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2 From Ribot and Dupré to Spitzer and RDoC: Does the Harmful Dysfunction Analysis Possess Historical Explanatory Power? Reply to Steeves Demazeux

Jerome Wakefield

I thank my dear friend Steeves Demazeux for his challenging critique of the historical validity, from Dupré and Ribot through to Spitzer and Research Domain Criteria (RDoC), of my harmful dysfunction analysis (HDA) of medical, including mental, disorder. The HDA claims that "disorder" refers to "harmful dysfunction," where dysfunction is the failure of some feature to perform a natural function for which it is biologically designed by evolutionary processes and harm is judged in accordance with social values (First and Wakefield 2010, 2013; Spitzer 1997, 1999; Wakefield 1992a, 1992b, 1993, 1995, 1997a, 1997b, 1997c, 1997d, 1998, 1999a, 1999b, 2000a, 2000b, 2001, 2006, 2007a, 2009, 2011, 2014, 2016a, 2016b; Wakefield and First 2003, 2012). Demazeux's systematic presentation in the first part of his paper of Robert Spitzer's successive attempts to define mental disorder immediately becomes an essential source for those reconsidering Spitzer's momentous definitional efforts in the course of his attempts to eliminate homosexuality as a category of disorder and create a new approach to psychiatric diagnosis. I am also grateful to Demazeux for excavating some of my early sexuality papers in which the notions leading to the HDA were gestating. Being reminded of these papers in the context of reconsidering Spitzer's conceptual efforts arouses some emotion. It was Spitzer's reading of one of those sexuality papers evaluating the efforts of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*) efforts to define female orgasmic dysfunction (Wakefield 1988) that caused Spitzer to contact me to discuss my work, and this meeting led to our subsequent scholarly collaboration and friendship until his death in late 2015.

Demazeux's goal is not to do history for history's sake. Rather, his analysis of Spitzer's work is aimed at challenging my claim that Spitzer's definition already contained an inchoate version of the HDA's "dysfunction" component and thus denying me a piece of evidence I have presented in support of the widespread nature of HDA-type intuitions. Moreover, in the second part of his paper, Demazeux attempts to parlay the Spitzer analysis into a broader historicist critique of my claim that the HDA captures a widespread historical understanding of the concept of medical disorder by exploring several other historical examples. Demazeux admits that no historical argument

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like this by itself can refute the HDA, which must ultimately be judged on conceptual grounds ("I acknowledge that the philosophical relevance of the HDA should be considered solely in the light of conceptual arguments"). However, he holds that his argument "impacts significantly on the postulated existence of a 'common pretheoretical concept of mental disorder' shared by professionals," thus paving the way for a broader historicist critique of the HDA. I will consider these two aspects of his paper in turn.

Demazeux versus Wakefield on How to Think about the 1975 Spitzer and Wilson Definition

As Demazeux explains, Spitzer initially made two brief attempts in 1973 and 1975 to formulate a definition of mental disorder in connection with the debate over the diagnostic status of homosexuality. I agree with Demazeux that these definitions were formulated strictly in terms of the negative consequences of a condition, specifically distress or generalized role impairment. I also agree that these early definitions made no use of "function" in the HDA biological design sense. When they did mention "function," it was only in a more general evaluative sense (e.g., as in "I am functioning effectively at work"). Demazeux, considering my choice to focus in my publications on Spitzer's later 1978 definition, laments, "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." There is no reason for regret because I agree with Demazeux's characterization.

The difference is in how we interpret these facts about Spitzer's early negative-consequence definitional attempts. Demazeux sees a basic intuition about the meaning of "disorder" that is divergent from the HDA and was sustained by Spitzer, whereas I see an obviously invalid initial approximation that was gradually corrected. In trying to understand the limitations of the 1973 and 1975 definitions and the subsequent changes in 1978, it is important to keep in mind that Spitzer was not a philosopher by training. He once told me he took no philosophy courses and only one course in logic in college. So, despite his clear natural talent for conceptual analysis, it is not surprising that he commits elementary mistakes in his initial attempts. Moreover, he was focused not on the perspicuity of the analysis but on justifying his decision regarding the elimination of homosexuality from the manual. His rejection of homosexuality as a mental disorder was based on the rationale that homosexuality need not directly (i.e., independently of oppressive social attitudes) give rise to distress or generalized impairment, and this rationale only depends on harmful consequences being a necessary condition for disorder. Thus, like so many of my students when they are learning to do conceptual analysis, he came up with a proposed necessary condition for disorder—negative consequences—that serves his purposes, but he fails to test systematically

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for counterexamples that would reveal the need for further necessary conditions to comprise a sufficient criterion. It is only in the 1978 definition that Spitzer took a leap forward as a conceptual analyst with his more sophisticated analysis that adds a dysfunction requirement. Demazeux says, "(a) the functional account was completely absent from the first two attempts, and (b) it gained a more important—but ambiguous not decisive—role in the subsequent attempts." I agree with "a," but "b" is manifestly incorrect; the role of dysfunction was decisive in the later definitions, as we shall see.

Indeed, I would hypothesize that Spitzer knew that his early definition of mental disorder in terms of a condition's consequences of distress or generalized impairment was seriously flawed but decided not at that time to open a conceptual-analytic can of worms because the early definition was adequate to accomplish his goal of defending his decision about homosexuality. Why do I say that Spitzer must have been aware of what he later acknowledged, that the harmful-consequences definition was inadequate? Spitzer may have been a neophyte at conceptual analysis, but he was a very sharp neophyte. The Spitzer-Wilson definition is subject to such obvious counterexamples to sufficiency—many nondisordered conditions cause distress, for example—that this must have been apparent to Spitzer. For example, when later, in his 1978 paper with Endicott, Spitzer mentions counterexamples to the 1975 definition, they include distress entailed by marital conflict. However, that obvious "distress" counterexample was already mentioned as a nondisorder—but not raised as a problem for the definition—in the 1975 paper. An entire category newly added to *DSM-II* by Spitzer himself, "conditions without manifest psychiatric disorder and nonspecific conditions," is described in the 1975 paper and is characterized as follows: "This category, not present in *DSM-I*, performs the function of encompassing the 'conditions of individuals who are psychiatrically normal but who nevertheless have severe enough problems to warrant examination by a psychiatrist.' These conditions are therefore not mental disorders" (1975, 844). One of the groups of conditions that are specified as falling under this category is "social maladjustment without manifest psychiatric disorder, such as marital or occupational maladjustment" (1975, 844). In writing those words, Spitzer could not be unaware that this posed a problem for his definition of mental disorder, although he did not face the problem until 1978.

Another piece of evidence lies in the definition of medical disorder that Spitzer and Wilson (1975) provide in passing. They are addressing the possible challenge that there is no formal definition of medical disorder in medical diagnostic manuals, so why does psychiatry need a definition of mental disorder? Their answer is that in physical medicine, there is good consensus over what determines disorder: "No definition is needed. Medical (nonpsychiatric) disorders are conditions associated with physical pain, disability, or death.…Consequently, persons with migraine headaches or painful, swollen, rheumatoid joints never insist that these conditions are normal and should not be classified as illnesses" (1975, 827). However, this "negative consequences" definition of

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physical disorder is manifestly invalid. The excruciating pain of childbirth, the discomfort of teething pain, and the painfulness of fatigue after extreme exercise do not make the respective conditions disorders. It is a conceptual-analytic neophyte's error to offer confirming instances (e.g., migraine, arthritis) as support for a conceptual claim rather than hunting for disconfirming instances. But surely Spitzer could not have failed to notice the obvious problem—which he does notice and address in 1978—even if he was not ready to alter his definitional approach at the time and did not need to do so in the context of the homosexuality debate because his argument there depended only on negative consequences being a necessary condition of disorder.

Demazeux versus Wakefield on How to Think about the Role of "Organismic Dysfunction" in the 1978 Spitzer and Endicott Definition and the *DSM-III* (1980) Definition

Spitzer and Endicott (1978) published a pivotal analysis in the run-up to *DSM-III* that at much greater length formulated the definition of mental disorder specifically as a form of medical disorder. In that analysis, they introduced the requirement that a condition must involve an "organismic dysfunction" to qualify as a disorder. The 1978 definition was the precursor for the much shorter definition of mental disorder that appears in Spitzer's (1980) introduction to the third edition of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-III*; American Psychiatric Association 1980). In slightly varying forms, it appears in all subsequent editions of the *DSM*, including *DSM-5*.

In two papers (Wakefield 1992b, 1993) that I published at about the same time as the paper in which I initially proposed the HDA (Wakefield 1992a), I analyzed and critiqued Spitzer's 1978 and 1980 definitions. I observed that although Spitzer and Endicott did not yet have an evolutionary understanding of dysfunction—Spitzer later admitted that he was quite baffled by the problem of how to explicate the idea that something has gone wrong inside the organism—they did make clear that "organismic dysfunction," which they intuitively expressed as "something has gone wrong with the organism," is a necessary condition for disorder. I interpreted their inclusion of the organismic dysfunction requirement as an inchoate precursor of the HDA's evolutionary dysfunction criterion and cited it in support of my claim that there are widespread intuitions consistent with the HDA.

Demazeux vigorously disputes my claim that an intuitive version of the HDA's "dysfunction" criterion played a role in the 1978 and 1980 definitions. He states that he will "contradict Wakefield's interpretation concerning the alleged centrality of the 'dysfunction requirement' in the text" and "highlight the fact that the notion of dysfunction does not constitute a primitive or a core intuition in the definition." His interpretation is that Spitzer's 1978 introduction of "organismic dysfunction" as

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a requirement for disorder is merely terminological window dressing, substantively continuous with earlier "negative consequence" definitions: "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." He acknowledges that the term "dysfunction" is introduced in 1978 for the first time into Spitzer's definitional attempts: "It is true that the notion of 'an inferred or identified organismic dysfunction' is introduced … as one of the three 'fundamental concepts' in the notion of a medical disorder, alongside 'negative consequences of the condition.'" He nevertheless argues that, despite the explicit "dysfunction" language, rather than inaugurating the inclusion of a novel dysfunction criterion, the 1978 paper and the subsequent *DSM-III* definition based on it have no affinity whatever to the HDA in this respect and that the dysfunction criterion is not intended in the sense I interpreted it. Rather, he claims, these definitions are simply using the language of dysfunction as a shorthand for harms like distress or impairment and are basically terminological variants of the 1973 and 1975 negative-consequence definitions.

Demazeux admits that the definition of medical disorder Spitzer and Endicott present has an uncanny structural resemblance to the HDA: "The abbreviated definition [of medical disorder] presents an undeniable resemblance with Wakefield's HDA." But, rather than accepting this fact as support for an affinity between the 1978 definition and the HDA, Demazeux interprets them as the explanation for why my interpretation so easily goes astray in my eagerness to see a connection: "This may explain why Wakefield has been unwittingly misled into a faulty reconstruction of the text. … Wakefield is somewhat overeager to detect a 'dysfunction requirement' central in the *DSM* definition." It seems worth mentioning that Spitzer himself seems to have been similarly misled, because he later endorsed the HDA and explained that the HDA captured what he was after but could not explicate when he used "dysfunction" to indicate that something has gone wrong with the organism (Spitzer 1997, 1999).

Understanding the Introduction of "Organismic Dysfunction" into the 1978 and 1980 Definitions as an Attempt to Eliminate Counterexamples to the 1975 Definition

It seems to have become clear to Spitzer after the *DSM-III* Task Force was formed in 1975 from criticisms by psychiatric colleagues that the definition of mental disorder must make clear why it is a subcategory of medical disorder if the definition was to accomplish the crucial task of legitimizing psychiatry as part of medicine. This in turn was critical for rebutting the arguments of the antipsychiatry movement that psychiatry illegitimately uses medical terminology in service of social control. The attempt to explain why "mental disorder" is best understood as a subcategory of "medical

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disorder" leads inexorably to a dysfunction requirement because, as we have seen (and will consider further below), the negative-consequence criterion obviously doesn't work as a stand-alone definition of physical disorder due to the many painful conditions that are not medical disorders.

The introduction of the "organismic dysfunction" requirement into the 1978 definition is in fact part of a coordinated introduction of three closely related novel elements aimed at addressing accumulating problems that made the earlier definitions inadequate to the demanding *DSM-III* context: (1) for the first time, there is a decision to analyze the more general concept of "medical disorder" and subsume mental disorder under the broader category as simply one type of medical disorder. (2) There is the introduction of "organismic dysfunction" as a fundamental requirement of medical and mental disorder. It is only causation by a dysfunction that is able to provide the needed distinction between true medical problems and other nondisordered causes of pain or disability. (3) For the first time, there is the use of the explanatory phrase that, in a disorder, unlike in problematic normal variation, "something has gone wrong" with the organism, which serves as a useful intuitive explication of the notion of dysfunction that Spitzer was unable to explicate more clearly; that is part of the HDA's contribution. These three features go together to yield a fundamentally new approach to the essence of medical and mental disorder and to address the counterexamples to the earlier negative-consequence definitions.

Demazeux interprets the 1978 and 1980 definitions with their reference to organismic dysfunction as essentially minor verbal variations on the 1975 analysis. However, the record indicates that Spitzer recognized, correctly, that the earlier definition was just plain wrong and the 1978 definition was aimed at correcting it. The fact that the 1978 analysis is a genuinely novel attempt and not just a verbal variation on the earlier definition is made clear in the paper itself. Spitzer and Endicott tell us that, far from simply repeating the essence of the earlier definitions, they are changing the definition in response to criticisms and deficiencies in the earlier definition: "We have continued to modify the definition to meet some of the criticisms received" (17); "We … hope that many of the deficiencies of the initial attempt have been corrected" (17). They explain that the impetus for reconsidering the definition of disorder is that the challenges of *DSM-III* require a more perspicuous definition than the one that sufficed for addressing the homosexuality debate: "As we considered the many conditions traditionally included in the nomenclature, we realized that … a broader definition seemed necessary" (1978, 16).

An impetus for the introduction of the organismic dysfunction criterion was the growing awareness and explicit recognition of many counterexamples to the negative-consequence definition. This concern is manifested throughout the 1978 paper. For example, at the outset of the 1978 paper, Spitzer and Endicott observe that there are obvious counterexamples to the simple definition of medical disorder as any condition

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that causes pain or certain other negative consequences, such as the pain of childbirth and the impairments of pregnancy: "Physicians rarely concern themselves with defining what is a medical disorder. … If questioned, they readily acknowledge that much of their work actually involves conditions which are generally not considered medical disorders, such as pregnancy or childbirth" (1978, 15). Again, after introducing "relative disadvantage" as an additional form of negative consequence that can sometimes indicate disorder, Spitzer and Endicott observe that there are many counterexamples to any attempt to use the disadvantage criterion as a stand-alone criterion because not all disadvantage is due to something being wrong with the organism: "Many conditions which place an individual at a relative disadvantage are not usually considered medical disorders, for example, short stature, tone deafness, greediness, poor sense of humor, unattractive appearance, and limited intelligence (but not mental retardation). Conditions such as these are usually regarded as the inevitable consequence of 'normal variation' rather than a result of 'something having gone wrong'" (24). Note that all of these negative conditions are "in the individual" and yet are not considered to be "something going wrong." The implication of these counterexamples is that the existence of negative consequences is one dimension of disorder and something going wrong as opposed to normal variation is another dimension, and both are requirements that must be fulfilled in order to have a disorder. So, contra Demazeux, "something is going wrong" must mean more than just "a condition in the individual has negative consequences" if it is to play its role of eliminating the counterexamples. The precise nature of that additional crucial meaning is not further elaborated by Spitzer and is explicated by the HDA's interpretation of dysfunction.

Demazeux's discussion suggests two ways that one might try to assimilate the novel phrase "organismic dysfunction" to something from past definitions that is not dysfunction in anything like an HDA sense. First, one might interpret "organismic dysfunction" with an emphasis on "organismic," as simply requiring that the problem be in the individual. Second, one might interpret "organismic dysfunction" as using "dysfunction" as a value term (e.g., "this marriage is dysfunctional") that just restates the fact that there are negative consequences.

There is a simple but strong argument against either of these interpretations. In carefully paring down the lengthy 1978 definition to yield the brief *DSM-III* definition, Spitzer, Williams, and Skodol (1980) note that "every word and comma was carefully examined" (153) in formulating the much-compressed *DSM-III* definition, which reads as follows:

> In *DSM-III*, a mental disorder is conceptualized as a clinically significant behavioral or psychologic 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, psychologic or biologic dysfunction and that the disturbance is not only in the relationship between the individual and society. (Spitzer 1980, 6)

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If, as Demazeux suggests, "organismic dysfunction" is not very important and was essentially redundant with "impairment of function," then in the radical shortening of the definition for *DSM-III*, one would not have expected the notion of dysfunction to survive the pruning. Yet, it not only survived but warranted its very own sentence, on a par with impairment of functioning. Indeed, "function" appears twice in this definition, first in the phrase "important areas of functioning (disability)," which is possibly a matter of negative consequences, and again in the phrase "behavioral, psychologic or biologic dysfunction," which has no apparent link to negative consequences. Given how carefully this definition reportedly was crafted, the two occurrences of "function" are unlikely to be mere sloppy redundancy; the second use presumably introduces a new idea. Moreover, the *DSM-III* definition states that to be a disorder, the condition must be "in the individual" and that it must cause distress or impairment, and then it states that "in addition, there is an inference that there is a behavioral, psychological, or biological dysfunction" (Spitzer 1980, 6). The phrase "in addition" indicates that the organismic dysfunction is different from either the harm or the location in the individual that is specified earlier in the definition. Finally, the harm and the location in the individual are manifest features "typically associated" with the condition, whereas the dysfunction is described as arrived at by inference, placing it in a different epistemological category. In any event, we have seen that by 1978, Spitzer understood that an internal condition with negative consequences is necessary but not sufficient for disorder and subject to counterexamples (e.g., grief, childbirth pain) because both normal and disordered distress and impairment are consequences that are in the individual. So, he understood that reiterating the in-the-individual or negative-consequence requirements would not address the definition's problems.

A close look at the 1978 paper reveals that Demazeux's central thesis that the notion of dysfunction is introduced as a superficial add-on with no intended important conceptual definitional role simply does not fit the paper's text. Spitzer and Endicott are quite explicit about the fundamental importance of the organismic dysfunction requirement, placing it on an equal footing with negative consequences, and make clear that it is introduced not as a stylistic variant but to address problems with the previous negative-consequence attempts. This is expressed quite clearly in an early section of the 1978 paper labeled "key concepts in the definition of medical disorder"—medical, not mental—and it begins:

> We believe that there are several fundamental concepts in the notion of a medical disorder: negative consequences of the condition, an inferred or identified organismic dysfunction, and an implicit call for action. There is no assumption that the organismic dysfunction or its negative consequences are of a physical nature. (1978, 17)

In analyzing the overarching concept of medical disorder, Spitzer and Endicott (1978) delineate "several fundamental concepts" in this notion—"fundamental," not superficial or redundant or unimportant. (I ignore the call to action as in fact redundant

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with negative consequences and in any event questionable on other grounds and later omitted by Spitzer in *DSM-III* and eventually explicitly disavowed [Spitzer, 1998].) The first fundamental concept is negative consequences, which includes distress, impairment, and disadvantage. Demazeux, implausibly, insists that this exhausts the essential meaning. The second fundamental concept, which is stated separately and distinguished from negative consequences, is organismic dysfunction. The next sentence, "There is no assumption that the organismic dysfunction or its negative consequences are of a physical nature," allows pluralism of etiological theory. It also makes clear that the pathological condition itself that has the negative consequences is in fact the organismic dysfunction and implies that the relationship between the organismic dysfunction and the negative consequences is a causal relationship, which, contra Demazeux, eliminates the possibility that the organismic dysfunction is just another way of specifying the negative consequences.

Relation of *DSM* Criteria to the Dysfunction Requirement

To buttress his case that dysfunction plays no role in *DSM* nosology, Demazeux calls me as a witness in my own prosecution, claiming that I assert that dysfunction plays no role in the formulation of specific diagnostic criteria:

> 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 1992, 236)

This is a misreading. Rather than stating that the *DSM* "does not pay the slightest attention to the dysfunction requirement," I state quite clearly that "the concept of dysfunction plays no *direct* role in the *formulation* of specific diagnostic criteria in *DSM-III-R*." I then go on to explain what I mean, namely, that unlike the definition that refers to dysfunction explicitly, in no diagnostic criterion do we find a direct and *explicit* reference to dysfunction, such as "the distress must have been caused by a dysfunction." Rather, the criteria capture dysfunction indirectly through the way the criteria are selected to reflect that something has gone wrong with the organism and to provide adequate grounds for inferring a dysfunction (First and Wakefield 2013), much as Spitzer and Endicott's operational criteria for mental disorder do in the 1978 paper.

This approach is understandable. Given the *DSM*'s goals of increasing reliability while retaining validity in diagnoses by working clinicians, simply referring to the abstract notion of dysfunction is a less attractive strategy than providing operationalized criteria sufficient for inferring the likely presence of a dysfunction. Every feature of the

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criteria, including durational requirements, symptom thresholds, the specific nature of the symptoms, and even contextual exclusions—for example, you don't have a sexual dysfunction if the reason you've never had an orgasm is lack of adequate stimulation (Wakefield and First 2012)—are all best understood as attempts to operationalize the distinction between dysfunction and nondysfunction (First and Wakefield 2013; Wakefield and First 2012). The many nuanced decisions about such criteria can best be explained as attempts to formulate criteria that indicate dysfunction in the HDA's sense.

Is RDoC a Threat to the HDA?

Despite having argued at length that the *DSM-III*'s definition of mental disorder and the HDA are conceptually unrelated, Demazeux nonetheless goes on to argue that the HDA's plausibility is in doubt because it is dependent on a link to the *DSM* approach, and the *DSM* approach itself is threatened as evidenced by calls for a *DSM-5* "paradigm shift" and the recent inauguration of the National Institute of Mental Health's (NIMH's) RDoC program seeking the brain etiologies of mental disorders: "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 recent enthusiasm for the RDoC project launched by the NIMH."

In fact, the HDA has no special dependence on *DSM*'s current theory-neutral approach to diagnosis. That approach is a pragmatic necessity thrust upon psychiatry by the lack of knowledge of etiology. The notion, raised in the revision process that led to *DSM-5*, of a "paradigm shift" that would incorporate pathophysiology and biomarkers into diagnostic criteria turned out to be premature and evaporated in the course of revising *DSM-5*. However, there was nothing in it antagonistic to the HDA. Indeed, such progress toward etiological criteria that explicitly identified the dysfunction in a disorder rather than using etiology-neutral symptom-based criteria to indirectly indicate dysfunction had been envisioned by Spitzer from the beginning. He states as much in the introduction to *DSM-III* that also contains the definition of disorder:

> The approach taken in *DSM-III* is atheoretical with regard to etiology or pathophysiological process except for those disorders for which this is well established and therefore included in the definition of the disorder. Undoubtedly, with time, some of the disorders of unknown etiology will be found to have specific biological etiologies, others to have specific psychological causes, and still others to result mainly from a particular interplay of psychological, social and biological factors. (Spitzer 1980, 7)

The *DSM-5* "paradigm shift" language was misleading and displayed a lack of understanding that theory-neutral criteria were created merely as a stop-gap against unreliability and invalidity given ignorance of the etiological essences of disorders. It is scientific progress, not a paradigm shift, to finally identify the long-sought essence of a phenomenon one has been studying.

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In any event, the potential "paradigm shift" has now become the task of RDoC. Given the reality of the lack of understanding of the hypothesized brain dysfunctions underlying mental disorders, even the RDoC website now disavows any intention of replacing standard diagnostic systems any time soon. We just don't know enough to do so. However, is Demazeux correct that in principle, the RDoC program's potential dethronement of the *DSM* etiology-neutral approach to diagnosis presents a basic challenge to the HDA?

Contrary to Demazeux's analysis, the *DSM* and RDoC approaches are equally consistent with the HDA. Nothing more clearly illustrates Demazeux's misunderstanding of the situation than the fact that leaders of the RDoC initiative themselves credit the HDA for being part of the inspiration for the initiative. One of the RDoC's primary developers and defenders, Bruce Cuthbert, includes in his standard PowerPoint slide set presenting the RDoC program the following slide: "RDoC: Conceptual Approach. Try to understand mental disorders in terms of deviations from normal functioning of psychological and neurobiological mechanisms. Cf. Wakefield, 'harmful dysfunction'" (Bruce Cuthbert, personal communication, May 27, 2015). Both the failed paradigm shift toward explicit pathophysiological underpinnings attempted in *DSM-5* and the current RDoC program's attempt to identify brain dysfunctions underlying mental disorders are entirely consistent with and indeed presuppose something like the HDA's account of disorder.

Demazeux seems to have been misled by the fact that in some sense, the RDoC program is (or was, as initially presented) "opposed" to *DSM*, and because the HDA explains *DSM*'s approach, the HDA must also be opposed by RDoC. Things don't work that way. Opposed views, if they are both views of disorder, will both be committed to an HDA conceptualization but opposed on other aspects of diagnosis. The ill-fated aspiration to a *DSM* "paradigm shift" as well as the current RDoC program has nothing to do with the concept of disorder per se and a lot to do with different approaches to identifying the dysfunctions required for disorder by the HDA.

The Historicist Challenge: Three Proposed Counterexamples to the HDA

Once Demazeux thinks he has established conceptual daylight between the core of Spitzer's 1978 and 1980 definitions and the HDA, this opens the historicist spigot and emboldens him to engage in a wider search for historical counterexamples to the HDA. Indeed, through his historicist-colored lens, Demazeux finds it beyond comprehension that I claim that human beings can share salient concepts across historical episodes, asking incredulously, "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?" The answer is "yes"; I believe the notion of disorder has been more or less constant since Hippocrates.

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Of course, theories of disorder and judgments about specific instances of disorder and nondisorder change over time for a variety of reasons, but the conceptual understanding of disorder—that is, the conceptual understanding of what is being asserted when one says that a given instance is or is not a disorder—can still remain constant over time. It is also true that in the history of views of mental pathology, there is much nonsense, and terms like "pathology" and its cognates are often used loosely and incorrectly as terms of abuse, exploiting the value component of disorder or denied as a means of liberation from medical categorization. However, the HDA implies that one can generally discern a harmful dysfunction structure behind such claims and counterclaims in serious discussions. There is no reason why one should see anything like such a correlation on Demazeux's ecumenical approach that allows sheer harm, which is everywhere, to determine disorder. I have offered examples: for example, conservative Victorian physicians claimed that female clitoral orgasm during intercourse is a disorder, whereas Masters and Johnson (1966) claim that lack of clitoral orgasm during intercourse is a disorder, and, as the HDA predicts, one finds that these opposite views represent not merely a relativistic historicist conceptual divide but two different theories of biological design that determine the opinion of what is a dysfunction. Similarly, the diagnosis of runaway slaves as having the disorder of drapetomania was not justified by an alternative account of disorder but through theories, common in the antebellum South, that those enslaved were naturally designed to be subservient.

Demazeux dismisses these examples in which mistaken diagnoses were justified by mistaken accounts of natural function and dysfunction and challenges me with his own examples that are supposed to illustrate the historical limitations of the HDA:

> 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 such conditions 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.

Demazeux appears here to take it as a criticism of the HDA that it does not cover various sociohistorical aspects of mental disorder judgments. However, the HDA is not designed to address such problems. Of course, I agree with Demazeux that there are endless historical insights and hidden influences and motives one might discover about disorder attributions that have nothing to do with conceptual validity or other conceptual issues related to the HDA. For example, social values and ideologies regularly determine what people think is natural functioning and dysfunction and can lead them to judge, often incorrectly, that various behaviors are disordered. The HDA is an account of the meaning of claims about disorder, not a theory of why such claims are made. Without an understanding of the concept of disorder of the kind provided by

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the HDA, sociological studies of shifting views of conditions as disorders or nondisorders are likely to be quite confused.

The relevant question is: Are the categories selected by Demazeux, two of which long antedate the *DSM*, counterexamples to the HDA, as he claims? I accept Demazeux's historicist challenge and examine whether the proposed counterexamples display an HDA structure that plausibly implies the presence of a dysfunction.

First, then, Ribot (1897/1903), writing of "the pathology of the moral sense," notes that one theory of criminality is "infantilism, which has recourse, not to heredity, but to arrested development, and alleges that the perversion which is permanent in the criminal is normal, but transient, in the child" (300). "Arrested development" in which what is transient in the child becomes fixated in the adult clearly refers to something going wrong with the natural design of the organism's development, that is, developmental dysfunction (cf. Wakefield 1997). If one has any doubt about this, consider Ribot's further descriptions of the general category of moral pathology as follows:

> "Moral insanity is a form of mental derangement in which the intellectual faculties appear to have sustained little or no injury, while the disorder is manifested principally or alone in the state of the feelings, temper, or habit." Such is the formula of Prichard … it signifies: a complete absence or perversion of the altruistic feelings, insensibility to the representation of the happiness or suffering of others, absolute egoism, with all its consequences. By a self-evident analogy, this state has been called one of moral blindness; and, like physical blindness, it has various degrees. It has also been compared to idiocy. (301)
>
> The character is an un-coordinated bundle of appetites and wishes, each of which, in turn, drives out the rest. Then there is weakness or total absence of will under its higher inhibitory form, which rules and coordinates. Are they impulsive for want of inhibition, or incapable of controlling themselves through the excess of their impulses? Both these cases are met with, and the result is the same. The formula of their character … is the same as that of the unstable—i.e., there is no constituted character.
>
> The term *infantilism* is equally applicable to the congenital and the acquired forms. The former have never left their childhood behind, the latter return to it. … In the one case we have arrested development, in the other retrogression. In short, … character has either not come into being or has ceased to exist. (422)

These descriptions are clear attempts to identify psychological dysfunctions of the kind that we too would currently recognize. Arrested development and atavistic return to a childlike state are standard views of dysfunction, and when Ribot characterizes infantilism as the failure of adult personality to develop, this suggests what today we would call a personality disorder. Note further that Ribot's views of the emotions were shaped by the James-Lange theory: "The doctrine which I have called physiological (Bain, Spencer, Maudsley, James, Lange) connects all states of feeling with biological conditions. … It is the thesis which has been adopted, without any restriction, in this work" (1903, vii). The James-Lange theory was itself explicitly an outgrowth of a Darwinian evolutionary functionalist analysis, as is Ribot's approach.

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Turning now to Dupré, I was unable to locate a translation of Dupré's work cited by Demazeux, but here is how Wikipedia summarizes his theory:

> Ernest Dupré developed a biopsychological theory of the origin of crime: the theory of instinctive perversions. For him, there are three instincts in man: the instinct of reproduction, the instinct of preservation and the instinct of association. In the criminal, these instincts are the object of abnormalities which can be excesses, atrophies or even inversions like suicide attempts for the instinct of preservation. According to Dupré, these anomalies can lead to perversions that may lead to the commission of offenses. (Ernest Dupré n.d.)

There is no question that Dupré's account, like Ribot's, falls within the HDA's conceptual umbrella. Dupré follows the standard classical schema of the triad of ways that biological functions can go wrong and become medical pathology. Relative to its natural normal-range level and target, a mechanism's functioning can go wrong by being hyperactive (higher than normal range), hypoactive (lower than normal range), or perverse (directed at a biologically unnatural target). Behind this triad is an implicit understanding of natural functions and how they can go wrong that makes Dupré's analysis consistent with an HDA-type schema.

Demazeux focuses on the harmful moral deviation that marked many early (and current) mental disorder categories, suggesting that somehow this focus on morality is in tension with the HDA. However, first, one must keep in mind the fact that at the time, "moral" was used broadly for mental and emotional conditions (Shorter 1993; Weiner 1990); for example, during this period, economics and sociology are described as "moral sciences." Demazeux emphasizes the "importance of such moral considerations which were built into the very conception of madness," but other historians insist that in this literature, "the fact that something is 'moral' in the psychological sense should not be taken to imply that it is also 'moral' in the ethical sense" (Charland 2008, 16). In any event, the above examination of Demazeux's examples reveals that it is not simply the moral or emotional deviance as such that warrants attribution of disorder in Ribot's or Dupré's accounts. Rather, it is the fact that the moral or emotional depravity is taken to reveal the presence of a dysfunction in the HDA sense, in which normal functioning of some internal mechanisms has gone awry to cause the moral symptoms.

Regarding Demazeux's example of *DSM-III* dependent personality disorder, it must first be said that the entire category of personality disorders and its diagnosis was quite controversial at the time of *DSM-III*. As discussed in Spitzer and Endicott's 1978 paper, a distinction was drawn between personality traits that are problematic but part of normal variation versus failure of personality organization to perform its hypothesized functions such as "the ability to form relatively stable and nonconflictual relationships" (1978, 34). *DSM-III* distinguished personality disorders from undesirable personality traits as follows: "Personality *traits* are enduring patterns of perceiving, relating to, and thinking about the environment and oneself, and are exhibited in a wide range of important social and personal contexts. It is only when *personality traits* are inflexible

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and maladaptive and cause either significant impairment in social or occupational functioning or subjective distress that they constitute *Personality Disorders*" (American Psychiatric Association 1980, 305). Whether or not one accepts the validity of *DSM-III*'s general characterization of personality disorders (I do not; e.g., Wakefield 2008), the requirement that pathological traits be "inflexible" and "maladaptive" are plausibly understood as an attempt to suggest a dysfunction of personality organization that causes the consequent harms.

Turning to Demazeux's specific example, to warrant diagnosis of *DSM-III* dependent personality disorder, the following characteristics of the individual's long-term functioning must cause impaired social or occupational functioning or subjective distress:

A. Passively allows others to assume responsibility for major areas of life because of inability to function independently (e.g., lets spouse decide what kind of job he or she should have).

B. Subordinates own needs to those of persons on whom he or she depends in order to avoid any possibility of having to rely on self, e.g., tolerates abusive spouse.

C. Lacks self-confidence, e.g., sees self as helpless, stupid. (American Psychiatric Association 1980, 325–326)

The description of an individual who is unable to function independently and is dependent on someone else to the degree of subordinating all his or her needs to those of the other is surely aimed at suggesting a problem that goes beyond undesirable normal variation to constitute some sort of dysfunction, as the 1978 discussion indicates. Nonetheless, one can easily see why this category has been quite controversial. The HDA can explain the nature of the controversy, whereas Demazeux's focus exclusively on harms like distress and impairment cannot. Credible questions arose as to whether these criteria, which were generally agreed to pick out characteristics that are negative and harmful in our modern society, do in fact pick out a dysfunction-caused disorder or merely label undesirable but normal-range functioning that is socially shaped. Feminist critics pointed out was that there was an alternative explanation to dysfunction for the inflexible and seemingly maladaptive maintenance of these submissive and often self-destructive patterns, namely, adoption of the traditional gender role model in our culture of ideal feminine behavior as passive and submissive to a partner's needs. Feminists argued that, given that women were traditionally socialized to be unassertive, this category pathologized those who most firmly embraced those traditional social values that were in conflict with newly emerging vision of more assertive and egalitarian female behavior. In such cases, there might be distress or impairment, but there was no genuine dysfunction, just social conformity. Opponents in the dependent personality debate agreed that the described degree of submissiveness is harmful and negative and should be the target of efforts at change, yet, contrary to a sheer harm-based approach, they still vigorously disagreed about its pathological status. What, then, were they disagreeing about? The HDA offers an answer; they were disagreeing about whether there is a dysfunction.

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Incidentally, despite the objections, the category has survived thus far and appears in *DSM-5*. This is perhaps because the claim that the diagnosis is undergirded by a dysfunction has been indirectly buttressed by the theory, disputable but widely accepted, that such dependent behavior represents an insecure form of attachment in childhood as described in John Bowlby's popular attachment theory and that such variants of attachment are inherently dysfunctions and pathological. Finally, regarding the relationship of the HDA to the personality disorders, it may be worth mentioning that in the run-up to *DSM-5*, there was explicit mention of the HDA and the citation of HDA articles in the work group's discussion of revisions to personality disorder categories.

Regarding the above examples, Demazeux states, "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." This may well be correct. The HDA, which is a theory of conceptual validity, does not address these or many, many other questions. It only addresses the one question of the logical structure of disorder attributions.

I conclude that, despite having centuries of examples from which to choose to prove his historicist point, Demazeux's handpicked categories fail to provide clear counterexamples to the HDA. The failure of Demazeux's historical excursion offers unexpected support for my hypothesis that "the concept of mental disorder has retained a fixed meaning" across a broad domain of times and places.

What about Foucault?

My thesis that the HDA has broad cross-temporal applicability requires further comment. I have argued that a full conceptual/sociohistorical analysis would include both a conceptual component and a "Foucaultian" archeological/genealogical component that analyzes why a particular concept came to have social power and how the details of its deployment reflect strategies of power (Wakefield 2002). However, a meaningful historical sociology of concept deployment depends on a prior conceptual analysis to understand what concept was being deployed and what features made it attractive. Ignoring the necessary conceptual step was, I think, a central weakness of some of Foucault's analyses.

Demazeux sees a contradiction between the universal pretensions of the HDA and Foucault's statement 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). In my view, there is no contradiction. For Foucault, the shift he describes matters because "madness" is not (and was not) the same concept as "mental disorder"; otherwise, there was a mere terminological change with no substantive implications. Foucault's point is that earlier, there were various ways of understanding a certain set of phenomena as "madness," but those phenomena were recategorized

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under a single concept, "mental disorder," and thus understood differently. To understand the shift and evaluate Foucault's claim, one must ask what it entails conceptually to categorize a condition as a mental disorder. The HDA explains what it means to label a phenomenon as a disorder and thus explains the meaning of Foucault's claim that madness was reclassified as disorder.

Foucault is no doubt correct that, for example, the Enlightenment's emphasis on the desirability of reason led to a new view of some forms of irrationality, including those formerly vaguely categorized as "madness." The excessive pathologization of irrationality following acceptance of Enlightenment ideals of human functioning was a typical elevation of social values into a mistaken view of functional normality, analogous to Victorian pathologization of socially disapproved sexual pleasures. Foucault was not the only one to notice this aspect of the reaction to the Enlightenment. Consider, for example, the following statement published in 1885 by Carl Lange, the co-originator of the classic James-Lange theory of emotion inspired by Darwin's book on emotion, in which Lange explains his motivation in exploring the evolutionary theory of emotions:

> Kant, in a passage in his *Anthropologie*, qualifies the affections [i.e., emotions] as diseases of the mind. He considers the mind normal only as long as it is under the incontrovertible and absolute control of reason. Anything that causes it to be disturbed seems to him to be abnormal and harmful to the individual. To a more realistic school of psychology, which knows no abstract "Ideal" man, but rather "takes men as they are," such a doctrine of the soul must appear strange. … Such a theory will consider the imperturbable arithmetic teacher, to whom every impression is merely an impulse to draw rational conclusions, as the only normal, healthy individual. (Lange 1885/1922, 33)

As Foucault and many others have made clear, the same conditions may be conceptualized in different ways at different times or places. Indeed, in our own time, there are heated debates about whether to understand various conditions, from depressive feelings during grief and fidgeting in school to the more provocative actions of President Trump, as normal-range features or disorders. The HDA does not attempt to explain the cultural history of thinking about the conditions that are now considered mental disorders or why the same conditions might be considered disorders at one time or place and nondisorders at another time or place. That is Foucault's domain. So, it is of course to be expected that there are endless points that "could remain obscure if one looks only at the 'conceptual validity' (according to the HDA) of each construct taken separately." The HDA is limited to attempting to explain the logic of what is being affirmed or denied when such attributions occur. One might add what I hope is clear by now: that there are equally many points that remain obscure if one looks only at the Foucaultian historicist claims without conceptual analysis.

From a Foucaultian perspective, the potential value of the HDA can easily be underrated. The HDA provides a framework for understanding how society can exploit medical concepts for social control purposes by relabeling as natural and unnatural socially desirable and undesirable behavior, respectively. Any serious attempt to explain medical

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disorder judgments, which have, to an amazing extent, been shared across epochs does lead one to the functional view, as documented in detail for the history of the category of depression in *The Loss of Sadness* (Horwitz and Wakefield 2007). In sum, with regard to historical understanding and explanation, the HDA provides illumination that explains much but not (as Demazeux unreasonably demands) more than an analysis of one concept can explain.

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Defining Mental Disorder

Jerome Wakefield and His Critics

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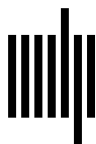

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