Defining Mental Disorder

Jerome Wakefield and His Critics

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27 On Harm

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Jerome Wakefield holds that disorders are harmful dysfunctions. Although the harmful element is an essential component of his account, Wakefield has said comparatively little about it and has concentrated on fleshing out the dysfunction part of his account. One of the key aims of Wakefield's project has been to use his account of disorder to weed out "false positives." In such applications, Wakefield has tended to use the dysfunction part of his account to do the work. Thus, he has argued that normal misery and much misbehavior by young people are not disorders because there are no dysfunctions (Horwitz and Wakefield 2007; Wakefield et al. 2002).

This chapter takes as its starting point that Wakefield is correct in thinking that disorders must be harmful and examines what it means to say a condition is harmful. In his best-known work, Wakefield argues that disorders are harmful dysfunctions where "harmful is a value-term based on social norms" (1992a, 373). I will argue that an account of harm as whatever is disvalued by a society should be rejected. This is because whole societies can be wrong in how they evaluate a condition. Determining the correct account of harm is very difficult, but I argue that on all plausible accounts, it will be possible to argue that a condition should not be considered a disorder because it is not harmful. Thus, when properly understood, the harm component of Wakefield's account can also be used to provide a barrier against medicalization. I finish by considering how the idea that disorders are necessarily harmful has a crucial role to play in ensuring that classifications of disorders, such as the influential *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*), do not medicalize normal oddities.

I. Wakefield's Struggle with an Account of Harm

In his 1992 paper "The Concept of Mental Disorder: On the Boundary between Biological Facts and Social Values," Wakefield sees the claim that disorders are harmful to be an essential part of his account. The criterion that disorders must cause harm allows Wakefield to say that certain conditions that may well be evolutionarily dysfunctional, but that cause no harm, do not count as disorders. In his paper, Wakefield offers fused

toes and slow aging as possible examples (1992a, 384). More influentially, although it is a case little discussed by Wakefield himself, the harm element of Wakefield's account also enables the claim that homosexuality is not a disorder; it may be an evolutionary dysfunction, but insofar as it is not harmful, it is not a disorder.

Wakefield (1992a) tells us that "harmful is a value-term based on social norms" (373), a disorder is a dysfunction that "impinges on the person's well-being as determined by social values and meanings" (373), and harmful is "a value term referring to the consequences that occur to the person because of the dysfunction and are deemed negative by sociocultural standards" (374). Wakefield doesn't tell us much about why he thinks that whether a condition is harmful should be determined by social norms. One gets the impression that to him, it seems obvious that this is the only way in which harm might be defined. In the course of this chapter, I will show that there are actually numerous possible accounts of harm (or the flipside of the good life). Figuring out what harms an individual, or what comes to the same thing—what the good life is for an individual—is very difficult. This is not an issue that I will be able to resolve here. On one point I am sure, however, and that is that saying that harm is determined by one's society will not do.

The problem with holding that any condition that a society values is valuable is that this claim has profoundly counterintuitive consequences. There are cases where it is extremely plausible that a cultural group can be mistaken about what is valuable. Take the case of "pro-ana" groups, which are groups that promote the idea that anorexia is a good thing. Pro-ana groups are generally web based. On their sites, you can access chat rooms in which people swap diet tips, compare body statistics, and support each other during fasts. There are also galleries of "thinspiration" images, which are photos of very thin people looking beautiful. The members of pro-ana groups celebrate an aesthetics of extreme thinness, they admire the control that is required to limit food intake, and they delight in the euphoric experiences that can be produced by fasting.

On Wakefield's account, it looks like one is forced to say that as a cultural group values anorexia, there is no harm in being anorexic. Maybe Wakefield would avoid this by claiming that anorexics merely form a subculture rather than a full-blown culture—perhaps on the basis that those who celebrate anorexia are few and far between and meet virtually rather than in person. However, this response is not robust to slightly different circumstances. Suppose that the members of pro-ana groups get fed up with members of the dominant culture interfering in their chosen lifestyle. They purchase a small island and set up their own community. Anorexia becomes fashionable, and the numbers of the island swell. At some point, the pro-ana group will form a culture that is just as surely a culture as any other. Nevertheless, and even though the pro-ana community thinks that anorexia is a good thing, I suggest that the group is wrong. Anorexia is not a good because people with anorexia become obsessed with food-related issues (and having a life that revolves around this is an impoverished life)

and risk death. Whatever their beliefs, anorexia remains a disorder because it remains harmful.

In a 2013 commentary, Wakefield shows sensitivity to this sort of case and starts to move away from the view that initial social judgments alone determine harm. Infamously, slaves who had a tendency to run away were at one time considered by some to be disordered. In earlier work, Wakefield had used the dysfunction component of his account to argue that the view that these slaves had a disorder was a mistake; they were not disordered because they did not have a dysfunction (2002, 150). Now, Wakefield considers the possibility that runaway behavior might in fact have been caused by some minor brain dysfunction that rendered certain individuals less able to adapt to oppressive environments (thus satisfying the "dysfunction" criterion). Given that the slave-owning society disvalued runaway behavior, on his original account, Wakefield would be forced to claim that the slaves were in fact disordered. The example now prompts Wakefield to concede that "to this extent, my (1992) claim that harm is judged by social values was overly simplistic" (2013, 1). He suggests, "The HD 'harm' component, being normative, reflects deliberation about broader normative commitments, not just immediate social reactions" (2013, 2). This idea goes in the right direction, but Wakefield does not expand on it. One of the main aims of section III is to consider in greater detail how we might reflect on our initial gut reactions regarding harmfulness and improve upon them. First, however, we need to consider further accounts of harm. Given that it is highly plausible that whole cultures can be mistaken in their assessment of harm, and insofar as Wakefield's initial account of harm struggles to allow for this possibility, we must look for a different account of harm.

II. Starting Again—How to Assess Harm?

Wakefield has struggled to provide an acceptable account of harm, but in this, he has the comfort of good company. The depth of the difficulty can be seen once it is appreciated that the flipside of deciding whether a condition causes harm is deciding what sorts of conditions are good for an individual. Figuring out what makes up the "good life" is, of course, one of the most long-standing and contentious of philosophical questions. Although various accounts of the good for an individual have been proposed, all are problematic (for an in-depth overview, see Griffin 1986). In this chapter, I will not be able to determine the correct account of the good life. My aims are more modest. I will briefly review a range of options and show the problems that they face. I will then move on to show how, even though we lack an acceptable account of the good life, some progress may yet be made in considering whether particular specific conditions are harmful.

The problems that emerge in seeking to develop an account of the good life can best be understood via thinking of the possible ways of determining what is good for an

individual as varying along a scale. At one end of the scale, one might rely on asking actual people what they want (the "subjective," or "desire," approach). At the other end of the scale, one might appeal to ideal standards of human flourishing (the "objective," or "Aristotelian," approach). Between these extremes lie methods that claim that something is good for an individual if that individual would judge it to be good in ideal circumstances, for example, if he or she were calmer, wiser, and better informed than in reality.

Wakefield's suggestion that harm might be judged on the basis of the judgments of the social group is an account that relies on the judgments of actual people. I have suggested that Wakefield's account runs into difficulties because actual communities can be mistaken in their assessments of harm. This is a basic problem that afflicts all those accounts of the good life that rely of the judgments of actual people (whether individually or in groups). The key difficulty is that people often do not know what is in their own best interest or in the best interest of others. People make mistakes for a multitude of reasons. It is an unfortunate fact that humans are quite commonly ignorant, self-deceived, short-sighted, biased, deluded, and foolish.

The fact that actual humans make mistakes makes accounts of the good life that rely on more abstract notions of the good seem attractive. Various neo-Aristotelian accounts have recently become popular. On some accounts, the character of the human good life can be thought of as being analogous to the good life for a species of plant or animal (e.g., Hursthouse 1999). For example, it is a natural fact about gerbils that they are social burrowing creatures who are thus happiest living in company and with something they can dig. Similarly, cheetahs are naturally such that they like to roam long distances and are solitary. The neo-Aristotelian may suggest that humans are creatures that are naturally such that they need friends and intellectual stimulation. Regardless of what any individual claims, such things are good for humans. Such views take on a certain amount of plausibility when one bears in mind that it is commonplace for individuals to come to take pleasure in certain activities even when they initially had to be coerced into them. It seems empirically plausible, for example, that exercise improves mood even in those who claim to enjoy being couch potatoes, because humans are animals that benefit from exercise.

The difficulty with neo-Aristotelian accounts is that it is unclear exactly what grounds the notion that certain ways of living are good for certain types of creatures. The risk is that the neo-Aristotelian either comes to lean too much on biology or else ends up making claims that are ultimately ungrounded. Relying on biology becomes problematic because it is highly implausible that the good human life is identical with that which is evolutionarily most successful. Evolutionary success is dependent on acting to ensure that one's genes spread, but plausibly, the good life cannot be reduced to this (consider that Genghis Khan is postulated to be an exceptional evolutionary success but surely doesn't represent a role model [Zerjal et al. 2003]). Turn away from

biology, however, and it becomes unclear what there is that might ground the claim that certain ways of living are good for humans quite apart from what anyone thinks. Appeals to "ideal standards of human flourishing" seem disturbingly abstract. It is not clear how the ideal standards are fixed, nor is it clear how we can find out about them.

Middling positions that appeal to the idealized judgments of humans also face problems. If there is only a bit of idealization, then mistakes can still be made. Suppose, for example, that we say that it is only the well-considered judgments of actual communities that should be considered in judging harm. The problem is that history shows that quite frequently, whole communities have reflected long and hard and have still reached the wrong conclusions. Consider, for example, all those traditional patriarchal societies that have had their best (male) minds thinking about the role of women for decades or even centuries; even after much thought, many still maintain that women are less worthy of respect than men. Oftentimes, actual deliberative processes misfire. Sometimes the fault lies with the individuals involved. For example, those who are very clever may still be self-deceived. Sometimes the deliberative forum lacks the sorts of social and cultural support required to move debate forward (e.g., a forum may be too deferential to authority or exclude those who could challenge prevailing beliefs). If we rely on idealization in our account of harm, we will need quite a bit of idealization if we are to rule out the possibility of mistakes being made. The problem is that the more idealization we have, the less grounded our account becomes. If I say, for example, that harm is to be judged by fully informed, unbiased, clever, and virtuous humans in a forum that involves all appropriate participants and is organized to promote progressive discussion, then I'm moving very far from the actual debates of actual humans. How I am to judge what such ideal agents would decide?

Here I will not resolve the problem of how to determine the nature of the good life or of harm. Luckily, we will be able to make some progress when it comes to evaluating the harmfulness of particular conditions even in the absence of an overarching account. Whatever account of the good we adopt, it is clear that rather than relying on gut reactions to determine whether a condition is harmful, we should require at least some reflection. This on its own will be enough to give the idea that disorders are harmful some critical bite. In the next section, I will show how we can use the claim that disorders are harmful to determine whether certain conditions should be considered disorders.

III. Making Progress

Suppose we accept that disorders must cause harm and set out to consider whether some particular condition causes harm. How should we proceed? I have argued that no fully satisfactory account of the good life exists. Luckily, however, seeking to establish whether some particular condition is harmful is often much easier than seeking

to produce some abstract account of harm in general. I will discuss three methods for thinking about harm. These methods are intended to be illustrative rather than comprehensive. Together, they show how the idea that disorders are harmful can do critical work. The legitimacy of each method should be uncontroversial, and yet each can be used to argue that particular conditions should not be medicalized.

3.1 Method 1: Think!

When it comes to judging specific conditions, quite often simply posing the question, "Does this condition cause any harm?" is sufficient to unearth conditions that have wrongly been classified as disorders. Wakefield (2002) discusses the example of childhood disorder of atypical stereotyped movement disorder, which was included in *DSM-III* (the third edition of one of the main classifications of mental disorders). Many children with severe developmental disorders engage in repetitive movements—rocking, repetitive hand movements, head banging, and so on. Some otherwise normal children also engage in such actions, for example, rocking before they go to sleep. The movements are voluntary and are often experienced as comforting. Under the *DSM-III*, all children engaging in these sorts of repetitive movements could be diagnosed. Wakefield thinks it likely that such repetitive movements may well be associated with some sort of brain dysfunction (even in the children who are otherwise normal). Yet, he points out that given that the movements themselves generally cause no harm (except in cases where, for example, a child head bangs walls), there is no good reason to consider the child to have a disorder. In this example, simply asking whether there is any harm in a child rocking can be sufficient to rule out the fallacious diagnoses.

Medical thought has on occasion displayed a tendency to elide the distinctions between a state being unusual, it being a dysfunction, and it being a disorder. Amundson (2000) discusses the ways in which medics have all too often viewed infants born with unusual genitals, extra fingers, or webbed toes to be disordered simply in virtue of their difference. Against such a climate of thought, merely stopping to question whether a condition causes any harm can in itself act as a buffer against unnecessary medicalization.

3.2 Method 2: Breaking Down Claimed Costs and Benefits

There are numerous conditions where we may be unsure whether they should count as disorders because we are unsure whether they are harmful. Consider Asperger's syndrome, asexuality, Deafness, and hearing voices. In such complex cases, I suggest we can adopt the following strategy: we should go through potential alleged benefits and disadvantages of having the condition one by one and see if they survive scrutiny.

In detail, we start by asking those who think a condition is a good thing why they think it is a good thing, and those who think it is a bad thing why it is a bad thing. We can expect the responses to involve a mixture of factual and value-based claims. For

example, someone with bipolar disorder may claim that an advantage of the condition is that during manic phases, they create great art. This claim is partly amenable to empirical investigation—do they paint more during manic phases? Are those paintings they produce then judged among their best? Partly, the claims depend on basic intuitions about values that may not be amenable to empirical evidence. Is it a good thing to produce art? And if so, how does this good rank against others? Is the production of great art worth producing even if its production involves creating distress in the artist, for example? In considering what sorts of things are good, we should start by making use of our commonplace intuitions. These intuitions are a starting point that in some cases will themselves be subject to critical revision. In seeking to evaluate claims that some condition is good, my suggestion is that we should break down the justification as much as we can and see whether the justification survives rational scrutiny.

In my 2007 paper "Can It Be a Good Thing to Be Deaf?" I employ this method in thinking through whether it can be a good thing to be Deaf. While being Deaf is not a mental disorder, the case serves to demonstrate the methodology and is useful because it has been subject to much discussion. The issue around Deafness is that some Deaf people claim that Deafness is not pathological but is rather a way of living.[1] This is because they think it is a good thing to be Deaf. Primarily, they have in mind people who have been Deaf from birth and use sign language, rather than those who have become deaf in later life. In considering whether it is true that it can be good to be Deaf, we need first to compile a list of the differences between Deaf and hearing people. Most notably, hearing and Deaf people differ in the sensations that they experience and in the languages that they typically employ. Once we have a list of the differences, we need to consider the benefits and costs that can be expected to flow from each difference. Thus, we should consider, for example, whether sign language is as good as spoken language. Those who argue for the benefits of sign languages make many claims that can be subjected to empirical test. For example, it is claimed that sign languages are often better able to convey information about the spatial location of objects. Whether this is true can be tested. Whether a difference should be considered a benefit or cost can be subjected to commonplace intuitions. In judging a language, for example, all things being equal, a language that can convey complex information easily is better than one that cannot. Or, consider the fact that Deaf people have different sensations than hearing people. Sensations provide us with pleasure and are a source of information. Deaf people miss out on sound sensations, but they may develop some enhancement in other sensations (e.g., better peripheral vision, being more attentive of vibrations). Again, the extent to which Deaf people do have different sensations can be tested. Once all the differences between Deaf and hearing people have been considered, a final summing of costs and benefits can be attempted. In the case of Deafness, I argue that the final summing is uncertain. Many factors are context dependent (using sign language is only practical where others sign) or depend on personal taste (some people

get more pleasure listening to music than others). Thus, whether it is good to be Deaf will probably vary between different Deaf people.

It should not be considered a problem that the application of my method yields an unclear conclusion. Knowing that it is unclear whether it can be good to be Deaf is itself useful. Uncertainty in itself has policy implications. In this case, it means that any justifications for interfering in cases where parents choose to bring up their child as either Deaf or as hearing are weak. There is, for example, thin justification for removing a Deaf child who is happy in a Deaf community and whose parents refuse cochlear implants.

Our commonplace intuitions about goods and harms can enable judgments as to whether some condition is harmful. But it's also the case that the experiences of those with various types of medical condition can help inform our notion of the good life. For example, we may start by assuming that it is bad not to be able to talk. We have a tacit assumption that all languages are verbal. Then we learn about sign languages. We revise our initial assumption. Rather than saying that it is bad not to be able to talk, we say it is bad not to be able to communicate. The experiences of those who are physically and psychologically different can also inform us of goods that we might otherwise overlook. Consider the unease produced by feelings of derealization. These may prompt us to consider "feeling at home in the world" to be an important good, although if we had never come across accounts of derealization, this good would never have become salient to us.

3.3 Method 3: Considerations of Consistency

In some cases, considerations of consistency can prompt us to revise our initial judgments as to whether a condition can be considered harmful. Let us compare two cases:

First let us consider someone who has no interest in sex. Asexuality has at times been considered a disorder, but many asexual people do not consider themselves to have a problem. The Asexuality Visibility and Education Network (AVEN) provides web forums for people who identify as asexual. The forum asserts, "We here at AVEN get along just fine without sex" (http://www.asexuality.org/home/), and many of those posting on the forum seem pretty content. Many asexual people do not consider it a disadvantage not to desire sex. They may not have a sexual relationship but have more time for friends, and they claim that nonsexual adult relationships can be as rewarding as sexual ones. Suppose the claim that it is perfectly okay to be asexual strikes me as reasonable.

Now consider a different case, someone whose sexual desires exclusively revolve around solitary activities with shoes. The interests of those with shoe fetishes can vary in ways that can significantly affect their likelihood of living a good life (see, e.g., the case studies in Krafft-Ebing 1965). Some fetishes involve partners (the shoes need to be worn by someone); some just involve shoes. Some forms of shoe fetishism involve

masochistic interests (being walked on, licking dirty shoes, etc.); some do not. In this case, I want to consider someone whose sexual interests revolve around masturbating with shoes that are bought from shops (as opposed to, for example, stolen).

Now suppose that having listened to the advocates of asexuality, I find it plausible that not having a sexual adult relationship is no loss. Fair enough, I think, the asexual person will have no adult sexual relationship, but this will be made up for by them having increased opportunities for forming friendships instead. But, then suppose that I listen to the shoe fetishist. He explains that he has an advantage in that his sexual desires are easily satisfied. Given that buying shoes is much easier than wooing women, he finds that he has more time to spend on other activities and on nonsexual friendships than do many of his conventionally heterosexual peers. He does not feel the lack of a sexual adult relationship. Suppose that in this case I find myself less convinced. As a good liberal, I assert that I make no judgment about how people get their kicks. So long as no nonconsenting partners are involved, I claim to judge all sexual pleasures equal. I claim that it's not that I find the shoe fetishist's pleasures ridiculous or disgusting but that I worry that in missing out on an adult sexual relationship, he misses out on something important.

Now, when I consider my responses to these two cases together, I notice that there is a tension. I must be consistent in my thinking as to whether an adult sexual relationship is an essential component of a good human life or not. If it's fine for an asexual person to have friendships instead, then this should also be the case for the shoe fetishist. Considerations of consistency can thus force the revision of initial judgments.

Through considering these cases, I have shown how we may make progress in deciding whether specific conditions cause harm and should be considered disorders or not. This enables the claim that disorders are necessarily harmful to have critical bite—that is, it will be possible to use it to argue that in certain cases, we have made a mistake. In some cases, we can use the claim that disorders are necessarily harmful to show that some condition that we currently consider a disorder should not be considered a disorder. What's more, we don't need to wait to establish a correct account of harm for such projects to get under way.

IV. Loose Ends

I have shown how we might use the idea that disorders are harmful in critical projects. In this final section, I address some loose ends.

4.1 Individualization

As the examples we have considered show, many conditions are such that they cause harm to some people but not others. Different people have different interests, abilities, and needs and live in different environments. Thus, the impact of Deafness varies

from person to person. Using sign is easier for someone who lives among signers; some people like listening to music more than others. The same condition can have very different effects on different people. Consider Tourette's; some tics are rude (breast touching, racist shouts) or hurt (hitting), and others are subtle (standing on one's toes).

That harm will vary from individual to individual presents us with a choice. We might say that a condition that is generally harmful within a particular society should be considered a disorder in the case of everyone who has that condition, even if a particular individual is not harmed. Thus, as schizophrenia is generally harmful, it will count as a disorder even in those individuals who only hear encouraging voices. Alternatively, we can say that whether a condition is a disorder will vary from person to person. Thus, schizophrenia is a disorder in those people that it harms and a mere difference in those individuals who it does not harm. In his writings, Wakefield seems to suggest that he adopts the first society-wide option (although he discusses harm so little that this is somewhat unclear). When Wakefield discusses how the harm criterion means that the same conditions can be a disorder in some contexts but not others, he considers dyslexia, which causes harm in literate societies but not in societies that do not use writing (2002, 151). If Wakefield's view is that a condition counts as a disorder for everyone in a particular society if it harms most people in a society, this is a mistake. It is better to claim that a disorder must be harmful for the particular individual who has it. This is for two reasons: the first ties in with the justification for having a criterion that disorders must cause harm at all. Wakefield (1992b) considers why we should require that disorders be harmful. He argues that attributions of disorder involve a value component because disorder is in certain respects a practical concept that is supposed to pick out only conditions that are undesirable and grounds for social concern, and there is no purely scientific nonevaluative account that captures such notions (Wakefield 1992b, 237). Such considerations suggest that we should consider whether a condition causes harm and will thus count as a disorder at the individual level, as only those individuals who are harmed are in need of help.

Second, judging whether a condition harms a particular individual is far easier than seeking to work out whether a condition causes harm for most people within a society who have it. Figuring out what counts as a "society" is tricky. In multicultural countries, "societies" are hard to delimit. Even once one has decided on the relevant grouping of people, figuring out whether most of them are harmed by a condition or not would require complex surveys. Asking whether a particular individual is harmed by their condition is easier because the individual can be easily identified and their context can be known.

On the downside, some worry that saying that the same condition should be considered a disorder for some individuals but not others will cause problems for certain types of research. Epidemiologists would prefer to be able to count cases of a particular disorder without having to worry about the life situations, hopes, and interests of each

individual. The way to get around this worry is to slightly reconceptualize the work of medical researchers and epidemiologists. Rather than characterizing this research as investigating disorders per se, we can think of it as investigating those conditions that are of interest because they often cause harm and are therefore often disorders. This allows researchers to employ criteria that pick out subject populations without regard to whether or not the particular individuals experience harm.

4.2 Harm to Whom?

Must a disorder cause harm to the individual who has it, or is harm to others sometimes sufficient? Examples of conditions that might be thought disorders because of the harm they cause to other people are the personality disorders and paraphilias (sexual perversions). Generally, Wakefield says that the harm must be to the patient, but on occasion, he wavers (e.g., 2002, 148), and this is a matter on which we need to be clear.

I suggest that we should claim that disorders must be bad for the patient. This stance is linked to the solution to another problem; how can we distinguish between disorders and normal criminal or antisocial behavior that harms others? The difficulty is that not all of those who harm others suffer from disorders. Everyone sometimes does things that are naughty, cruel, or selfish, and some people do bad things quite often. We need to be able to say what distinguishes disordered people from those who are simply criminal or antisocial.

The most plausible distinction is that normal badness is voluntary, while behavior that is symptomatic of a disorder is not under normal voluntary control. The distinction is not completely clear-cut, but the extremes of voluntary and involuntary behavior are clearly distinct. The normal criminal may get into fights for fun and manipulate others for cash. He may plan his misdeeds and boast of them afterward. He moderates his actions in a rational way; he picks fights only with those who are weaker and only when there is no CCTV. The criminal's actions are planned, motivated, and controlled; they are fully voluntary.

Consider in contrast this description of behavior performed during dissociative flashbacks associated with posttraumatic stress disorder. This is described as "unpremeditated and sudden and uncharacteristic of the individual. … Furthermore, there does not appear to be an alternate motive. Most individuals experience amnesia for the episode and are unaware of the specific ways they have repeated or re-enacted war experiences" (Frierson 2013, 83).

Plausibly, the difference between behavior that is indicative of normal bad behavior and disorder is that the former is voluntary, while the latter is in some way involuntary. Plausibly, it is also the case that not having normal control over one's behavior is a bad thing. If so, all those behaviors that harm others and that are also indicative of disorder will simultaneously be bad for the patient.

To illustrate how the idea that disorders must harm the patient and not just others might be applied in practice, let's consider pedophilia. Pedophiles may all be sexually attracted to children but differ in their behavior. Some find their desires repugnant and struggle against them; they may avoid the company of children and never act on their desires. In this sort of case, the pedophile is harmed by his condition; he finds himself with desires that cause him distress. Other pedophiles do not control themselves; they groom and abuse boys and girls. Possibly some abusive pedophiles would prefer not to abuse children but have unusually strong desires that they cannot resist. Given that it is bad not to be able to control oneself, such individuals are again harmed by their condition. But what of the individual who finds himself sexually attracted to children and acts on these desires without compunction? Does pedophilia harm this individual, or does it just harm others? This is a tricky question and depends on the account of good that one adopts. Some of those who adopt Aristotelian accounts will claim that the pedophile is harmed by his condition even if he claims to be quite happy. They can claim that the good human life is one that involves sexual relations only with other consenting adults. From this standpoint, the pedophile fails to flourish regardless of his claims. Some other accounts of the good life do not permit such a line to be taken. On desire-satisfaction accounts, the active pedophile who does not struggle against his desires is doing just fine. He has desires, and these desires are met. From such a standpoint, this pedophile harms others but is not himself harmed. If, as I suggest, one claims that behavior characteristic of disorders must be involuntary and that disorders have to harm the patient, then one is forced to say that the active and unrepentant pedophile should be considered bad rather than disordered. I think this is an acceptable line to take.

Of course, many of the disorders treated by psychiatrists are puzzling precisely because the behaviors associated with them seem to fall somewhere between those that are under normal voluntary control and those that are completely involuntary. In such cases, I suggest that it is simply unclear whether the condition should be considered a disorder or a moral failing.

4.3 Harm in Practice: The *DSM-5*

The importance of the idea that disorders are necessarily harmful is brought out if we consider the consequences for medical classification. The *DSM* is a classification of mental disorders that is published by the American Psychiatric Association and used by those many of those researching and treating mental disorders around the world. The *DSM* has long conceived of harm as being an essential element of disorder. This viewpoint came to be widely adopted in psychiatry following debates about the status of homosexuality in the late 1960s and 1970s. A consensus developed that although homosexuality might turn out to be some sort of evolutionary dysfunction insofar

as it is not harmful, it should not be considered a disorder. The definition of disorder included in editions of the *DSM* in use from 1987 to 2013 states that

> 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 significantly increased risk of suffering death, pain, disability, or an important loss of freedom. (American Psychiatric Association 1987, xxii; 1994, xxi)

However, in the latest edition, the *DSM-5*, published in May 2013, the role of harm has been downgraded. The new definition states only that

> mental disorders are *usually* associated with significant distress or disability in social, occupational, or other important activities. (American Psychiatric Association 2013, 20, emphasis added)

The *DSM-5* is a product of much work by many committees. The new *DSM-5* definition was a compromise between advocates of the view that disorders must necessarily be harmful and advocates of a quite different tradition, which considers "disorder" to be a value-free term. Among the committees involved in revising the *DSM*, the Impairment and Disability Assessment Study Group drafted a completely value-free definition of disorder that sought to bring the *DSM* into line with the view implicit in the *International Classification of Diseases* (*ICD*), published by the World Health Organization (WHO).[2] In the *ICD* system, disorder and disability are thought of as being quite distinct, and the WHO publishes a distinct classification, *The International Classification of Functioning, Disability and Health*, which supplies codes for disability. The thinking here will already be familiar to those who have had some exposure to disability studies, where the social model of disability conceptualizes impairment and disability separately; impairment refers to the biological difference (e.g., having no legs), and disability refers to problems in everyday living that are conceived of as arising from the social response to the impairment (e.g., a lack of ramps for wheelchairs). In the eyes of the Impairment and Disability Assessment Study Group, someone who, say, hears voices but is not bothered by them and has a good life should be said to have schizophrenia (supposing that criteria for duration, etc. are met) but not to be impaired or to necessarily need treatment. The value-free definition of disorder proposed by the Impairment and Disability Assessment Study Group was not adopted, but the downgrading of the role of harm in the *DSM* definition of disorder (from definitional to merely characteristic) is a legacy of the actions of this group.

So far, in practice, the altered *DSM* definition of disorder will have had little impact on the actual contents of the classification. The definition was developed far too late in the revisionary process to have influenced decisions about the contents the classification. Looking to the future, however, the change to the definition included in the *DSM* should be a real concern for those who think that disorders are necessarily

harmful. Currently, it remains the case that many of the individual sets of diagnostic criteria included in the *DSM* include a requirement that the particular disorder can only be diagnosed if it produces harm. The exact wording varies but generally requires that "the disturbance causes clinically significant distress or impairment in social, occupational, or important areas of functioning" (American Psychiatric Association 2013, 21). The *DSM-IV* had many similar criteria, and these have generally been maintained in the *DSM-5*. The difference is that, with the change in the definition of mental disorder, there is no longer a robust rationale for the inclusion of the harm-related criterion in the individual sets of diagnostic criteria. Previously, this criterion was included as a reminder to clinicians that the diagnosis should only be made if harm was caused because the definition of disorder required harm (i.e., the rationale was conceptual). With the change in the definition, there is nothing to guard against some future edition of the *DSM* deciding to ditch the idea that disorders have to cause harm altogether. The change to the definition of disorder included in the *DSM* means that the notion that disorders necessarily cause harm is under threat. This should be cause for concern because the criterion that requires that disorders cause harm is crucial to prevent some of those who are merely different from being diagnosed. In many cases, unwarranted medicalization can only be prevented by appealing to the harm part of the harmful dysfunction account.

Notes

1. In these debates, "Deaf" with a capital "D" is used to refer to people who culturally identify as Deaf people (they tend to have been Deaf from birth and sign), while "deaf" with a little "d" refers to all those who cannot hear.

2. This definition and the rationale for its development were available on an American Psychiatric Association website while the *DSM-5* was being developed but has been removed since its publication.

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