5 Against the Disorder/Nondisorder Dichotomy

Leen De Vreese

Introduction

In this chapter, I do not comment on Jerome Wakefield's harmful dysfunction analysis (HDA) as such but rather perform a meta-analysis of HDA's goals and aims, as well as evaluate the methods that are used in order to reach these goals. This means that I will focus on methodological and epistemological issues underlying the HDA approach, rather than on problems with the harm or dysfunction aspect of the HDA per se, counter-examples that can be raised against the HDA, or the like. Actually, I think Jerome Wakefield's approach is one of the best attempts to capture the meaning of the notion disorder. The goal of the HDA is nonetheless—as is the case for any traditional analysis of the disorder[1] concept—to provide a single description that can delineate what is and what is not a (mental) disorder. Now, the question that I will raise is whether any attempt at providing a universal definition of the notion disorder—no matter how valuable it is—can ever succeed in clearly delineating (mental) disorders. While I agree with Jerome Wakefield that the meaning of our notion disorder comprises both an evaluative and a factual component, I will argue that it cannot convincingly be argued that the harmful dysfunction analysis forms a basis for delineating disorder and non-disorder in a uniform way. I will argue that disorder is a multifaceted concept, for which a single definition making a straightforward dichotomy between disorder and nondisorder is not justifiable, not necessary, and not useful for practice. We rather need a pluralistic approach, which approves of both the normative and the factual component in the meaning of the concept but also recognizes the diversity in the practical application of the notion. This does not imply that the harmful dysfunction analysis is useless but rather that a reconsideration of how to conceive of it (and of its alternatives) is necessary.

In section I, I will focus on the methodology that has been used to develop the HDA (i.e., conceptual analysis) and on the presuppositions underlying the choice for this methodology. Further, I will clarify the aims of conceptual analysis in general and of Wakefield's HDA more specifically. In section II, I will analyze whether the HDA

can best be conceived of as a descriptive or revisionist conceptual approach. I will also argue that the HDA is problematic on both interpretations. In section III, I go a bit deeper into the problem of the vague boundaries of the disorder concept and of Wakefield's view on this. In section IV, I argue for an alternative way of analyzing the disorder concept, which is grounded in practice rather than intuitions. I will make a sketch of how such an approach might be developed and look at the implications for Wakefield's HDA. I come to final conclusions in the last section.

I. HDA as a Conceptual Analysis: Characteristics and Goals

Wakefield's approach fits in with the traditional philosophical approach using conceptual analysis as a tool to find *the* best definition of a certain concept. A conceptual analysis is concerned with our everyday causal intuitions, the way we think and reason about disorders in commonsense situations, and the way the concept is used when making everyday causal judgments. The following quote confirms that Wakefield has consciously chosen this tool in developing the HDA:

> The method used is conceptual analysis, in which proposed analyses are tested against shared judgments about which conditions do an do not fall under the concept of disorder. Consensual judgments are used to test the explanatory power of proposed analyses much as linguists use sentences commonly accepted as grammatical to test hypotheses about grammar. It is not assumed that consensual judgments are always correct. … In such cases, a good analysis will explain why background beliefs interacting with the concept of disorder produced the incorrect classificatory judgment. (Wakefield 1999, 376)

In this section, I look at the underlying motivations and aims for giving a conceptual analysis. In section 1.1, I will first analyze the general characteristics and presuppositions of a conceptual analysis of disorder. In section 1.2, I take a closer look at Wakefield's own motivations for analyzing the concept.

1.1 Characteristics and Presuppositions

Conceptual analyses of the concept disorder share some characteristics and presuppositions. This is not different for Wakefield's approach, as I will illustrate in this section using citations from his own work. First, all conceptual analyses of disorder try to give an account of the concept that is preferably valid for both physical and mental disorders. This is also the case for Wakefield's HDA, which is primarily meant as an analysis of mental disorders but about which Wakefield further states, "First, at issue is the concept of disorder as applied throughout physical and mental medicine. Therefore, the debate draws freely on physical and mental examples in testing proposed analyses. This generality is essential to one of the points of the HD analysis, which is to show that mental conditions can be disorders in the strict medical sense" (Wakefield 1999, 376).

Nevertheless, none of the traditional definitions can live upon its promise of giving the final definition of disorder. All kinds of definitions have been refuted in the literature on the basis of counterexamples, showing that the accounts offered are too broad to exclude nondiseases or too narrow to cover all diseases. Actually, the whole debate about the "right" definition of the concept is driven by a game of giving examples and counterexamples. A single counterexample is thereby supposed to suffice to refute a whole analysis. Further, new approaches presented in the literature are supposed to avoid any counterexamples. Wakefield is well aware of this:

> A classical conceptual analysis, such as the HD analysis, specifies features that are claimed to determine classificatory judgments for a category and its complement, thus taking a substantial risk of falsification. To refute a classical analysis, one simply has to present a clear counterexample in which the concept (as expressed in shared, intuitive judgments) and the proposed analysis of the concept yield divergent classificatory judgments. (Wakefield 1999, 377)

Wakefield is convinced that his own conceptual analysis in terms of harmful dysfunctions is superior to the rival analyses and does possess "the adequate explanatory power to account for common classificatory judgments regarding disorder and non-disorder" (Wakefield 1999, 374). However, it cannot be denied that Wakefield's approach has also been refuted in the literature on the basis of counterexamples demonstrating that people's intuitions are not always in accordance with the HDA. It is not the goal of this chapter to go into details about the shortcomings of, and counterexamples to, the HDA. These can be found in the literature (see, e.g., Cooper 2007; Schwartz 2007) and in other chapters of this book. Admittedly, one should not forget that Jerome Wakefield has put a great deal of work in defending his approach and refuting these counterarguments throughout his writings. It can be debated to what extent his counterarguments to the counterexamples are convincing.[2] But anyhow, it is not the case that the HDA is meanwhile accepted as the "agreed on and adequate analysis of this concept" (Wakefield 1992, 373), which is what Wakefield aimed for. In fact, the debate is still ongoing, and several new approaches have been brought to the fore more recently (see, e.g., Cooper 2007; Schwartz 2007).

And so the story goes on: authors in the field (among which Wakefield himself) keep arguing and counterarguing about the right definition of disorder. The way they do suggests the presence of a number of related, underlying presuppositions. First, that it is possible to find a single, delineating definition of what a "disorder" is. Second, that it is also necessary to search for such a single account that offers *the* necessary and sufficient criteria for disorder. Third, that on the basis of such a definition, one would afterward be able to discern disorders from nondisorders. And lastly, that all human conditions gathered under this definition will be of a single, uniform kind (or have a single, uniform essence). All this seems too much to expect from a single, monolithic definition. This is not surprising, but results from general problems for conceptual analysis. Schwartz extensively argued for this:

> As scientists have acquired better and better understanding of diseases and their causes, they find not a unifying microstructure, as for gold or water, but variation. While many have sought an essence that all and only diseases share, this quest has been blocked at every step by variability and heterogeneity. Any definition that would draw a sharp line through all conditions, determining for each whether it is a disease or not, looks like the imposition of a decision, rather than the application of a discovery.
>
> This means adopting any precise account will impose at least some changes on our currently non-reflective and relatively unprincipled way of distinguishing disease for health. Choosing a definition will partly involve deciding which changes from current practice are acceptable. (Schwartz 2007, 59)

It must be said that Wakefield partially acknowledges these problems for conceptual analyses at some points in his work. He seems to think nonetheless that they do not apply to the HDA approach, as he conceives of it. While he is convinced that the essence of disorder is harmful dysfunction, he allows for vagueness and continuity between disorder and nondisorder on the basis that what is harm and what is dysfunction themselves is sometimes vague and debatable. Hence, where there is vagueness and uncertainty about whether or not to conceive of a certain state as disordered on the basis of the HDA, this would not result from the definition of disorder as harmful dysfunction itself but from the vagueness that is characteristic for the defining notions of harm and dysfunction. However, this seems only to shift the problem to another plane, rather than solving it. I will come back to this later (see section 3.1 and section 4). In any case, this weakening of Wakefield of what can be expected from his conceptual analysis does not change the fact that he subscribes to the traditional aim of finding a *single, overall* definition that should (at least largely) cover the use of the concept on the whole.

1.2 Contradictory Motivations

Let us have a closer look at the motivations that Wakefield himself puts forward for his conceptual analysis. At different places in his work, Jerome Wakefield gives two major justifications for the development and adoption of the HDA. These reflect nonetheless two contrary goals.

On one hand, Wakefield states that the goal is *only to explain clear classificatory judgments* and not to impose decisions in unclear cases. The analysis of the clear cases should only demonstrate why there is ambiguity in some unclear cases without resolving them. This motivation is most clearly present in Evolutionary versus Prototype Analyses of the Concept of Disorder (Wakefield 1999):

> The analysis was aimed at explaining shared judgments about a range of important cases that clearly fall on one side or the other of the boundary. (379)

> Perhaps they are here once again confusing the task of setting a precise boundary for a concept, which does often depend on arbitrary conventions and value considerations, with the analysis

> of the concept's meaning, which is an attempt to explain clear classificatory judgments and is certainly not purely evaluative in the case of disorder. (397)
>
> It should also be cautioned that the status of a condition as disordered or nondisordered from the HD or any other perspective has no necessary implication for the priority the condition deserves with respect to treatment, prevention, or policy. Such issues require independent consideration not attempted here. (374)

The theory is, on the other hand, motivated on the basis that a clear concept is *necessary for solving controversies and correcting false positives*. This goal is brought to the fore in papers such as "The Concept of Mental Disorder" (Wakefield 1992), "When Is Development Disordered?" (Wakefield 1997), and "False Positives in Psychiatric Diagnosis" (Wakefield 2010). The following quotes are testament to this fact:

> Lack of a valid concept of disorder is not just conceptually and methodologically problematic, it is potentially ethically problematic as well. Classification of a condition as disordered has ramifications ranging from those of labeling a child or adult as disordered to determinations of whether it is appropriate to treat the condition with drugs. (Wakefield 1997, 271)
>
> Thus, if the symptom-based approach to diagnostic criteria and disorder, whatever its other merits, is potentially prone to false positives as I have argued, it is essential to reconsider the concept of disorder and what is supposed to fall under this core category. (Wakefield 2010, 12)

Hence, Wakefield seems to hesitate on whether he wants to passively analyze the concept for purely theoretical reasons or whether his analysis should also have practical implications. This ambiguity in Wakefield's goals seems to go hand in hand with mixing up of two kinds of possible but different goals of conceptual analysis, as I will further explain in the next section.

II. HDA as a Conceptual Analysis: Which of Two Flavors?

2.1 Descriptive versus Revisionist Conceptual Analysis

Traditionally, a conceptual analysis can have two goals: it aims for a descriptive account that tries to line up nicely with our intuitions, or it aims for a revisionist account that urges for a revision of the concept in order to clear out the inconsistencies in our intuitions. What concerns Wakefield's HDA, the question now becomes whether we should understand it as a descriptive conceptual analysis or as a revisionist one. Wakefield's contrary motivations for his theory seem to imply that he cannot choose between both. On one hand, he seems to interpret the HDA as a purely descriptive approach. According to his first motivation cited above, his analysis is based on "shared judgments about clear cases." Insofar as it is unclear whether a certain condition holds as a disorder or not, this would then reflect our unclearness on whether or not there is any harm involved and/or whether or not one can rightly speak of a dysfunction (in line with Wakefield's descriptions of these terms). This would imply that the HDA is a

descriptive conceptual analysis only of "the clear cases" of disorder. Further, it would imply that we have shared intuitions about what are the unclear cases. However, the fact that authors disagree with Wakefield as to what are the clear and unclear cases (see, e.g., Lilienfeld and Marino 1995) demonstrates that this weakened descriptive view does not solve the problem of ambiguities. When reading through Wakefield's papers, it also becomes clear that he does not just accept conflicting intuitions about counterexamples as illustrative of shared ambiguities surrounding the notions of harm and dysfunction. He rather tries to refute the counterexamples that are brought up against his theory by turning them into examples confirming his approach, that is, by fine-tuning how to interpret the notions of harm and dysfunction such that they are in line with the intuitions of his critics. In other terms: he gives arguments on the basis of which his opponents are directed to revise their intuitions as actually being in line with the HDA. Still in other terms: instead of urging the critics to revise their intuitions on whether or not their counterexamples are real disorders—which would be the most straightforward revisionist approach—he urges them to revise their view on whether or not the criteria of harm and/or dysfunction are fulfilled. This means that examples of clear cases of (non)disorders that, according to the critics, cannot be interpreted as such in terms of the HDA are then claimed by Wakefield to be clear cases of (non)disorders in line with the HDA, given certain more specific interpretations of what is a harm or dysfunction. Hence, from this reading, one can argue that Wakefield pleas for a partial revision of our everyday use of the concept. We do not just have shared ambiguous intuitions that can be understood on the basis of the vagueness of harm and dysfunction. We should have the same intuitions if we all interpreted harm and dysfunction in the way that Wakefield defends. Hence, Wakefield does not only shift the problem to another plane, as I stated earlier. He also enforces a solution by way of imposing certain interpretations of the notions of harm and dysfunction. These specific understandings of harm and dysfunction are nonetheless only necessary in function of resolving the controversies surrounding unclear cases.

To conclude, Wakefield's revisionary talk follows from the way in which he tries to solve controversies on the basis of his own theory. This is in line with Wakefield's second motivation that I brought up in the previous section.

I hope to have convinced the reader by now that it is unclear what kind of conceptual analysis Wakefield aims for or how he wants to combine the two kinds of conceptual analysis (that are, in fact, inherently contradictory in their aims). However, no matter which of two flavors he eventually chooses, both of them have further problems, as I will show in the next two sections.

2.2 Problems for the Descriptive Aspect: Intuitions

Intuitions about "clear cases" form the basis for the HDA. Nevertheless, what are "clear cases" can be discussed. Whose intuitions do we need to follow on this point? Those of the author? Those of medical doctors? Those of the general public? In fact, intuitions

might differ more than we are aware of (see, e.g., Smith 2002). Further, one can never start from scratch. Intuitions always rely on value-laden and/or theory-laden presuppositions about what is and what is not a disorder. This brings us to an unavoidable circularity: someone's thoughts about whether or not something is a "clear case" is already determined by his or her underlying theoretical presuppositions beforehand. What concerns the dysfunction aspect, Wakefield nonetheless argues in defense of his own approach: "However, the fact is that when one asks people for their judgments about disorder and non-disorder, their judgments go against the 'current mismatch' approach and in favor of the evolutionary approach" (Wakefield 2010, 15).[3]

Can such claims be justified? Is it really true that all people (all people, in all situations) really reason about disorder and nondisorder on the basis of "a breakdown in a mechanism x, that is not in line with how humans are designed" in combination with some kind of harm? Or how should we interpret this kind of defense of the HDA as a superior approach? The real test would be to, first, collect all judgments on "clear cases of disorders" on which all people agree and that are based in the same and justified background knowledge. The proof of the pudding would lie then in answering whether all these judgments are justified by the HDA, while they cannot be captured by alternative approaches.[4]

Is it not much more plausible that intuitions will vary widely (across people, across situations), according to varying presuppositions, that might be explicated by various conceptual approaches? If so, choosing for the HDA as the best analysis of disorder already automatically implies a revision (in light of the preferred theory) of how we conceive of disorder/nondisorder, even in "clear cases." This would also imply that choosing for the HDA as the best descriptive conceptual analysis among alternatives is arbitrary.

2.3 Problems for the Revisionist Aspect: Generalization

What about the HDA as a revisionist approach? Interpreting the HDA as a revisionist approach raises additional problems. Even if the HDA would form the best approach to clear cases of disorder, one can argue that those judgments on disorder that all people with justified background knowledge share might concern too little cases to justify a generalization of the HDA to all diseases.

What would then justify the generalization of the HDA from "the clear cases" to "all cases"? Won't we narrow down the scope of what it means to be disordered to only these kinds of diseases about which we have "clear intuitions"? Further, what justifies that contrary intuitions are not a problem once we are applying the HDA to "unclear cases," while such intuitions form the basis on which alternative approaches were first rejected? And on which basis can we justify the selection of this single theory to all others as the basis for revisions? All these questions remain unanswered.

The problems for a conceptual analysis of "disorder" along traditional lines are clear. We seem unable to discover the essence of what it means to be disordered. This implies

that deciding to pick out just one or another definition as *the* definition will automatically result in a revision of the everyday use and meaning of the concept in light of this decision. In other words, any conceptual analysis of disease resulting in a monolithic definition seems to lead to a revisionist account instead of a descriptive one. The question that follows is whether we really want to revise the concept or whether we prefer a description of the concept's actual use. When considering this, we should recognize that it is unclear on what basis one can privilege one account above the others as *the* single, true one. The only possible justification seems to be the intuitions one already had beforehand about whether or not certain example diseases are "true" cases of disease or not. The choice for any final definition on the basis of which we should revise our intuitions will therefore be arbitrary.

III. Boundaries

In this section, I would like to make some final remarks concerning boundaries and the vagueness of the concept disorder. Wakefield gives two justifications for vague boundaries (Wakefield 1999, 378). First, what appears to be a vague boundary can result from a lack of knowledge about factors that would provide a precise boundary if known. This kind of vagueness seems to me to be the least problematic for a conceptual analysis of disorder, since it implies that there is a clear distinction in principle. The other kind of vagueness is the vagueness from vague boundaries of the defining criteria themselves. This is the kind of vagueness that Wakefield most explicitly defends as unproblematic for the HDA. As I stated before, Wakefield allows for vagueness of boundaries of the disorder concept (and hence for some kind of continuity between disorder and nondisorder) on the basis of the vague boundaries of the concepts of harm and dysfunction: "The concept of disorder is analyzable as harmful dysfunction, but harm and dysfunction themselves may contain vagueness and indeterminacies that give a degree of imprecision to the overarching concept" (Wakefield 1999, 378).

Wakefield does not perceive of this as a problem for his conceptual analysis: "analyzing a concept's meaning or definition, which is what the HD analysis aims to do, is different from setting a precise boundary for the concept. Most meaningful concepts, like red and tall, do not have precise boundaries but are useful for classifying clear cases" (Wakefield 1999, 378). Nonetheless, I am convinced that such vagueness subverts the power of his conceptual analysis. This kind of vagueness seems to lead to one of the following implications for the HDA:

Either (1) one is in the end really limited to describing only the clear cases using the HDA. This would imply that the HDA is a descriptive conceptual analysis which has no significant practical implications at all. This is in line with Wakefield's quotation above. However, this seems also in contradiction with Wakefield's second motivation for the HDA (cf. section 2.2) and would really impoverish the usefulness of the HDA. Is it not a pity that after providing a conceptual analysis which is aimed at clarifying what

are disorders, and what not, Wakefield has to conclude regarding some medical conditions: "In none of these cases is there a precise boundary between dysfunction and nondysfunction, yet for practical medical purposes physicians are able to 'adequately distinguish disorder from nondisorder'" (Wakefield 1999, 380)?

Or, (2) one might in fact end up with three kinds of disorders: harm and dysfunction-related disorders (where you have a clear case of harmful dysfunction), primarily dysfunction-related disorders (where you have a clear dysfunction and vague reasons also to suspect harm), primarily harm-related disorders (where you have a clear case of harm and vague reasons also to accept the presence of a dysfunctional mechanism). This would lead us to a pluralist definition, which is clearly in contradiction with Wakefield's goal of finding an overarching definition and with Wakefield's first motivation for the HDA (cf. section 2.2).

IV. Relation with (Medical) Practice

The previous sections make clear that the combination of Wakefield's method, motivations, and goals brings him into a difficult position. Although he made a very reasonable attempt to give an analysis of the concept disorder, it turns out that his HDA as such has little bearing in practice. This is a pity and should not have been the case if he would have had a wider view on how an analysis of the concept disorder could look like.

Looking back at my analysis of the HDA in this chapter, the following questions (and answers) arise:

What is problematic about the possibility that there are different kinds of disorders that might need (partially) different analyses? (I think nothing is.)

Is vagueness not rather the result of the fact that our concept cannot be simply defined because disorder is a multifaceted concept? (I think it is.)

Is it useful to keep on searching for analyses that aim at clarifying the concept but nonetheless do not have practical implications? (I do not think so.)

Is it not much more fruitful to try to offer an approach that can form a basis for critical reflection in practice, instead of holding on to the traditional methodology of conceptual analysis and the traditional aim of a unifying approach? (Yes, I think it is.)

Is it not better to recognize and analyze the diversity in our use of the concept disorder, instead of trying to lump all instances as much as possible together in a single, overarching approach? (Yes, I think this makes much more sense.)

In general, I think the problem can be brought back to the starting point of our traditional analyses. Why do we not just admit that presuppositions cannot be excluded and start in the development of an approach from the use of the concept in *practice?* Would this not be much better than acting as if one can start from scratch in making a traditional philosophical conceptual analysis on the basis of armchair intuitions?

Clearly, no single physician will change his or her mind on whether, for example, attention-deficit/hyperactivity disorder is a "real" disease on the basis of a conceptual analysis of disorder according to which it is not. Therefore, it seems better to recognize the diversity in the meanings we put on the concept disorder in practice. This will also make the resulting framework much more useful for reflection in medical practice. Actually, one can assume that practitioners are very well aware of the diversity in diseases and disease kinds and therefore suppose that "for practical medical purposes physicians are able to 'adequately distinguish disorder from nondisorder'" (Wakefield 1999, 380). But on the other hand, practitioners might tend to classify people's problems too often as diseases, given that they were trained and work in a strictly scientific-medical setting. Therefore, a practice-related, pluralist framework might not only provide us with a more realistic descriptive account of the meaning of disorder but also be very useful for practitioners as a basis for reflection and comparison.

Hence, we should find a way to get a grip on how the notion of disorder is used in practice, even when this use is not uniform. Instead of aiming for an overarching approach, it seems therefore much more useful to aim for a pluralist conceptual approach that is based in, and can be critically evaluated in relation to, practice. Within such a framework, different (aspects of different) traditional approaches can be used as an analyzing tool rather than as final definitions. This would imply that the HDA remains very useful but should no longer be defended as the only superior approach. What we primarily need is a basis for reflection, not a basis for arbitrary decisions. A conceptual approach to disorder should keep us reflecting instead of relaxing. Within a pragmatic, pluralist approach, "counterexamples" will no longer form a reason to reject or revise everything, but they will help us in further reflection, further comparison, and further nuancing of disorder labeling. This is probably the best an analysis of the concept disorder can do for us all.[5]

Conclusion

An analysis of the HDA from a methodological and epistemological point of view demonstrates that it cannot convincingly be argued that the HDA should be accepted as a superior conceptual analysis of disorder. Disorder rather seems to be a multifaceted concept for which a single definition that hopes to make a straightforward dichotomy between disorders and nondisorders is not justifiable, not necessary, and not useful for practice. This does not imply that the HDA is useless but rather that a reconsideration of how to conceive of it (and of its alternatives) seems necessary.

Notes

1. An important preliminary remark needs to be made. I am well aware of the slight differences in meaning and use of the concepts of disease, disorder, illness, and related terms—at least in the

English language. The differences between these are also discussed in the philosophical literature. I will nonetheless sidestep this discussion and use the terms "disorder" and "disease" as broad, general terms referring to all those things people usually refer to as a disease, disorder, illness, injury, sickness, and suchlike. Herein I follow Wakefield, among others, in his discussion of the concept (see Wakefield 1992, 374).

2. At least, I can attest that some of his arguments go against my intuitions and against my intuitions about what are "common classificatory judgments."

3. According to the current mismatch approach, we should focus on how well we are adapted to our current environment and not on how we have been biologically designed in the past. The latter is what the HDA focuses on. The discussion itself is not important for my argument here. I use this quote only to demonstrate how Wakefield reasons from intuitions on how people would usually reason about disorder.

4. If so, one should ideally also be able to explain all the "unclear cases" that remain on the basis of ambiguities in the concepts of harm and dysfunction.

5. It is not the aim of this chapter to describe in more detail how such an approach might look like, but a more concrete outline of such an approach can be found in De Vreese (2014).

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Defining Mental Disorder

Jerome Wakefield and His Critics

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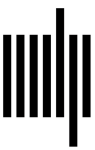

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