

## Introduction

This Element examines some of the controversies and debates concerning mental illness. Much more so than physical or bodily illness, the very idea of mental illness and illnesses is subject to critical scrutiny and impassioned disagreement. This occurs at the level of the generality of the question: does mental illness, as such, exist? But, also, particular illnesses are questioned. Is, for example, attention deficit hyperactivity disorder (ADHD) a real illness, or is it merely the normal distraction and disruption experienced by some children? The latter *may* be negatively valued by society and teachers without being indicators of a medical kind.

Even more contentious examples are personality disorders: disorders of deep-seated and long-term behaviour and experience, generally related to difficulties in interpersonal relations. The American Psychiatric Association's *Diagnostic and Statistical Manual-5 (DSM-5)* subdivides personality disorders into ten kinds grouped into three clusters. The diagnostic criteria for cluster B personality disorders, including borderline personality disorder, seem to be highly value-laden, giving rise to the accusation that they are primarily moral rather than clinical conditions (Charland 2006). Such an objection need not take for granted that the moral and the medical must be distinct realms. It is enough to serve as a challenge that negative evaluations need not imply medical pathologies. The challenge for a defence of the pathological status of putative mental illnesses that do carry moral connotations is to establish that they are not merely expressive of *moral* opprobrium.

Sceptics of the diagnostic category of ADHD or personality disorders do not usually question the existence of the behavioural phenomena that underpin a psychiatric diagnosis of illness but question whether those signs really signal illness or pathology. Hence, although empirical factors are relevant to both the general and the particular debates, the debates also raise conceptual or philosophical issues of what constitutes an illness, disease, or disorder.

In the sections that follow, I will (occasionally) use the word 'madness' to indicate in a rough and ready general manner the phenomena that are typically agreed by all parties in debates about the status of mental illness or illnesses. (While some may find this word offensive, it has been adopted as a positive non-medicalised term by many mental health service user activists, and I happily use it of my own illness.) I will (more often) use 'illness' to designate a medicalised view of madness as a genuine, albeit distinct, form of pathology, suitable for medical intervention.

Some authors place weight on distinctions between illness, disease, and disorder. The American Psychiatric Association, for example, favours the

term ‘disorder’ and offers a general definition of mental disorder (see Section 1). The philosopher Christopher Boorse proposes a value-free definition of ‘disease’ and then defines ‘illness’ as a subcategory of it meeting further constraints. The psychiatrist and philosopher Bill Fulford argues that illness, a more directly experiential notion, is logically prior and that disease is an abstraction from it. In what follows, except where setting out specific views, I will place no weight on these distinctions and generally use ‘illness’ to cover them all.

Given that the very idea of mental illness and illnesses is questioned, there is no easy neutral starting point. But since the focus of attention is usually the class of putative mental illnesses recognised as such by psychiatry, after highlighting some of the *prima facie* puzzles about mental illness and its apparent difference from physical illness, Section 1 will briefly describe the history of the two main psychiatric taxonomies – the World Health Organisation’s (WHO) *International Classification of Diseases (ICD)* and the American Psychiatric Association’s *DSM* – and set out the definition of mental disorder that was added to the third main revision of the *DSM*.

Sections 2 and 3 set out and assess general analyses of illness (or disease or disorder) offered by psychiatrists, psychologists, and philosophers. Section 2 begins with one of the key challenges they face: Thomas Szasz’s argument that mental illness cannot exist because it is a contradiction in terms. A key distinction in the various accounts is whether ‘illness’ (or ‘disease’ or ‘disorder’) is value-free or value-laden one. Section 3 ends with an assessment of an argument presented by the philosopher Neil Pickering that the form of argument used both by Szasz and by those opposing him could never resolve the issue of whether mental illness as such or particular putative mental illnesses really are illnesses.

Section 4 examines what type of category (what kind of kinds) that putative mental illnesses might be, assuming that some, at least, exist, including a challenge raised by the National Institute of Mental Health (NIMH)’s Research Domain Criteria (RDoC) that the existing classifications may be attempting to carve nature in the wrong places.

Section 5 examines the philosopher Ian Hacking’s suggestion that mental illness kinds are novel in being neither natural kinds – as many defenders of contemporary psychiatry have assumed – nor merely lying in the eye of the beholder, as critics have assumed. Instead, they might be ‘looping’ or ‘interactive’ in that the existence of the label directly affects those who fall under it, which can cause the kind itself to mutate.

Section 6 examines the status of transcultural psychiatry, increasingly recognised in the *DSM*, and considers the prospects for balancing some claim to

objectivity in psychiatric classification with a genuine and substantive cultural variation.

It may come as a surprise that in conclusion, I offer no general analysis of mental illness, nor a definitive view of its status. But I take it that philosophy's main aim need not be a definition or reductionist analysis but rather the exploration of the conceptual geography of puzzling notions with the aim of shedding light on them in whatever way is possible. To naturalise, that is, to place puzzling concepts less puzzlingly into a conception of nature, need not require reduction (Thornton 2019: 12–17). While still genuinely perplexing, mental illness is a useful concept and is value-laden or normative, but its values are *sui generis* medical values and its norms are essentially related to a notion of health, though the fundamental connections between mental health and broader notions of flourishing will not be explored in this brief Element.

## 1 Mental Illness and Psychiatric Diagnosis

Madness is a subject that ought to interest philosophers; but they have had surprisingly little to say about it. What they have said, although often interesting and important, has failed to penetrate to the properly philosophical centre of the topic. They have concerned themselves with its causes and effects, with its social and ethical implications, but they have said little that is useful or definitive about what it is in itself. Preoccupied with its accidents, they have failed to engage with its essence.

(Quinton 1985: 17)

Why is madness, and its conceptualisation as mental illness, philosophically interesting and worthy of scrutiny? As is common in a number of more well-established philosophical topics, one reason is that it is subject to a puzzling but everyday tension.

On the one hand, madness or mental illness is a well-known phenomenon. It is said to be experienced by a significant proportion of the world's population though accurate statistics are hard to determine. (According to data from the Institute for Health Metrics and Evaluation's Global Burden of Disease, about 13 per cent of the global population suffer from some kind of mental disorder (Charlson *et al.* 2019).) Self-reporting of the symptoms of mental illness is reasonable grounds to seek primary medical care. Diagnosis of severe illness can serve as an excuse or exculpation in law and equally can be a justification for being detained involuntarily for treatment under the Mental Health Act. It is thus subject to legal codification. Mental illness is stitched into the fabric of everyday life. Distressing and debilitating though it is, it seems to be an ordinary hardship of human existence for which medical care is, where possible, an appropriate remedy.

On the other hand, madness or mental illness sometimes seems to combine aspects of the medical and non-medical but value-laden realms. The insanity defence in law allows for acts that would otherwise be morally bad to be exculpated as expressions of illness, sometimes summarised in the question ‘mad or bad?’ More recently, the debate about whether feelings of bereavement should count as natural and functional experiences or as expressions of depression can be summarised as ‘mad or sad?’ Madness is conceptualised as illness and pathology, just as physical or bodily illness is, and yet it concerns the mental rather than the bodily. If illness is constituted as a deviation from a norm, then, at first sight at least, it looks as though mental and physical illnesses answer to different norms. That prompts the question of why the phenomena and experiences that constitute madness are conceptualised medically – as mental illness – rather than in some other way, for example, in moral or other value-laden terms.

This uneasy combination is long-standing. According to the philosopher Antony Kenny, the idea of *mental* health and illness has a specific origin in the history of ideas: Plato’s *Republic*. ‘The concept of mental health was Plato’s invention. Metaphors drawn from sickness are no doubt as old as metaphor itself . . . . But nothing in Greek thought before Plato suggests that the notion of a healthy mind was more than a metaphor’. (Kenny 1969: 229)

Kenny argues that Plato applied the standard ‘medical’ humoral model of the time – according to which health depended on a balance of the elements of the constitution – to ‘disorders of the soul’, identifying three main constituents: reason, appetite, and temper. Although developing what appears to be a *moral* concept of mental health, Plato was, according to Kenny, intent on assimilating the moral to a *medical* model. Kenny compares Plato’s approach to a similar assimilation of the moral to the medical which, he argues, was made in the 1959 Mental Health Act. This introduced to English law the concept of the psychopath: a medical diagnosis based, apparently, on a moral judgement.

Furthermore, there seems to be a number of obvious general differences between mental and physical illnesses. Champlin suggests:

- 1) No mental illness can be fatal, mortal, deadly or terminal in the way that some physical illnesses can be. No one can die of schizophrenia, or indeed of any mental illness at all, as you can die of smallpox or malaria . . . .
- 2) Mental illness is never a trivial affair of brief duration or minor importance, as are some minor childhood ailments . . . .
- 3) At the earliest stages of life, in the cradle and even in the womb, you may suffer from a physical illness, say, jaundice. But it makes no sense to suppose that a two-hour old baby has depression, paranoia, pyromania, kleptomania, etc . . . .

- 4) No mental illness can be spread by infection in the way that many physical diseases are . . . . These differences are *so* profound that they do seem to support the view that any connection between physical and mental illness will be paper thin, no more than nominal. (Champlin 1989: 25–6)

Champlin's characterisation is open to question. Mental illnesses do play a causal role in some deaths. Anorexia can lead to starvation, for example, even if there is always a logically sufficient more proximal explanation of the death in physical illness terms. And there can be brief episodes of mental illness. Nevertheless, Champlin's descriptions of typical differences help motivate the question of whether it is correct to classify mental and physical illnesses as species of the same genus. Perhaps the concepts of mental and illness are not so suited for each other, after all.

A second reason for philosophical interest in mental illnesses comes from the ambiguous status of apparent historical continuities. It is tempting, for example, to view the modern diagnosis of depression as continuous with long-standing notions of melancholy and melancholia and thus to think that the latter helps ground the former. But, as the philosopher of psychiatry Jennifer Radden argues, while depression and melancholy/melancholia overlap in some features, they differ in others (Radden 2009). Like depression, melancholia combined sadness with anxiety, was unreasonable and objectless, involved self-centred oversensitivity, and was associated with restless manic exaltation, but it also included what would now be called delusions and also obsessions and compulsions, which lie outside the modern diagnosis of depression. Furthermore, unlike modern depression, melancholia also carried glamorous associations of intellectual brilliance and later even genius.

A third reason derives from the opposing versions of the history of mental illness in the seventeenth and eighteenth centuries. According to the philosopher and historian Michel Foucault, the mad were separated from productive members of society, using facilities that had previously been used to segregate lepers, during the 'Great Confinement' (Foucault 1989). Later, at the end of the eighteenth century, there was a second transformation in which the mad were confined in hospitals under medical doctors. However, according to Foucault, neither transformation was a response to the underlying kind 'mental illness' coming more clearly into view. Rather, the very idea of mental illness was constructed to separate unproductive members of society from productive in the service of the rise of capitalism. I will return to this contentious idea, albeit briefly, in Section 5.

A fourth reason for philosophical interest follows from this. Opponents of psychiatry argue that madness should not be thought of in medical terms and,

further, that there is a contradiction in the very idea of mental illness.. The most famous proponent of this claim is the psychiatrist Thomas Szasz, who argues, partly via the claim that mental and physical illnesses are constituted by deviation from different norms, that there could be no such thing as mental illness (Szasz 1960). If Szasz were correct, then the supposed legal and ethical consequences of mental illness would be undercut. (Szasz's arguments will be discussed further in Section 2.)

Although politically opposed, Szasz is sometimes grouped together with the 1960s and 1970s countercultural movement called 'anti-psychiatry' whose members are often said to have included the psychiatrists David Cooper and R. D. Laing, the sociologist Irving Goffman, and the historian of ideas Michel Foucault. Whether or not these and other people self-identified as members of any such movement, the label 'anti-psychiatry' does help represent an intellectual opposition to medical psychiatry that finds no parallel in, say, cardiology. (A brief sketch of Foucault's social constructionist approach to medicalising madness as the illness is discussed in Section 5.)

A fifth reason is an opposition to particular psychiatric diagnoses. Perhaps the most striking recent contested (and now former) diagnosis is homosexuality, originally classed as a sexual deviation, which was officially removed from its list of psychiatric disorders by the American Psychiatric Association by a vote of its membership in 1974. But other diagnoses and symptoms remain contested. Members of the Hearing Voices Network argue that hearing voices is not the symptom of a disorder but merely a different expression of human subjectivity, akin to homosexuality. Debate continues about ADHD, which some regard as an illicit medicalisation of normal naughtiness while others campaign for its continued status as a disorder so that sufferers can continue to access medical support. Personality disorder is perhaps the most stigmatising of diagnoses, and some say (as Kenny said of Plato's model) that it medicalises a moral category. Such disputes do not seem to be simply empirical matters but rather highlight a lack of clarity as to what is meant to be 'mental illness'.

The tension between the everyday taken-for-granted status of mental illness and the suspicion that there is something fundamentally problematic about it suggests the need for philosophical inquiry.

### A Thumbnail Account of the Recent History of the Classification of Mental Illnesses

The mental illnesses that are recognised by medical professionals are codified in two classificatory systems: the WHO's *ICD* and the American Psychiatric Association's *DSM*. These have been frequently revised, and the current

versions are numbered *ICD-10* and *DSM-5*. Although formally independent of one another, the two systems of classification have converged so there is now a great deal of similarity.

The broad shape of both taxonomies can be traced back to textbooks of the German psychiatrist Emil Kraepelin. Starting in 1883, Kraepelin published and revised his textbook, which, unlike previous neurological attempts to ground psychiatry in brain science, was based on psychologically influenced accounts of symptoms and the course of illness that he recorded in the case notes of patients. In the sixth edition, published in 1899, Kraepelin divided mental illnesses into thirteen broad kinds (Shorter 1997: 106–9). He also divided psychotic illnesses – illnesses without an organic cause in which the subject loses ‘contact’ with the world and lacks insight into their own condition – into those with an affective component and those without, as follows:

This division of [psychotic forms of] insanity into two big groups made diagnosis quite simple. If the patients were melancholic or euphoric, cried all the time, were always tired without a cause, or displayed any of the other signs of depression or mania, [i.e., their condition had an affective component] they were classed as ‘manic-depressive illness’. If they were psychotic in the absence of an affective component, they had dementia praecox. If they were manic-depressive, they would probably get better; if they had what everybody was soon abbreviating as ‘d. p.’, they probably wouldn’t. Thus by 1899, Kraepelin had elevated the two greater nonorganic (‘functional’) psychoses – manic-depressive illness and schizophrenia – to the top of the pyramid, where they remain in only slightly modified form to this day as the object of endeavor of serious psychiatry. (Shorter 1997: 107)

What Kraepelin termed ‘dementia praecox’ is the historical forebear of schizophrenia.

In addition to the apparent overlap of specific mental illnesses with contemporary classification, Kraepelin’s textbook also shaped some underlying assumptions of contemporary psychiatry. In his *History of Psychiatry*, Edward Shorter summarises this influence as follows:

In addition to providing a new way of classifying illness, Kraepelin’s structure insisted that there were a number of discrete psychiatric illnesses, or diseases, each separate from the next. Depression, schizophrenia, and so forth were different just as mumps and pneumonia were different. Finally, being ‘Kraepelinian’ meant that one operated within a ‘medical model’ rather than a ‘biopsychosocial’ model, as the battle lines later became drawn.

(Shorter 1997: 108)

Both the *ICD* and *DSM* are neo-Kraepelinian in this broad sense.

The *ICD* is the WHO's publication. In 1948, it took over a French classification dating back to 1853 and originally called the *International List of Causes of Death* and published an expanded version called *ICD-6*, which incorporated non-fatal illnesses for the first time, in 1951. Most chapters of the *ICD-6* classification, those dealing with bodily disorders, were well received and readily adopted around the world. The psychiatric section alone proved problematic, with most countries, indeed most psychiatric institutions, continuing to operate with their own systems.

The WHO commissioned the British psychiatrist Erwin Stengel to investigate why this had happened and to propose a basis for a classification that would be more widely acceptable. It was in this connection that a conference was set up at which Carl Hempel, a philosopher of science, was invited to speak. Stengel chaired Hempel's session, and some of Hempel's ideas provided the basis for his report to the WHO.

In fact, the key change Stengel proposed was based on an intervention by the UK psychiatrist Sir Aubrey Lewis. The change was to abandon attempts at a classification based on theories of the causes of mental disorder (because such theories were premature) and to rely instead on what could be directly observed: that is, symptoms. The result was *ICD-8*, which was widely adopted. The present version, *ICD-10*, and, indirectly, *DSM-5* are both derived from *ICD-8* and retain their focus on symptoms. This was not, however, a key moral in Hempel's paper, which instead stresses the eventual goal of theory, rather than observation, based classifications. But psychiatry was not thought to have reached that stage of development.

The *DSM* is the system of the American Psychiatric Association, which formed a task force in 1948, to create a new standardised diagnostic system. At the time, there were five separate diagnostic classification systems being used in the United States in different settings, including the insane asylum system, the Army system, the Navy system, the Department of Veterans Affairs system, and the American Prison Association system (Fischer 2012). *DSM-I*, as it became known, was based on the Veterans Affairs system and was divided into two main sections: disorders with established organic brain disease and disorders without brain disease. The latter disorders were labelled 'functional'. One feature of *DSM-I*, and even more so of its first revision as *DSM-II*, was the presence of causal or 'aetiological' theories. Disorders were defined as reactions to events (and in *DSM-II* as neuroses, reflecting a Freudian heritage).

There was a parallel change within American psychiatry, which shaped the writing of *DSM-III*. Whilst *DSM-I* and *DSM-II* had drawn heavily on psychoanalytic theoretical terms, the committee charged with drawing up *DSM-III*



drew on the work of a group of psychiatrists from Washington University of St Louis. Responding in part to research that had revealed significant differences in diagnostic practices between different psychiatrists, the ‘St Louis Group’, led by John Feighner, published descriptive criteria for psychiatric diagnosis. The *DSM-III* task force replaced reference to Freudian aetiological theory with more observational criteria.

As a result, both classification systems – *ICD* and *DSM* – are light on aetiological theory, and both stress clinical signs (what the clinician can observe) and symptoms (what the patient reports). Both are thus more clearly neo-Kraepelinian than their more aetiological earlier versions. This has had a positive effect on reliability – the agreement in diagnosis by clinicians – though the effect on validity, on the ability to ‘cut nature at its joints’ is disputed.

The following extract is an example of the form that a codification of diagnosis takes. These are the key criteria for a diagnosis of schizophrenia in *DSM-5*.

Schizophrenia Diagnostic Criteria 295.90 (F20.9)

- A. Two (or more) of the following, each present for a significant portion of time during a 1-month period (or less if successfully treated). At least one of these must be (1), (2), or (3):
1. Delusions.
  2. Hallucinations.
  3. Disorganized speech (e.g., frequent derailment or incoherence).
  4. Grossly disorganized or catatonic behavior.
  5. Negative symptoms (i.e., diminished emotional expression or avolition).
- B. For a significant portion of the time since the onset of the disturbance, level of functioning in one or more major areas, such as work, interpersonal relations, or self-care, is markedly below the level achieved prior to the onset (or when the onset is in childhood or adolescence, there is failure to achieve expected level of interpersonal, academic, or occupational functioning).
- C. Continuous signs of the disturbance persist for at least 6 months. This 6-month period must include at least 1 month of symptoms (or less if successfully treated) that meet Criterion A (i.e., active-phase symptoms) and may include periods of prodromal or residual symptoms. During these prodromal or residual periods, the signs of the disturbance may be manifested by only negative symptoms or by two or more symptoms listed in Criterion A present in an attenuated form (e.g., odd beliefs, unusual perceptual experiences).
- D. Schizoaffective disorder and depressive or bipolar disorder with psychotic features have been ruled out because either 1) no major depressive or manic episodes have occurred concurrently with the active-phase symptoms, or 2)

- if mood episodes have occurred during active-phase symptoms, they have been present for a minority of the total duration of the active and residual periods of the illness.
- E. The disturbance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition.
  - F. If there is a history of autism spectrum disorder or a communication disorder of childhood onset, the additional diagnosis of schizophrenia is made only if prominent delusions or hallucinations, in addition to the other required symptoms of schizophrenia, are also present for at least 1 month (or less if successfully treated).

(APA 2013: 99)

### The *DSM-5* Definition of Disorder

In addition to the codification of the various mental illnesses or disorders that it recognises, the current version of the American Psychiatric Association's *DSM-5* also contains a *general* definition of mental disorder.

A mental disorder is a syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behaviour that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. Mental disorders are usually associated with significant distress or disability in social, occupational, or other important activities. An expectable or culturally approved response to a common stressor or loss, such as the death of a loved one, is not a mental disorder. Socially deviant behavior (e.g. political, religious, or sexual) and conflicts that are primarily between the individual and society are not mental disorders unless the deviance or conflict results from a dysfunction in the individual, as described above. (APA 2013: 20)

This is a complex and inelegant definition combining a number of elements. A disorder is (1) a clinically significant disturbance that, additionally, (2) reflects an underlying mental dysfunction and that, additionally, (3) is *usually* associated with significant distress or disability. Two further elements are ruled out: neither expectable or culturally approved responses such as to loss nor deviant behaviours in itself are disorders.

This definition raises a number of immediate questions. What counts as 'clinically significant'? Note that any answer to this question that preserves the informativeness of the definition cannot itself rely on an understanding of disorder. So 'clinically significant' cannot be analysed as meaning *signifying mental disorder*. Second, what are the grounds for saying that a disturbance *reflects* underlying dysfunction? And is the fact that such disorders are *usually* associated with distress or disability part of a definition of disorder or an empirical claim about them?