicott 1978, 16).

In 1975, the broadening of the definition was obtained by adding a strange third subcriterion: "Voluntary behavior that the subject wishes he could stop because it is regularly associated with physical disability or illness" (Spitzer and Wilson 1975, 829). This "new concept" aimed at capturing those conditions that did not fulfill the two first criteria but that still deserved clinical attention, such as "compulsive cigarette smoking" or "compulsive eating."

It is worth noting that nowhere in the definition does the idea of a dysfunction appear.[4] Moreover, it is important to stress the fact that the two authors do not envisage that the demarcation problem between the normal and the pathological might be solved by means of an etiological assumption. Their narrow approach, as they state, "also accepts the notion of a continuum of conditions highly desirable (positive mental health) to highly undesirable (mental illness) but places the cut-off point for mental disorder closer to the highly undesirable end of the continuum so that only conditions clearly associated with suffering and disability are designated as illness or disorder" (Spitzer and Wilson 1975, 4).

Elsewhere in the text, they explicitly deny the existence of any etiological consideration in their account: "It should be noted that the criteria for a mental disorder proposed here in no way depends on the etiology of the condition" (Spitzer and Wilson 1975, 9). So far, the contrast with Wakefield's personal account on mental disorder is striking since, according to the HDA, "the condition must be due to an internal dysfunction of some mental mechanism. This is an etiological assumption" (Wakefield 1997, 644; see also Wakefield, 1999b, 966).

2.3 A Divergent Interpretation of Spitzer and Endicott (1978)

From Spitzer and Wilson's (1975) definition to Spitzer and Endicott's (1978) proposed operational criteria for mental disorder, there is clearly some continuity in the basic ideas underlying the two approaches. Yet, for the first time, the expression "organismic dysfunction" is used. How should we interpret this sudden appearance?

According to Wakefield, the HDA is already implicit in the definition provided by Spitzer and Endicott: "The heart of Spitzer and Endicott's (1978) definition of disorder is the insight that a disorder is a harmful dysfunction" (Wakefield 1993, 163). The whole LO paper aims at revealing this core intuition contained in the long and clumsy operational definition. Wakefield patiently analyzes every single passage of the 1978 definition to show that there is extensive redundancy and obscurity in the proposed criteria and that the sole concept of "dysfunction" can efficiently resolve all the ambiguities. Wakefield seems at times to hesitate between hermeneutics (What are the implicit assumptions in the text?) and recommendations (How could we improve the proposed definition?), but his conclusion is univocal: by focusing too exclusively on the reliability of their criteria, the two authors have sacrificed the conceptual validity of the definition.

There is no room here to provide a complete exegesis of the 1978 definition. I will only contradict Wakefield's interpretation concerning the alleged centrality of the "dysfunction requirement" in the text. It is true that the notion of "an inferred or identified organismic dysfunction" is introduced at the beginning of the long twenty-five-page chapter as one of the three "fundamental concepts" in the notion of a medical disorder, alongside "negative consequences of the condition" and "implicit call for action" (Spitzer and Endicott 1978, 17). Furthermore, the "highly abbreviated form" of the definition of medical disorder—provided without much comment at the end of the introduction—integrates these three consensual dimensions of the pathological phenomenon as a medical entity (disease), a personal suffering (illness), and a sick role (sickness).

The abbreviated definition presents an undeniable resemblance with Wakefield's HDA. And this may explain why Wakefield has been unwittingly misled into a faulty reconstruction of the text. He indeed interprets the text as following a "three-step procedure" (Wakefield 1993, 162) where the abbreviated definition of "medical disorder" played a primitive role, before its application to the special case of "mental disorder" (step 2) and the final elimination of the notion of dysfunction in the operational definition (step 3). In this light, Wakefield concludes, while the term "dysfunction" has disappeared, "in effect the third step constituted an analysis of dysfunction" (Wakefield 1993, 162).

I think a more accurate interpretation of the text is to consider that the abbreviated definition came at the end rather than at the beginning of the process. The authors first refined and expanded the Spitzer and Wilson (1975) operational definition and tried in

a second step only to summarize the result into a highly abbreviated form. If we accept this interpretation, as we shall see, the "dysfunction requirement" appears to be much less crucial than Wakefield thinks.

To begin with, consider the fact that the operational definition of "medical disorder" by Spitzer and Endicott incorporates all the criteria from the previous definition. Central in the first new criterion (criterion A) are the "three Ds": "Distress," "Disability" (i.e., generalized impairment), and "Disadvantage" (which replaces and broadens the "harmful voluntary behavior" criterion from the 1975 definition—I will comment on this important shift later). The criterion of clinical distinctness (criterion D) remains mostly the same. So the real novelty is the addition of two monothetic criteria: to summarize, a "largely within the organism" criterion (criterion B) and a "necessary price" criterion (criterion C). As it clearly appears through the authors' comments, these two criteria have been introduced in order to immunize the new broader and more ambitious definition against some important common counterexamples: distress or disability that directly results from a noxious environment—like "poverty," "irritable wife" [*sic*], "lack of opportunity in job advancement"—and distress or disability, which appears are the "necessary price for some positive goal" (like in "warranted pregnancy") (Spitzer and Endicott 1978, 28–29). In other words, criteria B and C *complete* the definition in order to exclude conditions that are clearly not pathological. By reconstructing the original intents of the authors behind criterion choice, my ambition is not to deny the growing importance of the notion of internal dysfunction. It is simply to highlight the fact that the notion of dysfunction does not constitute a primitive or a core intuition in the definition.

The latter point becomes even more evident when one focuses on the structure of the first criterion (A). There is indisputably a hierarchy introduced between the three Ds. The first two subcriteria ("distress," always introduced in the first place in all accounts, and "disability," broadly understood as "some impairment in functioning in a wide range of activities"[5]) still do not attach special importance to the notion of dysfunction. Concerning the third new subcriterion, "disadvantage," it is interesting to note that its first consideration by Spitzer can be traced back to 1976. This was not out of a broad reflection on the concept of medical disorder but specifically in order to resolve some special issues raised by the Sexual Disorders Subcommittee during the construction of the *DSM-III* (Decker 2013, 160). It is furthermore crucial for our interpretation to point out that "disadvantage" is explicitly held to be the "most controversial" criterion in the definition (Spitzer and Endicott 1978, 23). In this regard, there is an important concession in the definition that Wakefield fails to report: "It should be noted that if criterion A is met only by virtue of A.3, disadvantage, the designation of the condition as a disorder is *heavily dependent on social definitions of the degree of disadvantage or undesirableness*, as well as other considerations, as to the consequences of considering the condition as a medical disorder" (Spitzer and Endicott 1978, 21, my emphasis). This

quotation should be read in conjunction with the following one, where we find the only mention of the notion of "organismic dysfunction"[6] in the operational definition: "The following forms of disadvantage, even when not associated with distress or disability, *are now considered, in our culture*, as suggestive of some type of organismic dysfunction warranting the designation of medical disorder" (Spitzer and Endicott 1978, 20, my emphasis).

Wakefield will interpret a similar phrase in the *DSM-III-R*[7] as a faulty concession to relativism (Wakefield 1992b, 234). I rather interpret this as an argument that "organismic dysfunction" plays a contentious and subaltern role in the definition. This is something like a *last resort* criterion, fragile and value laden, when physicians have to justify the inclusion in the pathological domain of certain contentious conditions without any clear distress or generalized impairment: "There is an extremely small number of conditions generally regarded as medical disorders which are not directly and intrinsically associated with either distress or disability. … For these reasons, all the conditions considered medical disorders on the basis of the criterion *alone* [i.e., disadvantage] are the ones that are most apt to be a source of intense controversy, particularly those regarded as mental disorders" (Spitzer and Endicott 1978, 24).

If such cases are controversial, it is not because—as a straightforward interpretation of the HDA would suggest—these conditions do not apply to *both* components of the concept (a dysfunction *with* harmful consequences).[8] It is rather because the "organismic dysfunction" reference *by itself* is held to be a fragile criterion. To provide just one proof that dysfunction is not an essential component of the 1978 definition, see how Spitzer, with evident satisfaction, justifies the usefulness of his definition by applying it to "tobacco use disorder." According to him, this is not only a predisposing condition to a medical disorder but a truly mental disorder to be included in the *DSM-III* by virtue of criterion A.1 (distress) or A.3.d ("Atypical and inflexible sexual or other impulse-driven behavior which often leads to painful consequences") of the definition (Spitzer and Endicott 1978, 33). How can we explain that Spitzer is concerned only by the harmful consequences of heavy tobacco use and at no stage of his argumentation by the alleged presence of an "organismic dysfunction"?

To conclude, the supposed centrality of the notion of dysfunction in the 1978 definition does not withstand close examination. Wakefield is wrong when he claims that Spitzer and Endicott "specifically and exhaustively addressed the dysfunction requirement" in their definition (Wakefield 1993, 160). Moreover, I strongly disagree with him when he adds that "there is a hint that the evolutionary model of natural functions is accepted by Spitzer as the basis for attributions of dysfunction" (Wakefield, 1992b, 236; see also Wakefield 1993, 164). Evolution plays strictly no role in any part of the chapter. This is a somewhat excessive interpretation.[9]

What is, however, clear is that the 1978 definition has been deeply influenced by the refinement of the biological arguments defended by such authors as Scadding (1967),

Kendell (1975), and Klein (1978). Slightly perceptible also is the growing influence of arguments from the flourishing field of philosophy of biology. In the mid-1970s, biological function became a hot philosophical topic, to which Larry Wright (1973), Robert Cummins (1975), and Christopher Boorse (1975)[10] were leading contributors. It is not surprising that it progressively infused the psychiatric debate.

III. HDA in the Light of *DSM*

Our brief historical reconstruction has consisted up to now in mitigating Wakefield's strong claim that the notion of "dysfunction" was a central intuition in the definition of Spitzer and Endicott (1978). In this last section, I draw some important conclusions regarding three claims made by Wakefield: (1) the idea that there is a "basic error" in the *DSM*, in the sense of a discrepancy between its general conceptual strategy and the specific solutions it offers; (2) the idea that the concept of mental disorder underpins the "foundation" of the *DSM*'s theory-neutral strategy; and (3) lastly, and more fundamentally, the idea that the HDA exhibits a "widely shared concept, intuitive medical and lay concept" of mental disorder that had already been accepted long before the *DSM* era.

3.1 The "Basic Error" of the *DSM* Concerning the Dysfunction Requirement

The two constant and central criteria in the successive attempts by Spitzer and his colleagues to provide a definition of mental disorder are "subjective distress" and "disability" (i.e., generalized impairment). Even though much complexity developed around the definition, the conceptual strategy remained the same.

This conclusion strongly contrasts with Wakefield perceiving a "dramatic" difference between the 1978 account and the *DSM-III-R* definition.[11] According to him, by focusing on statistical concepts, the *DSM-III-R*'s definition "fails to match the dysfunction requirement that inspired it" (Wakefield 1992a, 381). But actually, it has never inspired it, so it does not go against its main purpose when it puts all the emphasis on "unexpectable distress and disability."

This is a very important consideration for clarifying the whole relation between the HDA and the *DSM*, since Wakefield thinks there is a gap between the (correct) conceptual structure of the *DSM* and its (too frequent) faulty realization. Wondering about the *DSM* system, Wakefield deplored that its "basic error" has been to "pay insufficient attention to the 'dysfunction' requirement" (Wakefield 1997, 652):

> I believe that this conflict within *DSM* is derived from a conflict within the views of the one person who more than anyone else influenced the conceptual structure of *DSM*, Robert Spitzer. The conflict is between Spitzer's sophisticated analysis of the concept of mental disorder (Spitzer & Endicott 1978), from which the *DSM* definition is derived, and his belief that specific disorders must be defined in terms of their symptomatic effects, from which *DSM* diagnostic criteria are derived. (Wakefield 1997, 643)

He thus claims that there is a conflict within the *DSM* and, more precisely, in Spitzer's views. In reality, there has never been any conflict of the sort. Spitzer's main focus, both in his definitional work and in the characterization of specific disorders, has always been the symptomatic effects. And the same can be said for the vast majority of the experts involved in the *DSM* Task Force. Wakefield himself recognizes that the whole classification rests on a strategy that does not pay the slightest attention to the dysfunction requirement:

> We can reason backward from the criteria for specific mental disorders to the definition of mental disorder that would make sense of them. Such an examination reveals that the concept of dysfunction plays no direct role in the formulation of specific diagnostic criteria in *DSM-III-R*. In no criterion do we find, for instance, a clause like "the distress must have been caused by a dysfunction in the person" or any other reference to the existence of a dysfunction. (Wakefield 1992b, 236)

I could not agree more. But this is an argument that reinforces my interpretation that the dysfunction requirement has never been operant in the minds of the *DSM* architects. The diagnostic criteria in the *DSM* have always been consistent with the spirit of the general definition directed toward "unexpectable distress and disability."

3.2 The Foundation of the *DSM* Atheoretical Strategy

Another important consequence of our historical reconstruction concerns the appreciation of the purely descriptive strategy brought forward by the *DSM-III*. Wakefield is right to state that there is a strong congruence between the *DSM* atheoretical strategy and the theoretical neutrality of the HDA. This is perhaps the strongest common point between the *DSM* and the HDA. But whereas I agree with him on the consideration that "philosophy of science supports use of a theory-neutral nosology for now" (Wakefield 1999b, 963), I nevertheless disagree on the idea that the concept of disorder is at the "foundation" of the *DSM*'s theory-neutral nosology (Wakefield 1999c, 1001). Wakefield confounds the "is" and the "ought" when he says that "a theory-neutral manual of mental disorders must rely heavily on the concept of disorder to provide a criterion for inclusion and exclusion of conditions. … Its use of symptoms and other theory-neutral resources to define disorders is guided only by the requirements of the concept of disorder" (Wakefield 1999c, 1003).

With the noteworthy exception of Robert Spitzer, who was always convinced of the necessity of a general definition of mental disorder and praised its usefulness for certain critical decisions (Spitzer and Endicott 1978, 16; Spitzer et al. 1980, 153), very few psychiatrist experts involved in the *DSM* process have ever been convinced that an overarching definition of mental disorder would be needful or even useful (see, e.g., Frances 2013; American Psychiatric Association 1994, xxi). Historically, the "descriptive approach" was developed in the psychiatric field before and quite independently

of the search for a general definition of mental disorder. When, in 1959, Erwin Stengel was already praising the usefulness of operational definitions in psychiatry, he was explicitly encouraging a "frankly practical and utilitarian attitude to psychiatric classification" (Stengel 1959, 612). And it was the same crucial concern (i.e., the improvement of the extremely low reliability of psychiatric diagnoses) that, during the 1970s, guided the development of the Feighner criteria (Feighner et al. 1972) and later the Research Diagnostic Criteria (Spitzer et al. 1978). These historical considerations do not of course invalidate Wakefield's central argument that, in any case, a theory-neutral nosology has to rely on some underlying general notion of mental disorder. But actually, for the most part, professional experts did not—and still simply do not—care about what Wakefield calls "conceptual validity." Furthermore, there is little evidence that they all share the exact same notion of mental disorder. This is indeed deplorable, but it is a fact.

3.3 HDA in the Broad Historical Perspective

Throughout his impressive academic work, there are very few papers where Wakefield does not mention the *DSM* at all. The centrality of the American classification is logical in the sense that since 1980, it has constituted the second most frequently used diagnostic system worldwide, just behind the *International Classification of Diseases* (*ICD*) by the World Health Organization (WHO). Moreover, since 1992 and the publication of the *ICD-10*, the two systems, *DSM* and *ICD*, have shared the same methodological grounds.

However, from a broader historical point of view, it should be noted that the universality of the *DSM* approach in psychiatry is recent and fragile, as attested by the recurrent appeals for a "paradigm shift" and by the enthusiasm for the Research Domain Criteria (RDoC) project launched by the National Institute of Mental Health (NIMH). Wakefield has been repeatedly critical of the many conceptual flaws that taint the *DSM* classification. He has nevertheless defended the *DSM* against radical behaviorists (Wakefield 2003), proponents of dimensional approaches (Wakefield 1997), or RDoC advocates (Wakefield 2014).

Wakefield's HDA is based on the fundamental assumption that the concept of mental disorder is a "widely shared concept, intuitive medical and lay concept" (Wakefield 1999a, 375). As we have seen, there is no evidence that the HDA was implicit from the start in the *DSM*.[12] Might there be more evidence that the HDA was implicit in pre-*DSM* classification systems? Does Wakefield really think that, despite the many hesitations and theoretical reversals in the long run, the concept of mental disorder has retained a fixed meaning? In other words, does the functional account of mental disorder correspond to a traditional view that has remained constant throughout history? Wakefield's "black box essentialism" account suggests that it does: "Disorder is commonly

conceived as failure to function (*dysfunction*), so Aristotle's claim that reason is the function of a human being can be considered a progenitor of the common view that mental disorder often consists of a breakdown in the capacity for rational thought and action" (Wakefield 2000, 18). Wakefield thinks that the same broad fixed intuitive meaning runs from Aristotle through Albert Ellis, Sigmund Freud, and the *DSM*. His essentialist account conflicts both with constructivist accounts and with Meehl's conciliatory conception of "open concepts" (Wakefield 2004). For sure, many functional "hints" can be found in the classical psychiatric literature, as in all medical history. We do not have to espouse Foucault's skeptical claim when he says that "the very notion of 'mental illness' is the expression of an attempt doomed from the outset" (Foucault 1976, 76). Still, many historians would acknowledge with Foucault that "in fact, before the nineteenth century, the experience of madness in the Western world was very polymorphic; and its confiscation in our own period in the concept of 'illness' must not deceive us as to its original exuberance" (Foucault 1976, 65–66).

Wakefield's essentialist account takes a charitable view of the scientific intention of psychiatry back to its birth. But the all-embracing ambition of the HDA does not account for all the nonaccidental differences of meaning and contextual variations scattered throughout classical psychiatric literature. For instance, the HDA does not explain why moral depravation modeled so many accounts up to the end of the nineteenth century. It would be a mistake to relativize the importance of such moral considerations that were built into the very conception of madness—and that by the way are still highly associated with the notion of mental disorder nowadays. To try to explain this core importance on the basis of a (wrongful) functional attribution by nineteenth-century alienists would just lead to a huge historical misunderstanding. The risk of the HDA account, from a historiographical point of view, is to fall into what we can call "Whig history" (i.e., the tendency to interpret history as the continuing and inevitable victory of progress over error). Wakefield is obviously right when he writes, "Cultures can be wrong about whether a condition is a disorder or normal, as Victorian physicians were wrong to think that clitoral orgasm was a disorder, ante-bellum confederate U.S. physicians were wrong to think that slaves who ran away from their slavery were disordered" (Wakefield 2007, 155).

It is not a risky claim to say that clitoral orgasm and drapetomania were once wrongly conceived as mental disorders, since the ideological motivations are easy to reconstruct. By contrast, it is a more difficult task to historically investigate conditions such as pathological infantilism (Ribot 1896), childish character (Dupré 1903), or the diagnosis of dependent personality disorder in *DSM-III* (American Psychiatric Association 1980, 324). There is a historical relation in the conceptualization of these three labels that could remain obscure if one looks only at the "conceptual validity" (according to the HDA) of each construct taken separately.

Concluding Remarks

In this chapter, I have shown that Wakefield is somewhat overeager to detect a "dysfunction requirement" central in the *DSM* definition. In his zeal to defend the relevance of his own conceptual approach, he has inadvertently overstated the presence and meaning of the term "dysfunction" in the short *DSM-III* definition of mental disorder. This mistake reveals two important consequences regarding both the *DSM* and the HDA. First, Wakefield appears to be too confident in the overall conceptual validity of the *DSM* atheoretical project. Second, he neglects the fact that the *DSM*, given its historical and ideological background, is far from being able to provide a sound and stable reference for the defense of a universal and ahistorical notion of mental disorder.

It is important to point out that my demonstration does not constitute a direct attack on the conceptual relevance of the harmful dysfunction analysis. I agree with Jerome Wakefield on the fact that psychiatrists should be more concerned by the conceptual validity of the medical entities that they promote. As a philosopher, Wakefield has done a great job in convincing contemporary psychiatrists about this specific importance. Be that as it may, this concern about conceptual validity is quite new in the psychiatric profession and it is not prevalent, even today. This may attest to the still "incredible insecurity of psychiatric nosology" (Kendler and Zachar 2008), rather than the existence of a universally shared pretheoretical notion of mental disorder.

Appendix

1973: *DSM II*

Spitzer position statement for the American Psychiatric Association in "Homosexuality and Sexual Orientation Disturbance: Proposed Change in the *DSM-II*, 6th Printing":

"For a mental or psychiatric condition to be considered a psychiatric disorder, it must either regularly cause subjective distress, or regularly be associated with some generalized impairment in social effectiveness or functioning. With the exception of homosexuality (and perhaps some of the other sexual deviations when in mild form, such as voyeurism), all of the other mental disorders in *DSM-II* fulfill either of these two criteria."

1975: Spitzer and Wilson

(a) Preprint version

"I. The manifestations of the condition are primarily psychological and involve alterations in behavior. However, it includes conditions which are manifested by somatic changes (e.g., psycho-physiologic reactions) if an understanding of the etiology and course of the condition is largely dependent on the use of psychological concepts, such as personality, motivation, and conflict.

II. The condition in its full blown state is regularly and intrinsically associated with either:
   a. Subjective distress, or
   b. Generalized impairment in social effectiveness or functioning, or
   c. Voluntary behavior that the subject wishes he could stop because it is regularly associated with physical disability or illness
III. The condition is distinct from other conditions in terms of clinical picture, and ideally, follow-up, family studies and response to treatment."

(b) Published version

"1. The manifestations of the condition are primarily psychological and involve alterations in behavior. However, it includes conditions which are manifested by somatic changes, such as psycho-physiologic reactions, if an understanding of the cause and course of the condition is largely dependent on the use of psychological concepts, such as personality, motivation, and conflict.
2. The condition in its full blown state is regularly and intrinsically associated with subjective distress, generalized impairment in social effectiveness or functioning, or voluntary behavior that the subject wishes he could stop because it is regularly associated with physical disability or illness.
3. The condition is distinct from other conditions in terms of clinical picture and, ideally, follow-up, family studies, and response to treatment."

1978: Spitzer and Endicott

(a) Definition of medical and mental disorder in a "highly abbreviated form"

"A medical disorder is a relatively distinct condition resulting from an organismic dysfunction which in its fully developed or extreme form is directly and intrinsically associated with distress, disability, or certain other types of disadvantage. The disadvantage may be of a physical, perceptual, sexual, or interpersonal nature. Implicitly there is a call for action on the part of the person who has the condition, the medical or its allied professions, and society.

A mental disorder is a medical disorder whose manifestations are primarily signs or symptoms of a psychological (behavioral) nature, of if physical, can be understood only using psychological concepts."

(b) Operational definition

"All four criteria, A through D, must be met for a condition to be designated as a medical disorder. It should be noted that if criterion A is met only by virtue of A.3, disadvantage, the designation of the condition as a disorder is heavily dependent on social definitions of the degree of the disadvantage or undesirableness, as well as other considerations, as to the consequences of considering the condition a medical disorder.

A. The condition, in the fully developed or extreme form, in all environments (other than one especially created to compensate for the condition), is directly associated with at least one of the following:
   1. Distress—acknowledged by the individual or manifested,
   2. Disability—some impairment in functioning in a wide range of activities,

3. Disadvantage (not resulting from the above)—certain forms of disadvantage to the individual in interacting with aspects of the physical or social environment because of an identifiable psychological or physical factor.

   The following forms of disadvantage, even when not associated with distress or disability, are now considered, in our culture, as suggestive of some type of organismic dysfunction warranting the designation of medical disorder:

   a. Impaired ability to make important environmental discriminations.
   b. Lack of ability to reproduce.
   c. Cosmetically unattractive because of a deviation in kind, rather than degree, from physical structure.
   d. Atypical and inflexible sexual or other impulse-driven behavior which often leads to painful consequences.
   e. Impairment in the ability to experience sexual pleasure in an interpersonal context.
   f. Marked impairment in the ability to form relatively lasting and nonconflictual interpersonal relationships.

B. The controlling variables tend to be attributed to being largely within the organism with regard to either initiating or maintaining the condition.

   Therefore, a condition is included only if it meets both of the following criteria:

   1. Simple informative or standard educational procedures do not lead to a reversal of the condition.
   2. Nontechnical interventions do not bring about a quick reversal of the condition.

C. Conditions are not included if the associated distress, disability, or other disadvantage is apparently the necessary price associated with attaining some positive goal.

D. Distinctness from other conditions in one or more of the following features: clinical phenomenology, course, response to treatment, familial incidence, or etiology."

1980: *DSM-III*

"In *DSM-III* 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 typically associated with either a painful symptom (distress) or impairment in one or more important areas of functioning (disability). In addition, there is an inference that there is a behavioral, psychological, or biological dysfunction, and that the disturbance is not only in the relationship between the individual and society. (When the disturbance is *limited* to a conflict between an individual and society, this may represent social deviance, which may or may not be commendable, but is not by itself a mental disorder.)"

1987: *DSM-III-R*

"In *DSM-III-R* each of the mental disorders is conceptualized as a clinically significant behavioral or psychological syndrome or pattern that occurs in a person and that is 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. In addition, this syndrome or pattern must not be merely an expectable response to a particular event, e.g., 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 person. 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 person, as described above."

1994 and 2000: *DSM-IV* and *DSM-IV-TR*

Same definition than in *DSM-III-R*, but with the preceding mention:

> "Although this manual provides a classification of mental disorders, it must be admitted that no definition adequately specifies precise boundaries for the concept of 'mental disorder.' The concept of mental disorder, like many other concepts in medicine and science, lacks a consistent operational definition that covers all situations. All medical conditions are defined on various levels of abstraction—for example, structural pathology (e.g., ulcerative colitis), symptom presentation (e.g., migraine), deviance from a physiological norm (e.g., hypertension), and etiology (e.g., pneumococcal pneumonia). Mental disorders have also been defined by a variety of concepts (e.g., distress, dysfunction, dyscontrol, disadvantage, disability, inflexibility, irrationality, syndromal pattern, etiology, and statistical deviation). Each is a useful indicator for a mental disorder, but none is equivalent to the concept, and different situations call for different definitions.

Despite these caveats, the definition of *mental disorder* that was included *in DSM-III* and *DSM-III-R* is presented here because it is as useful as any other available definition and has helped to guide decisions regarding which conditions on the boundary between normality and pathology should be included in DSM-IV."

2013: *DSM-5*

"A mental disorder is a syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. Mental disorders are usually associated with significant distress or disability in social, occupational, or other important activities. An expectable or culturally approved response to a common stressor or loss, such as the death of a loved one, is not a mental disorder. Socially deviant behavior (e.g., political, religious, or sexual) and conflicts that are primarily between the individual and society are not mental disorders unless the deviance or conflict results from a dysfunction in the individual, as described above."

Notes

1. All these definitions can be found in the appendix at the end of the chapter. The reader is invited to compare them carefully in order to follow our demonstration.

2. In the same way, it would be difficult to find such an account later when Spitzer writes, in 1980, "With this definition (the *DSM-III* definition) it becomes clear (at least to us) that the issue

is not one of *factual* matters about homosexuality, such as whether or not certain familial patterns predispose to the development of the condition, but rather a *value* judgment about the importance of heterosexual functionings" (Spitzer et al. 1980, 154). It is striking that what Spitzer considers "factual matters" here do not refer to any putative internal dysfunction but only to some epidemiological data as evidence of familial predisposition.

3. "Many expected that the logic of the 1973 decision to delete homosexuality from the classification of mental disorders would lead the task force on *DSM-III* to define Necrophilia as a disorder only if the individual complained of the symptom!" (Spitzer et al. 1980, 154).

4. A confirmation of this absence can be found in the rationale that Spitzer provides in 1975 to exclude the possibility, at a time envisaged, that "racism" may constitute a mental disorder: "the racist is not necessarily in either distress or having difficulty with his general functioning, even though he makes others miserable" (from Decker 2013, 157–158).

5. It is important to correctly interpret the "wide range" requisite, which explicitly demands that "there is impairment in more than one area of functioning" (Spitzer and Endicott 1978, 23). Contrary to Wakefield, who considers that "it is not disability but how it is caused that makes it pathological" (Wakefield 2009, 87), Spitzer clearly assumes here that what matters is disability itself (i.e., the general impairment of the patient in his or her daily life). The following passage proves that the emphasis is not put on the causal internal attribution of a dysfunction: "As a consequence of the requirement of generalized impairment, it is possible for a condition to be associated with impairment in a single function but not be classified as a disorder, providing that the condition does not result in any of the other two Ds" (Spitzer and Endicott 1978, 23).

6. Just as Wakefield was right to consider that the mere use of the term "dysfunction" in the diagnosis of POD proposed by Masters and Johnson was not indicative of an underlying theory of natural functions, I think that an accurate interpretation of the term here excludes such an indication. Actually, I believe that the emphasis in "organismic dysfunction" should be placed on *organismic* rather than on *dysfunction*. The difference is subtle but decisive. The term "organismic dysfunction" is taken in the text as a strict synonym of "any disturbance within the organism." As it appears through the examples discussed by Spitzer and Endicott, what matters is to assign a "locus" to the disorder (i.e., "largely within the organism"), not to involve a putative natural function. Retrospectively, Spitzer will concede that his idea that "something is not working in the organism" was not very clear in his mind (Spitzer 1999, 431).

7. "Whatever its original cause, *it must currently be considered* a manifestation of a behavioral, psychological, or biological dysfunction in the person" (American Psychiatric Association 1987, xxii, my emphasis).

8. Contrary to Wakefield's HDA, Spitzer's definition does not rely on the integration of two distinctive components; instead, it is based on a fundamental alternative. As he will explain retrospectively, "It became clear to me that the consequences of a condition, *and not* its etiology, determined whether or not the condition should be considered a disorder… I therefore proposed that the criterion for a mental disorder was either subjective distress or generalized impairment" (Spitzer 1987, 404, my emphasis).

9. Wakefield's argumentation is based on a quotation where Spitzer and Endicott acknowledge that their approach is close to Donald Klein's, proposed in the same volume. But it should be noted that Spitzer disagreed with Klein's insistence that "all legitimate usages [of the term "illness"] imply actual dysfunction" (Klein 1978, 48). It is on the homosexuality issue that this disagreement appears clearly: Spitzer contradicts Klein's argument that homosexuality, even when it is not associated with subjective distress, is a disease since it "demonstrates operationally an intrinsic involuntary incapacity," that is, a natural dysfunction (Klein 1978, 65). In any case, Wakefield's HDA has always been closer to Klein's than to Spitzer's position.

10. Spitzer and Endicott do not reference this influential paper. Boorse specifically addressed the psychiatric debate from the point of view of a philosopher of biology and provided the first clear defense of an objectivist account of disorder based on the notion of biological function.

11. "Despite the historical relation between the two definitions, Spitzer and Endicott's (1978) definition is dramatically different from *DSM-III-R*'s in its conceptual strategy" (Wakefield 1993, 160). Wakefield tends to overestimate the difference between the *DSM-III-R*'s definition summarized by him as "unexpectable distress and disability" and Spitzer and Endicott's definition, which was said to have "eschewed the statistical approach." Actually, exactly the same statistical concerns can be found in the two proposals.

12. But we do not mean that the HDA has not influenced the subsequent editions of the *DSM*. It is interesting to note in the recent definition of mental disorder provided by the *DSM-5* that, for the first time in the history of the manual, "distress" and "disability" are relegated to a subsidiary position, after the presence of a dysfunction. It is very likely that the members of the *DSM-5* Task Force accepted the following specific recommendation made by Wakefield and First to Stein and colleagues (2010): "Because of the centrality of the 'dysfunction' criterion to the logic of the definition, we also suggest moving this criterion up to appear as the second sentence, immediately following criterion A" (First and Wakefield 2010, 1781).

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Defining Mental Disorder

Jerome Wakefield and His Critics

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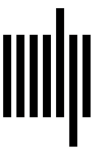

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