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Defining Mental Disorder

Jerome Wakefield and His Critics

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28 Must Social Values Play a Role in the Harm Component of the Harmful Dysfunction Analysis? Reply to Rachel Cooper

Jerome Wakefield

Rachel Cooper is one of our field's most productive and insightful thinkers, and I have learned much from her. I thank Cooper for her critique of the "social" aspect of the harm component 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, 2007, 2009, 2011, 2014, 2016a, 2016b; Wakefield and First 2003, 2012).

Cooper accepts the HDA's claim that harm is a necessary requirement for disorder ("Wakefield is correct in thinking that disorders must be harmful") and undertakes to examine "what it means to say a condition is harmful," particularly objecting to my claim that harm must be understood in terms of social values. Cooper hopes to deploy a culturally transcendent harm criterion to prevent misdiagnosis ("when properly understood, the harm component of Wakefield's account can also be used to provide a barrier against medicalization"). Her critique is part of a recent surge of interest in the nature of the HDA's harm component (e.g., Feit 2017; Limbaugh 2019; Muckler and Taylor 2020; Powell and Scarffe 2019), and I thank her for pushing that discussion further. In the course of considering harm, she also proposes an analysis of "disorder" based on the involuntariness of action, which I address.

Cooper's chapter focuses on the HDA's harm component, but elsewhere Cooper (2007b) critiques the HDA's dysfunction component and disputes the HDA's claim that disorder requires evolutionary dysfunction. That critique is cited by other critics in this volume, including Leen De Vreese, who cites Cooper's discussion as a justification for considering the HDA to be refuted. Consequently, in a supplementary reply, I respond to Cooper's objections to the HDA's evolutionary perspective on dysfunction.

As Cooper observes, with a few recent exceptions (Wakefield 2013; Wakefield and Conrad 2019; Wakefield and First 2013), I have written relatively little about the HDA's harm component other than to defend the necessity of a harm criterion against pure

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naturalist accounts (Wakefield 2014). One reason for this emphasis is that the HDA is intended partly as a response to antipsychiatric claims that mental disorder judgments are nothing but social value judgments, so I have focused on explaining how disorder judgments go beyond social value judgments via the dysfunction criterion, yielding some degree of scientific objectivity and locating them within a legitimate medical domain that is partly factually anchored. Cooper observes as well that my focus on dysfunction was motivated by my specific interest in false-positive diagnosis, which was the problem at the heart of the antipsychiatric critique, because the most egregious false-positive abuses of psychiatric diagnosis have generally been due to failures to observe the dysfunction requirement. Moreover, the analysis of function and dysfunction has broader implications for philosophy of biology, philosophy of science, philosophy of mind, and the human sciences.

A further and more negative reason for focusing more on dysfunction than harm is that it seemed to me that something useful and relatively incisive can be said about dysfunction, whereas this is less clear for the harm component. Serious exploration of the harm component quickly leads one to confront profound disputes in value theory that are notoriously intractable and unlikely to be advanced by evidence of intuitions about disorder versus nondisorder. Indeed, one might wonder if harm is so contestable that it is best left imprecise within the HDA for the time being. We shall see that Cooper's contribution strongly underscores these doubts about attempting to be precise about harm.

Mea Culpa!

Before addressing the specifics of the harm criterion, I start with some general reorienting comments about the nature and limits of my "social values" qualifier to the harm criterion. I stoked controversy from several quarters by stating that harm is evaluated relative to social values. Some psychiatrists saw the reference to social values as introducing an unwanted element of cultural relativity into disorder diagnosis. Some philosophers saw it as a threat to a larger naturalist program. Other philosophers were concerned that I was embracing a naive cultural relativism that conflicts with the aspirations of some metaethicists to establish the transcultural objectivity of value judgments.

It has become obvious that I was not sufficiently clear or careful regarding the "social values" aspect when I formulated the HDA, and as Cooper notes, I (Wakefield 2013) recently attempted to clarify my intentions and present a broadened vision of harm in the context of social values. It apparently seemed to many readers that I was saying that actual social attitudes, opinions, and judgments at a given time are final arbiters of harm for medical purposes. That's absurd, of course. What is thought to be harmful may not really be harmful upon reflection when one takes into account a culture's overall moral vision, its changing circumstances, and basic human aspirations

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that infuse all social value systems. Social values in the sense I intended are not initial superficial subjective reactions but value claims that have been subjected to a dialectic that goes deeper than immediate reactions or consensus to explore which of a culture's many often-conflicting value commitments are its most basic values, which serve long-run interests of justice, which might be reactions that rationalize power relations, and so on. I thus agree with Cooper's three methods for challenging initial value judgments (see below) and more; social values include what can emerge from such a process.

When I claimed that social values provide an essential filter for judgments of medical harm, I did not mean to assert absurdities such as that "whatever is disvalued by a society should be rejected" or that "any condition that a society values is valuable"—views that Cooper targets for criticism as my views. The reference to social values was intended not as a relativist metaethical statement or an absolute constraint—harm is harm, and if it can be shown that there is diagnostically relevant harm that transcends social value systems, then I accept that that can qualify as HDA harm—but rather as a qualifier to explain features of actual medical diagnostic practice, detailed below.

I want to emphasize that the social values guideline went beyond strict conceptual analysis of the general concept of disorder and should be understood analogously to the HDA's commitment to the selected effects reading of dysfunction (see Lemoine and my response in this volume) as a theoretical codicil to the conceptual analysis. Bluntly put, disorder is harmful dysfunction, period, however harm can be established. Nonhuman nonsocial organisms, for instance, can have disorders because they can have harmful dysfunctions without reference to social values. However, my discussions focus on the human case, and in my view, the best available understanding of "harm" in the human case is through the prism of social values, for reasons provided below. Humans are social animals whose values and judgments of harm—and actual harms—are to a large extent mediated by, and vary with, social context. Of course, there are harm judgments that are virtually universal, but such universal values are expressed as well through cultural value systems, even if only latently, and so are encompassed within a broad social values perspective. But, the social values addendum is not strictly part of the concept of disorder, and an alternative theory of human harm would be possible.

Cooper is particularly concerned that my "social" approach anchors judgments of medical harm in the judgments of fallible "actual people"—think here of an earlier homogeneously homophobic America—who can err about what is harmful: "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.… The key difficulty is that people often do not know what is in their own best interest or in the best interest of others."

There are two ways to respond to this concern and "correct" what are seen as a culture's potential moral errors. One is to seek a realm of culture-transcendent moral

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values that override cultural values; this appears to be Cooper's solution, but it raises challenging epistemological and metaethical questions that are, as we shall see, quite difficult to answer. The other is to seek redress in the potential for moral change that exists within the resources and complexities of any actual human culture's value system; Cooper inadvertently seems to take this route as well, in her proposed methods for correction of faulty harm judgments (see below). Until the viability of the transcendent route is proven, the value-system approach seems to me to make the most practical sense. The process of self-interrogation of a culture's values in the domain of medically relevant harm is well illustrated by the remarkable reading of our culture's deeper values by Robert Spitzer and the consequent revolution in attitudes toward gay marriage and homosexual civil rights partly triggered by depathologization. No simple reduction of a social value system to a poll of the people in a society can explain such dynamic phenomena, nor can it best be explained by appeal to a transcendent value universe, for all the value issues Spitzer raised lie squarely within the complexities of our society's social value system.

Consistent with such an approach, a close examination of what I said in my papers reveals that my references to social values are not people's opinions or feelings or the "judgments of actual people" but are consistently to a more abstract level of "social norms" and "sociocultural standards" that allows for conflict and dialectic. As Cooper documents, in my original HDA publication, I indicated that harm is "based on social norms" (1992a, 373), "determined by social values and meanings" (373), and "deemed negative by sociocultural standards" (374). Fifteen years later, in a presentation of the HDA to a psychiatric audience, I (Wakefield 2007) said that harm "is judged negative by sociocultural standards" (149) and is judged "according to social values" (150). These references are not to the reactions of specific actual people but to more abstract entities that are complex and have various conflicting currents and levels that dynamically interact and evolve. Although supervenient on an ongoing meaning system of a culturally coherent collective of individuals, a system of values has structures and potentials that do not necessarily map on to any superficial reading of what people think or feel at a given time. As to my openness to any form of harm that can be defended, I stated that harm "is construed broadly here to include all negative conditions" (2007, 151).

The concept of disorder evolved in a world in which cultural values in relatively homogeneous societies may have seemed like ultimate objective values; indeed, societies sometimes support their value systems by erroneously seeing local values as objective universal truths, just as they support their values by elevating values into features of human nature and deviance into dysfunction and disorder. Such objectification of cultural values can lead to the devaluation of alternative ways of life and the oppressive deployment of medical power in the name of some supposed universal (e.g., see Powell and Scarffe 2019). Cooper is focused on addressing this danger in her attempt to go beyond cultural values and postulate an objective way of evaluating a condition's

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harmfulness in making a diagnosis. However, her solution is open to the same danger of reification of local values into transcendent truths as is the problem it is meant to solve.

There is nothing sacred about the precise way I formulated the harm criterion. I am open to rethinking and amending it if an alternative approach can be cogently elaborated and defended so that it is not an arbitrary imposition that is simply an expression of Western triumphalism (for discussion of some of the inevitable dangers of such an attempt, see Wakefield and Conrad 2019). I argue below that Cooper fails to provide any such rationale. For now, I tend to see such hypothesized transcendent value considerations as latent or implicit strands in virtually every human community's social value system rather than something standing outside of and in addition to social values.

Why Social Values?

All that said, why, then, did I feel it useful to specify that diagnostic harm reflects social values? One tactical motive was to prevent the possible misunderstanding that the harm is also, like dysfunction, related to evolutionary theory and represents a lowering of fitness. The evolutionary view of harm has been expressed in the literature and is easily confused with the HDA, and I disputed it in my original HDA paper (Wakefield 1992a). Without clarity on this point, the disorder status of conditions that cause sheerly socially anchored harms, such as dyslexia (reading disorder), is more difficult to address. Dyslexia has been a much-discussed controversial example deployed by critics of the HDA from the outset because its harm seems distant from evolutionary considerations and it does not involve alteration in fitness so far as we know, and the "social values" addendum makes clear how dyslexia can be harmful in the relevant way.

However, the primary motivation for the social values addendum was a theoretical-explanatory consideration. Whether a condition is a disorder is not determined by how the diagnosed individual subjectively happens to feel about the condition's effects but by more "objective" standards determined by the culture's value system. Thus, for example, infertility at prime childbearing age is a disorder even if a patient has decided not to have children because ability to reproduce is generally considered a valuable capability in our society and deprivation of this ability is considered a prima facie harm irrespective of benefits that might accrue. Harm is also not determined by the idiosyncratic values of the physician. Medicine in our time is a socially sanctioned activity that carries with it the obligation to alleviate harm as it is understood by the society at large. Of course, in medicine, as in all professions, there are occasional conflictual situations in which supererogatory moral commitments override such standard understandings.

The "social values" qualifier also captures the inevitable degree of social relativity present in disorder status. If a failure of function has no impact on anything valued by a specific culture, it is not a disorder for that culture but merely a harmless dysfunction

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or anomaly. The HDA allows for an appropriate degree of such cultural relativity. The HDA of course severely limits value-based cultural relativism of disorder because of the factual dysfunction requirement that is in principle independent of social values. The factual dysfunction requirement prevents disorder from being manufactured from the whole cloth of cultural values. But, equally, the social values anchoring of harm prevents disorder from being manufactured from dysfunction within a culture in which the dysfunction is not harmful.

For example, assume that the theory is true that dyslexia is caused by a minor malfunction of the corpus collosum linking the two brain hemispheres, such that the dysfunction limits the rate of information transfer from one hemisphere to the other, and it is then difficult to learn to read due to the unique and extraordinary cross-brain-hemispheric information integration demanded by our reading, but the dysfunction has no other negative effects. Because in our culture, reading is a highly valued practice, this dysfunction is harmful and thus a medical disorder. However, the same dysfunction in a preliterate society that existed 1,000 years before reading was invented, or in a postliterate society 1,000 years from now in which reading is obsolete, would not be considered a medical disorder but rather a harmless anomaly. Variations in values from society to society also enter into harm judgments when there may be agreement on broader values but disagreement on the details of how those values are realized. It seems to me that some degree of such cultural relativity of disorder cannot be avoided.

Social context must enter into the medical evaluation of harm because it is possible for different cultures to have different fundamental values that yield differences in what is harmful, and yet both societies are morally acceptable. Consequently, what is harmful dysfunction in one society can be a harmless anomaly in another society. To take a well-known example, there are fundamental differences between cultures in the attitude toward the balance between personal striving and individual autonomy, on one hand, and group cohesiveness and subservience to group well-being, on the other. In a society focused on individual self-realization, a dysfunction that caused pronounced behavior fitting the group-above-self society's ideal of subservience to the group might be considered a disorder, but the same dysfunction would not be considered a disorder—and might actually be considered a desirable advantage—in the other society. To consider a more mundane example, there are many harmless "commensal" viruses that infect human beings with no harm, and they are not considered disorders. There is also a virus that causes a modest weight gain due to disruption of appetitive mechanisms and no other negative effects. In our society, we are very weight conscious in our aesthetics, and this virus would be considered a disorder. However, in other societies in which an ample figure is the ideal, this virus would not be considered a disorder but commensal.

Moreover, there are many universal human features that have culturally variable parameter settings so that the actual instantiations of these values differ across cultures.

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What foods are acceptable to eat, what sexual activities are acceptable at what age and with whom, what emotions at what intensity and duration are acceptable and are proportional reactions to events (e.g., how much sadness or grief is appropriate and for how long given each kind of loss), and so on all vary enormously. This is not necessarily a matter of one society having better values than another and is comparable to different societies having different languages that instantiate the universal human capacity for language, so that whether an utterance is a grammatical sentence depends on the culture within which it is uttered. The social embedding of harm is indicated by the *Diagnostic and Statistical Manual of Mental Disorders*'s (*DSM*'s) emphasis on role impairment as a basic form of harm. Role impairment is a form of *pro tanto* harm across cultures, but cultures differ in their social roles and role expectations and thus will differ in whether specific inabilities represent role impairment. An inability to deal with certain bureaucratic social demands of a developed economy may be irrelevant in a simpler society in which individuals can go alone on long hunting trips for much of the year. Conversely, a dysfunction that causes an inability to engage in a simpler society's most important activities of hunting and gathering may be irrelevant in a developed society in which there are myriad occupations with varying required abilities from which to choose.

Anorexia Island

As we saw, Cooper's basic objection is that my "social values" approach to harm anchors harm in the judgments of fallible "actual people" who can err about what is harmful. Cooper at times appears to look to some other source of value that lies beyond the entire social value system, given that "people often do not know what is in their own best interest or in the best interest of others." If we interpret her in this way, then what we would need to make sense of Cooper's position is some account of the nature and epistemological accessibility of the culture-transcendent values that determine medically relevant harm within a culture. However, such a rationale is not on offer. Cooper oddly combines an unwavering confidence that the HDA is incorrect in specifying that harm is understood in terms of social values with a professed lack of any systematic rationale for judging harm in any other way, other than by her own intuitions. Cooper repeatedly asserts that she has no such account that would justify or explain the validity of her intuitions and suggests that no such account is in reach: "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"; "Although various accounts of the good for an individual have been proposed, all are problematic"; "In this chapter, I will not be able to determine the correct account of the good life"; "Here I will not resolve the problem of how to determine the nature of the good life or of harm"; "I have argued that no fully satisfactory account of the good life exists." Having no theory of value transcendence, she still insists, "On one point

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I am sure, however, and that is that saying that harm is determined by one's society will not do."

Nevertheless, Cooper is confident that the social values construal of harm is wrong, and she thinks that she has a knock-down counterargument: "There are cases where it is extremely plausible that a cultural group can be mistaken about what is valuable." That is, entire societies can be wrong about what is harmful, so social values cannot be the baseline for judging harm. In support of the claim that entire societies can be wrong about what is harmful, Cooper provides the following thought experiment in which a society adopts an anorexic-like aesthetic:

> 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.… 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.

I am not sure I agree that a special-purpose isolated group set up for people who already share a minority aesthetic that emerged in a larger culture is therefore a culture. But leave that issue aside. This seems on its face to be an example about harm and culture, not about medical judgment. The individuals on this imagined island think anorexic-level thinness is a desirable aesthetic ideal, but that does make them anorexic in the psychiatric sense because their behavior does not result from a dysfunction. It becomes relevant to the HDA if we imagine either that they are all suffering from dysfunctions and are truly anorexic and embrace their condition (much like, say, the hearing impaired have created a community that embraces their lack of hearing), or that in such an anorexia-positive society, an individual develops a dysfunction that causes anorexia. Let's proceed with the latter scenario, in which there is a dysfunctional individual whose dysfunction's effects match the culture's anorexic ideal. The question is: first, does this individual have a disorder and, second, do they have a disorder according to the HDA? Cooper's point is that such an individual would not be harmed as judged by cultural standards, and thus would not be judged to have a disorder by the HDA, when in fact the individual is harmed and does have a disorder.

I think the anorexic individual in the anorexic society would still have a disorder according to the HDA. To see why, we might first ask, how does Cooper know that the anorexic ideal that is highly valued in this culture is harmful in the case of the dysfunctional individual despite being valued? She explains, "Anorexia is not a good because people with anorexia become obsessed with food-related issues (and having a life that resolves around this is an impoverished life) and risk death. Whatever their beliefs, anorexia remains a disorder because it remains harmful."

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Cooper's supposedly culture-transcendent judgment that there is harm is perfectly accessible to members of the anorexic society, but Cooper seems to run together the anorexic ideal with the described harms of being anorexic so as to suggest that the afflicted individuals don't judge there to be harm. However, like just about all other human beings, pro-ana individuals presumably understand that death is a bad thing and should be avoided if possible. They may, like mountain climbers and military officers, realize that their chosen ideal life entails a greater risk of physical weakness or death than they might otherwise have but accept the management of that risk as part of the pursuit of their ideal. They also understand that it is bad to lead an impoverished life, although whether they consider a life focused on sharing ideas with friends about dieting, food regulation, and the pursuit of bodily aesthetics (as occurs on the pro-ana websites) to be an impoverished life remains questionable; obsessed "foodies" or extreme-thinness-yields-longevity dieters seem to have related preoccupations that do not necessarily yield impoverished lives. Moreover, like virtually all human beings, the pro-ana people understand that a very large part of the good life is being a successful and admired member of one's society, which entails partaking of socially valued roles and aims. Those who fail to engage in these cultural practices may thereby lose out in multiple social domains and roles or fail to participate socially as well as they might, which is a basic *pro tanto* harm. On the other hand, those who have a dysfunction causing their anorexic pursuits do benefit from successful social engagement but suffer a variety of other harms easily recognized as direct *pro tanto* harms by the pro-ana members themselves, eventually possibly including, for example, such harms as pain, loss of mobility, fatigue, and, ironically, the inability to thus present one's desirable body to others in social interactions.

In sum, in ways that Cooper does not acknowledge, the pro-ana people have the resources within the values of their culture to engage in the very dialectic that Cooper is engaging in. They are capable based on their available value resources of arriving at a reasoned conclusion about the potential harmfulness of their pursuit of thinness, but they value it nonetheless. And, they are able to understand that any individual—whether everyone in the society or just a few individuals—who has a psychological dysfunction that causes the individual to pursue anorexic values is disadvantaged in not being as capable of managing the potential *pro tanto* harms that come with these pursuits. These *pro tanto* harms, which are separable from the anorexic ideal itself, are sufficient for satisfying the harm requirement for HDA disorder attribution.

All that said, I would not want to deny that there is a sense in which entire cultures can be wrong about what is harmful. I believe, however, that whatever universal values can come to the rescue of such a culture are already implicit in and excavatable from within a culture's value system. Moreover, it is simply a fallacy to reason from "social values can get medically relevant harm wrong" to "therefore, there must be a source entirely beyond social values for discovering medically relevant harm," just as it is a

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fallacy to reason from “perception of what is immediately around us can go wrong” to “therefore, there must be a source entirely beyond perception for discovering what is immediately around us,” and a fallacy to reason from “the available evidence in support of a theory can mislead us” to “therefore, there must be a source entirely beyond the available evidence for discovering which theory it is justified to believe.”

Cooper is sufficiently confident that her intuitions can override the value foundations of an imagined society devoted to the value of thinness that she does not stop to wonder whether her judgment could just be her own culturally anchored values being projected into the world, in much the same manner as in an earlier time, “objective” European values were seen as superior to the immoral and harmful practices of “primitive” cultures. Should we equally reject culturally accepted practices such as lip-stretching, tattoos, circumcision, and other potentially harmful bodily modifications that define entry into a community or are aesthetic ideals in cultures other than our own? Oddly enough, while a society supporting thinness doesn’t make the grade for Cooper as an acceptable cultural value, elsewhere she (Cooper 2007a) is sympathetic to deaf mothers depriving their children of the cochlear implants that would give the children the lifelong ability to hear because the parents prefer the child to be a full part of the deaf subcommunity. This suggests a lack of parity of reasoning that may reflect a confusion of local views du jour with transcendent insight.

Three Methods for Challenging Initial Harm Judgments

Having claimed that a culture’s judgments of harm can be fundamentally wrong, Cooper then offers her attempt at a solution to how to reach culturally transcendent values (“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”), namely, three methods for how to engage in extended reflection and challenge standard gut-reaction views on whether a condition is harmful. The three methods are as follows: *(1) Think: Does this condition really cause any harm? (2) Break down claimed costs and benefits and make a list. (3) Consider consistency across judgments*.

Cooper’s methods for exploring harm are innocuous enough, but there are several problems. First, the “list” approach of method 2 reveals an important point on which Cooper goes astray, undermining several of the arguments in her paper. The harm component of the concept of disorder works in terms of *pro tanto* direct harms (except where there is a biological “trade-off” situation), whereas Cooper allows her guidelines to encompass all the possible harms and benefits that a condition may bring and aims to judge overall benefit versus harm. This diverges dramatically from the way “disorder” is used in medicine.

Medical judgments of disorder examine harm in a restricted, diagnostically relevant way that stays close to the immediate effects of the dysfunction and usually involves

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pretty basic harms. There are many larger considerations regarding whether a diagnosed disorder should be treated, but those larger considerations do not generally enter into the diagnostic judgment itself. In judging more generally whether a dysfunction is harmful outside of a diagnostic context, one can take into account all the negatives and positives that issue from the dysfunction and form an "on-balance" judgment of overall harm versus benefit. However, the harm component of medical diagnosis does not work this way, which is why a physician does not need to evaluate your overall life, consider your life plans, and discern your hidden desires to reach a diagnosis. The diagnostically relevant harm associated with dysfunctions is not a matter of on-balance overall net harm but of *pro tanto* harm that emerges relatively directly from the dysfunction. This has long been obvious from examples such as the fact that cowpox can prevent smallpox; cowpox is a disorder due to its direct harmful *pro tanto* symptoms even if it later saves you from dying of smallpox and is an overall benefit. Similarly, your broken arm is a disorder even if it earns you a fortune from insurance that outweighs in benefit any harm suffered from the broken arm itself. In judging whether or how to treat a condition, of course all potential benefits and harms can be taken into account, but when judging whether a condition is a disorder, only *pro tanto* harm is relevant. Cooper's discussions of disorders here and elsewhere include a wide-ranging identification of harms and benefits in a way that potentially runs afoul of the *pro tanto* nature of diagnostically relevant harm for disorder attribution. Cooper's recommendation to evaluate whether a condition is harmful by making a list of the condition's overall harms and benefits is not in any simple way applicable to attribution of disorder versus nondisorder, although it may serve other purposes such as deciding whether overall it is preferable to treat or leave a condition untreated, as in the case deafness (Cooper 2007a).

Schwartz (2007) makes a similar error in his critique of the HDA's harm component, arguing that a disorder, whatever harm it causes, might have a benefit as well that makes it overall beneficial and not harmful: "Making harm a necessary requirement opens the theory to counterexamples involving diseases that benefit their victims, such as flat feet keeping a young man out of the army or cowpox conferring immunity during a smallpox epidemic" (56). However, a dysfunction's direct *pro tanto* harms, not on-balance harms, are the diagnostically relevant harms, which is why *DSM* contains symptom lists, not vast questionnaires for evaluating a condition's possible overall impact on a person's life. Thus, if flat feet are due to a dysfunction and cause discomfort when walking or running or bearing weight, then there is a disorder, even if the condition has the indirect and on-balance beneficial effect of saving one's life by keeping one out of the army. Moreover, harm is not judged on an individual basis that depends on accidental facts like one's being evaluated for forced entry into the armed services. One would judge the harmfulness of flat feet in terms of the disposition to typical and direct harm from the condition itself.

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Second, Cooper does not really demonstrate with her examples that the guidelines are likely to yield agreement on conclusions about harm, with the outcomes of the described explorations seeming quite uncertain. For example, as anyone who has used the method of making lists of pros and cons will know, her advice to make a list of harms and benefits (and leaving aside her embrace of all possible harms and benefits rather than *pro tanto* harms) may not help very much. This is because, although listing may usefully bring additional considerations into play, it offers little guidance when it comes to the main obstacle to decision making, namely, figuring out which choice provides an overall superior outcome given the incommensurability of many desired goods (or in this case, harms versus benefits). For example, responding to claims by some members of the deaf community, Cooper (2007a) engages in an extended consideration of whether, based on a listing of harms and benefits, deafness should be considered harmful: on one hand, one is unable to hear music, but on the other, one is part of a vibrant community, and so on. In the end, she is unable to make a firm judgment on whether deafness is a disorder given these diverse and difficult-to-compare harms and benefits ("I conclude that whether it is a good or bad thing to be deaf is hard to determine" [579]). Making a list did not really address the issue, which is the incommensurability and variability of various benefits and harms. In any event, as argued above, whether or not deafness is overall harmful and should be treated, it is *pro tanto* harmful and a disorder.

Finally, recall that Cooper's argument is that the value considerations in judging harm may transcend culture, and the motive for the guidelines for challenging one's immediate superficial value reactions is to enable one to transcend one's culturally anchored reactions. The problem is that there is nothing in her three guidelines for amplifying value considerations that offers any grounds for going beyond one's existing culturally anchored value assumptions, though they do helpfully promote an exploration of value implications in a potentially challenging and deeper manner. I would argue that this reveals the actual situation, namely, that we can engage in a value dialectic to get a deeper insight into the harmfulness of a condition and thereby challenge the immediate superficial standard cultural view, but that dialectic takes place within a broader value framework that is itself culturally anchored but at the same time may move the culture forward. Perhaps in putting forward these guidelines, this sort of within-social-values dialectic is all that Cooper had in mind, and if so, we are in agreement.

I believe the above perspective applies to what would thus far be the prototype for supposed culture transcendence, the value arguments put forward by Spitzer when confronting the diagnostic status of homosexuality in the context of the deeply anchored disvaluing of homosexuality in our culture. Rather than standing outside our culture and declaring superior moral knowledge as Cooper does in her pro-ana example, all of the considerations Spitzer brought forward with regard to homosexuality's harmlessness, ranging from lack of distress or role impairment to the lessening importance of childbearing in an overpopulated world and the primary importance of the ability

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to have loving adult relationships, were culturally anchored considerations. However, they were edgy and pushed the culture beyond immediate reactions to confront foundational value issues in a value dialectic that allowed values that were already existent in the culture—for example, equality and acceptance in certain respects—to newly extend to individuals and features they previously did not cover.

Cooper on the Concept of Mental Disorder

In the course of her argument regarding the nature of the harm required for disorder, Cooper offers her own analysis of the concept of mental disorder as an alternative to the HDA. Taking Cooper's statements literally, it might appear that she is proposing that involuntary behavior in general is pathological: "Plausibly the difference between behavior that is indicative of disorder and normal bad behavior is that the former is voluntary, while the latter is in some way involuntary" [*sic*: presumably "former" and "latter" are switched here—JW]; "behavior characteristic of disorders must be involuntary." However, any notion that involuntariness is somehow intrinsically pathological is implausible on its face because many involuntary reactions are perfectly normal, ranging from emotional reactions (e.g., inability to be calm in the face of an immediate danger; inability to focus on work when one is intensely in love; inability to be cheerful when one has just experienced a loss) and biologically or developmentally based limitations (inability to engage in deliberate action when one is asleep; inability to will oneself to fall sleep; involuntary sexual attraction and arousal) to constraints imposed by moral conscience in individuals of firm conviction (inability to hurt a child or betray a lover). One passage, however, hints at the more plausible proposal that involuntariness is disordered when it is a deviation from what is normally voluntary ("The most plausible distinction is that normal badness is voluntary, while behavior that is symptomatic of a disorder is not under normal voluntary control"). In accordance with this passage, I will more charitably interpret Cooper as proposing not that psychopathology is involuntariness of action per se but that it is rather involuntariness of actions that is usually or formerly or expectably—or "normally"—under voluntary control.

I thus take Cooper to be proposing that a condition is a mental disorder when and only when there is a lessening of voluntary control of behavior from former or expectable levels. The lessening of the scope of the individual's agency is claimed by Cooper to be intrinsically harmful, so distress or role impairment is not required for disorder, just lessening of voluntariness. Note that if there is a loss of normal voluntary control over action, that often constitutes a dysfunction, that is, a failure of some internal system to operate as biologically designed, as in compulsive disorders. If Cooper is correct that such losses of voluntariness are intrinsically harmful, then in those cases both dysfunction and harm would be present, and so that subset of the conditions that Cooper's criterion identifies as disorders would also be disorders under the HDA.

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Cooper's emphasis on the voluntary versus involuntary distinction as defining of disorder is reminiscent of Widiger and Sankis's (2000) "maladaptive dyscontrol" account of mental disorder, as well as Bergner's (1997) account, in the course of his explicating a definition of disorder proposed by Ossorio (1985), according to which the essence of psychopathology is loss of ability to engage in deliberate action: "When we observe that persons cannot, to a significant degree, choose their actions—that is, when they seem to lack considerable control with respect to initiating or restraining these actions—we take this as grounds for the attribution of psychopathology" (Bergner 1997, 239).

Cooper's proposal fails for reasons similar to the problems that confronted these earlier proposals (Wakefield 1997). When action that is normally under voluntary control becomes involuntary, that sometimes constitutes a dysfunction and, if harmful, a disorder, but not all such reductions in voluntariness are dysfunctions, and so the proposal is overly inclusive. Moreover, by limiting disorders to dyscontrol of normally controlled behaviors, Cooper and these other authors narrow the range of relevant psychological dysfunctions to those that concern failures of agency, yet surely that is not the only way psychological functioning can go wrong. The HDA can make the discriminations necessary here, whereas Cooper's definition cannot.

So, first, it is plain that mental disorder does not in fact require as a necessary condition the movement of some psychological process from the domain of the voluntary to the domain of involuntary control. For one thing, there are many disorders that occur entirely within the domain of the involuntary, where both normal functioning and pathological failure are involuntary. For example, we do not normally have willful control over when we fall asleep, yet the inability to involuntarily fall asleep is a disorder. We do not normally have voluntary control over our feelings of sadness after a loss, yet there are malfunctions of involuntary sadness responses that are depressive disorders. Going all the way back to Augustine, it has been lamented that we normally lack voluntary control over whether or not we become sexually aroused, yet the involuntary inability for a male to have an erection under standardly arousing conditions is considered a disorder. We generally do not have voluntary control of what we perceptually experience when we look at the world around us, yet malfunctions of visual perception (i.e., visual hallucinations) indicate disorder. Contrary to Cooper's analysis, in these and many other cases, involuntary responses are considered disorders despite the fact that the relevant kinds of responses have not previously or normally been voluntary, so there is no change from voluntary to involuntary. Cooper's analysis thus provides no way to distinguish normal from pathological involuntary responses (i.e., responses that are normally not under voluntary control) and thus fails to explain the many disorder judgments about such conditions. These examples are all counterexamples to the necessity of Cooper's analysis.

In addition to pathologies of normally involuntary responses, another kind of counterexample to the necessity of Cooper's voluntary-to-involuntary analysis of mental disorder consists of voluntary reactions that are disorders. Indeed, sometimes increases

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in voluntariness can constitute a disorder. There are some internal mechanisms that are biologically designed to act involuntarily and some mechanisms designed to preclude or inhibit certain potential voluntary behaviors, and in those cases, an increase in voluntary control can reveal a dysfunction and, if harmful, a disorder. Consider a person completely in control of his or her emotions, so that the person experiences no involuntary, spontaneous sadness or joy or surprise or love. Or imagine someone who must voluntarily and deliberately select each word when speaking rather than this process occurring largely outside of voluntary awareness. The ability to voluntarily engage in certain behaviors, such as the ability to easily betray those closest to one, to harm other people terribly without suffering involuntary guilt and without involuntary empathy, the ability to act without a sense of integrity limiting one's behavior, and so on, would all be considered health under Cooper's definition because they increase the domain of voluntary psychological action from the normal level. However, these conditions are more likely to be considered pathologies by experts and laypersons alike, just as the broadening of voluntary control in normally automatic physiological functions such as adjustment of heart rate to exercise, the adjustment of pupil dilation to the level of ambient light, and the adjustment of visual perception to indicate size and distance of objects from complex cues would be considered potential pathologies.

Cooper's theory of disorder as transformation of voluntary control to involuntary action does not work as a necessary condition even for some of the very sorts of cases that she cites, such as personality disorders and paraphilias. Both of these kinds of disorders involve behavior that need be no less voluntary than their normal counterparts. The problem is often not the voluntariness but the nature of the desires and perceptions on which the voluntary choice is based. Personality disorders involve voluntary actions within the distorted lens of the personality disorder, but in response to the distortions of that lens, the actions can be just as voluntary as the normal-range individual's actions are voluntary within the lens of a normal-range personality formation. Indeed, sometimes personality disorders open areas of potential action that the normal individual's meaning system would not allow. Although it is true, as Cooper argues, that "we need to be able to say what distinguishes disordered people from those who are simply criminal or anti-social … the criminal's actions are planned, motivated and controlled; they are fully voluntary," it is chillingly true that even the pathologically violent psychopath's behavior can be equally planned, motivated, and controlled but take places within a meaning system that allows the performance of cruel actions that are not often psychologically possible for the normal person of conscience. All personality traits, normal or disordered, shape and constrain subsequent voluntary actions, so the voluntary versus involuntary distinction cannot be what generally discriminates personality disorder from nondisordered personality.

With regard to paraphilias such as pedophilia, there may in general be a range of degrees of voluntariness and involuntariness in responding to one's sexual desires, but

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the diagnosis of paraphilias depends on the paraphilic nature of the content of one's desire and whether harm results, not on anything having to do with voluntariness or involuntariness. There is nothing necessarily more or less voluntary about attraction to and desire for sex with an adult versus attraction to and desire for sex with a child. It is the paraphilic content of the desire in pedophilia and the harm that results that indicates disorder. Just as normal sexual desire varies in many ways as to the content that is found arousing but the voluntariness level can remain the same across normal sexual preferences, so across the disorder/nondisorder divide the voluntariness level can also remain the same. Indeed, the widened scope for instrumental action beyond the normal range of inhibiting processes might be part of the reason why the pedophile is seen as having a dysfunction.

There are also compelling reasons why Cooper's "involuntariness" analysis is not sufficient for disorder. Many normal psychological processes involve the movement of initially voluntary deliberative processing into a background of learned skills that are no longer within routine voluntary control. Think of learned skills such as playing a piano or speaking a second language. One starts out with entirely deliberative voluntary actions, but as one becomes skilled or fluent, the choice process disappears into the background and action becomes automatic to the point that one becomes totally unaware of the process. Such biologically designed capacities to decrease the degree of voluntariness of behavior are integral to normal psychological functioning. Beyond these sorts of examples, there are many areas of life in which emotional reactions to an object ranging from love to disgust create increasingly involuntary reactions to the object (e.g., when a lover becomes increasingly "simply irresistible"), but such reductions in voluntary responses are not necessarily disorders.

It is also worth noting that a serious consequence of defining mental dysfunctions as pathologies of voluntary control is that this approach defeats one of the central purposes of the analysis of "mental disorder," which is to explain how psychiatry can be a legitimate subdiscipline of medicine and thus how mental disorders are medical disorders. The voluntary/involuntary distinction does not apply to most physical disorders, so the "involuntariness" account cannot serve as a general analysis of the concept of medical disorder, although it can certainly be a theory of the specific type of problem in some mental disorders. To explain what unites medical disorders across mental and physical domains, one needs something like the HDA that proposes a feature, dysfunction, that applies to both domains. With that in hand, one could then test the involuntariness account as a specific theory of some mental dysfunctions.

Why, one might ask, does Cooper feel the need to propose such an obviously inadequate account of disorder? After all, the HDA offers a clear answer to the question with which she starts, "How can we distinguish between disorders and normal criminal or antisocial behavior that harms others?" The HDA explains this sort of distinction in terms of dysfunction. That is, disorder always involves the failure of some mechanism

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to perform its biologically designed function, where biological design is interpreted in evolutionary terms. It is a plausible hypothesis that a dysfunction occurs in severe antisocial conditions, but there are other more plausible explanations for routine criminality. However, Cooper ignores this feature of the HDA because elsewhere (Cooper 2007b), she has rejected the HDA's evolutionary dysfunction component and argued against its validity. Though Cooper does not herself mount this argument here, De Vreese leverages it in the course of her chapter in this volume, and I examine it in some detail in a supplement following this reply to Cooper.

In sum, dysfunctions that cause harm are disorders whether the functions that they interfere with involve voluntary or involuntary responses. Voluntary control is one domain of natural functions and thus one domain for potential dysfunctions, but it is not defining of mental disorder. Involuntary behavior is a disorder when and only when it is a harmful dysfunction.

DSM-5 and Harm

Toward the end of her paper, Cooper considers "harm in practice" as it relates to *DSM* diagnosis and specifically "how the idea that disorders are necessarily harmful has a crucial role to play in ensuring that classifications of disorders, such as the influential *DSM*, do not medicalize normal oddities." The harm criterion prevents harmless biologically normal (nondysfunction) states from being classified as disorders, but those conditions are already eliminated from disorder status by the lack of a dysfunction. Thus, the primary impact of the harm criterion is to eliminate *dysfunctions* that are not harmful from disorder status, where there might be a temptation to pathologize the dysfunction despite it doing no harm.

Cooper's statement that the harm requirement prevents pathologization of "normal oddities" is subtly misleading because "nondisordered" does not imply "normal." Nonharmful dysfunctions include anomalous biological design failures, ranging from harmless genetic mutations to fused toes, and inhabit an ample middle ground between disorder and normality. Consequently, for example, the common inference from depathologization of homosexuality to the conclusion that homosexuality is a normal variation of sexual desire is problematic because of the possibility that homosexuality in some forms could still turn out to be due to a dysfunction even if not a disorder (e.g., De Block and Sholl, this volume; Powell and Scarffe 2019).

Cooper tends to emphasize the distress or impairment requirement in the definition of mental disorder and the parallel distress-or-impairment clinical significance criterion (CSC) in diagnostic criteria sets as *the* harm criterion. However, distress and role impairment are not the only kinds of harms in which people can suffer from dysfunctions, and most disorders' symptom-based diagnostic criteria include harmful symptoms of various kinds. So, in many cases, the clinical significance criterion is

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unnecessary to ensure harm (Spitzer and Wakefield 1999). It is intended as a backup criterion to ensure harm reaches a certain level and to provide suggestive evidence that there is indeed a dysfunction in cases when symptoms are mild.

Given her view of the importance of the harm requirement in protecting against invalid pathologization, Cooper's primary concern is that *DSM-5*'s (2013) definition of disorder says that the dysfunction "usually" (rather than always) causes distress or disability: "Mental disorders are *usually* associated with significant distress or disability" (20, emphasis added). This, Cooper argues, weakens the conceptual link between disorder and harm and so could open the door to classifying harmless conditions as disorders or even to eliminating the harm requirement entirely as superfluous. I think there is no such danger and that Cooper's apprehension is based on a misinterpretation of the point of *DSM-5*'s "usually" qualifier.

Cooper interprets the "usually" qualifier as an attempt to coordinate with the goal of the *International Classification of Diseases* (*ICD*) to separate diagnosis from role impairment due to the cross-cultural possibilities for spurious diagnosis based on differences in social roles. However, despite that goal, the recent *ICD-11* incorporates virtually the same definition of mental disorder as *DSM-5*, including the "usually" qualifier, so this cannot be the heart of the story.

The "usually" qualifier is intended to allow diagnosis under unusual circumstances in which a type of dysfunction is linked to harm but is either not harmful at the time of diagnosis in the present patient for one reason or another or causes harm that does not fit into the distress-or-role-impairment category. This preserves the link between disorder and harm rather than challenges it. Moreover, Cooper's notion that this is a misconceived novelty introduced into *DSM-5* is factually mistaken. *DSM-III* (1980), the edition that inaugurated the modern *DSM* system of operationalized diagnostic criteria and the first edition to include a definition of mental disorder, defined a mental disorder as "a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is *typically* associated with" harms such as distress or role impairment (Spitzer 1980, 6, emphasis added). So, *DSM-5* simply returns to the earlier *DSM-III* approach on this matter.

Indeed, this sort of qualifier was included in definitions long before *DSM-III*. For example, in defining "medical disorder" in a paper that presented a lengthier forerunner of the *DSM-III* definition of mental disorder, Spitzer and Endicott (1978) state that the condition "in the fully developed or extreme form" (18) is associated with certain harms, including distress, disability, or certain forms of disadvantage. They explain, "The phrase *in the fully developed or extreme form* is used because in medicine many conditions are recognizable in an early form, frequently with the aid of laboratory tests, before they have any undesirable consequences" (1978, 19). Thus, they imply that disorders are not always at the time of diagnosis associated with harm. In a still earlier attempt at defining mental disorder, Spitzer and Wilson (1975) propose the following

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criterion: "The condition *in its full blown state* is *regularly* and intrinsically associated with" (829, emphasis added) various harms. They explain,

> The phrase "full blown" acknowledges that some psychiatric conditions in an early stage of development may not be associated with subjective distress or impairment, just as many nonpsychiatric medical illnesses may be initially asymptomatic. Similarly, the phrase "regularly…associated with" recognizes that, just as some highly unusual cases of carcinoma may remain totally asymptomatic, so it is possible that some rare persons with even a psychotic illness may not evidence subjective distress or impairment in social effectiveness. These criteria are for defining conditions that are mental disorders, not for defining persons who are overtly ill. (829)

So, Cooper is wrong to portray the introduction of the qualifier "usually" as a break with the past that threatens the integrity of diagnosis. Spitzer and Wilson's comment that "these criteria are for defining conditions that are mental disorders, not for defining persons who are overtly ill," is particularly enlightening in understanding the dispositional nature of the harmfulness criterion.

What, then, happened in between *DSM-III* and *DSM-5*, when no such qualifier was included? In its place, Spitzer introduced a new set of potential "harms" in the form of risks of harm. Consequently, a disorder was now defined as a dysfunction "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, emphasis added). The risk clause was in effect a replacement for the "typically" qualifier because the cases that the qualifier was designed to address were all cases with a risk of harm. These include prodromal conditions at an early stage before actual harm has occurred—for example, in *DSM-5*, mild neurocognitive disorder prior to overtly harmful dementia—and instances of full-blown dysfunction in which usual harms are for some idiosyncratic reason not yet expressed at the time of diagnosis even though the condition is disposed to cause harm. The "risk" criteria had their own validity problems (e.g., they encouraged risk of disorder to be confused with actual disorder) and have been eliminated in *DSM-5*. And so, the "usually" qualifier has returned.

In sum, Cooper is incorrect to portray the introduction of the qualifier "usually" as a major break with the past that threatens the integrity of diagnosis. At no point from the earliest *DSM*-related attempts to define mental disorder in 1975 to the latest *DSM-5* definition was there a definition that required actual harm in every instance of diagnosed disorder. Despite this, clear examples of false positives due to ignoring or misattributing the harm component are hard to find given the manifest harmfulness of most *DSM* symptom criteria and the clinical significance requirement. Indeed, Cooper's paper contains not one clear instance of a current *DSM* false positive due to lack of harm. Of her two past examples, eliminating homosexuality from the *DSM* was a relatively unique situation, and *DSM-III* stereotypic movement disorder was quickly recognized as not harmful and corrected in *DSM-III-R*. In contrast, in my opinion,

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DSM abounds with false positives due to ignoring the dysfunction requirement. It thus remains to be demonstrated that attention to the harm requirement is in fact important in safeguarding the validity of *DSM* psychiatric diagnosis in the way that attention to the dysfunction criterion is manifestly critical. Caution is warranted because there is a danger that premature attempts to impose a culturally transcendent harm criterion to "provide a barrier against medicalization" without any systematic account of harm can lead to tendentious diagnostic constraints that block treatment of culturally specific direct *pro tanto* harms (Powell and Scarffe 2019; Wakefield and Conrad 2019).

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