CHAPTER 28

WHAT IS MENTAL ILLNESS?

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HOW DO WE GET TO THE CLINIC?

In the 1970s the American Psychiatric Association was obliged to ask itself the question whether homosexuality, which it had included as a mental illness in the second edition of the Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-II; American Psychiatric Association 1968), really was such, and in particular whether it should or should not be included in the third edition. This raised the general question what mental illness, or mental disorder, is. And among the many difficulties raised by this question was the fact that there was no definition in the DSM-II. On reflection it seemed to several contemporary commentators that no definition had seemed to be needed, that the "mental illnesses" were just the conditions that physicians regularly attended to in the clinic. Donald Klein, for example, commented (1978, p. 41):

Strikingly there is no explicit statement within the Diagnostic and Statistical Manual of Mental Disorders [second edition] that defines the sort of condition categorizable within this document. Such a logical lapse is not restricted to psychiatry, however, since the International Classification of Diseases also lacks such a statement. It seems plain that these compendia are actually compilations of the sorts of things that physicians treat; a circular classificatory principle but a useful historical clue. Our definitions of illness are derived from medical practice.

While the great majority of psychiatry literature comprises mainly work on classification, causes, and treatments of conditions, there is a smaller but important literature on the definition of mental illness. Aspects of this will be covered in this chapter, particularly the conceptualization that came to be used in the DSM from its third edition onward, and influential subsequent approaches relying on concepts from evolutionary biology and psychology. There are also literatures on the social processes involved in diagnosis of illness and its consequences, related to medical power, prescribing, excuse from social role obligations,
and sometimes from legal responsibility. Relatively less attention has been paid in the academic literatures to what goes on before the doctors and other health care professionals get involved, to what goes on at home, among family and friends, and in the individual’s mind.

What conditions do people take to the clinic, and why? Here we could list the several hundred conditions in the current edition of the DSM, the DSM-IV (American Psychiatric Association 1994), though it should be said that many of these are subtypes, and many are relatively rare, so we could draw up with a much shorter list of the common mental health problems, anxiety and depressive disorders, severe mental illness such as schizophrenia, a variety of developmental or neurodevelopmental problems such as autism and attention-deficit/hyperactivity disorder (ADHD), and some others familiar in the culture such as obsessive-compulsive disorder and bipolar disorder, previously manic depression. All these conditions, so characterized, are of course as seen through the mental health care gaze; they are the phenomena as conceptualized following an assessment by the mental health care professional and a diagnosis. These diagnostic formulations are, on the other hand, increasingly what the person or family brings to the clinic, because they have looked up their symptoms on the Internet, following their own searches or suggestion from a friend.

Before the diagnostic formulations are the sets of symptoms, so a description of the conditions people take to the clinic could be a list of symptoms or patterns of symptoms, and these are very well laid out in the diagnostic manuals, the American Psychiatric Association’s DSM-IV and the World Health Organization’s International Classification of Mental and Behavioural Disorders, tenth revision (ICD-10; World Health Organization 1992). Here we find patterns of symptoms of many, many kinds, such as: long periods of uncontrollable, distressing worrying; paralyzing anxiety in social situations; suicidal thinking or intent; withdrawal to isolation; hearing persecuting voices when none are there; no friends as a child; and episodes of couldn’t care less activities, instances of which would be, for example, temporarily forgetting about the children and spending large sums of money on credit cards which can’t be paid back.

The compilations of symptoms and syndromes in the DSM and ICD are clear descriptions of the kinds of mental health problems people bring to the clinic, but they are descriptions from the outside, of an observer, and they are indeed clinical descriptions, based on what is ascertainable in the clinic from one or more informants. Descriptions from the inside, from the person who has the difficulties, or from the families who live with the person and the troubles, who have seen these troubles unfold in their loved ones, notwithstanding all efforts—are to be found elsewhere, in life-writing of people who have experienced mental health problems in themselves or in their family.

There is also a strong, rich, and complex history of phenomenology in psychiatry that eludes the quality of inner experience involved in mental health problems. Psychiatrists early in the twentieth century gave clear descriptions, based on fine attention to the patient’s experience, to the subjective quality of, for example, a “delusion” and how it differs from an “obsession” (these descriptors being those of the doctors of course). This so-called “descriptive phenomenology” may be distinguished from, and it has contested linkages with, philosophical phenomenology originating in the nineteenth and early twentieth centuries. Both aspects continue to play an important role in elucidating the experience.

The mental illness life-writing literature is extensive; see, e.g., Campbell (1999), Campion (2012), Mental Health Foundation (1999), and Read and Reynolds (1996).
of mental illness—its appearance from the inside—and as counterpoint to the objectivity and materiality of neuroscience.²

A person attends the clinic for themselves—or the family takes a person to the clinic—because they believe that something serious is, or may be, wrong with them, and that a doctor or other health care professional may be able to advise or help. In the case of mental health problems—as they will be called when the decision to attend the mental health clinic has been taken—coming to this belief can be, though is not always, complex, difficult, and protracted. There is, according to the person himself, or family, something wrong with the person, in a range between not quite right and very wrong, something not as it should be; some deviation in the wrong direction, it may be said, from the normal. What “the normal” is taken to be is a complex question, signaling large sets of issues involved in the conceptualization of mental illness. Standards immediately available to us, the clinic aside, in our everyday lives, include: the person is not themselves, they are not feeling or behaving as they usually do—there is a rupture in the personal narrative. And/or: the person is not feeling or behaving as is usual for comparable people—this often being the standard parents use, for example, when trying to assess their child and his development. And/or: the person is falling below commonly endorsed social standards, for example, in a child’s showing some concern for other children, or paying attention and learning at school; or self-care. In all these cases there is the question: How much is too little, or too much? The standards are not clearly marked. How much variation within the person over time, or relative to others or to social standards, is within the normal range—so not to worry after all? Normalizing in this way is always an option, at least until things get very bad, or come to a crisis. A variation on this theme is finding an explanation which means the problem is self-limiting: it’s just a temporary thing, he will grow out of it as he gets older; it’s because he’s upset because of such-and-such an event, he will get over it. Or consider another reaction in our repertoire: coping. There is a problem but we can help manage it; I can talk to the teacher and we can put in more support; I can try harder; I just to have put up with all this upset; it’s just the way I am/he is. All these options interweave with just how serious the problem is thought to be, a matter likely to be revisited on a continuous basis. What does “seriously something wrong” amount to? There is much that can be said about this, but to cut the story short it probably means: gets in the way of activities which are essential to our way of life, to what people or myself in particular can and should be—highly valued things. So, for example, for children these might be: making use of educational opportunity, being able to get along with the peer group, make some friends or a friend, have some fun. For adolescents: begin to be able to get on with their increasingly independent activities (peers, sexual, work) without coming to harm, without causing too much harm. For adults: work, friendships, developing and consolidating a worthwhile life, if they have children, raising them well enough. In old age: respect, safety. This is just a list I have composed and we can all make one up and refine it, personalize it—but what we mean by “something seriously wrong” is disruption in these kinds of areas. But then, should we go for help to an expert? This problem interacts with many personal and social variables. Should we not be self-reliant? Can we trust doctors anyway? What about the shame; or the stigma? And there is, to complicate the position further, a whole other set of issues more or less raised to different extents in different cultures and subcultures: even if there is something seriously wrong, and we need expert help, why

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WHAT IS MENTAL ILLNESS?

The DSM Conceptualization

Following its deliberations as to the meaning of mental illness (or mental disorder) for the purposes of inclusion in its DSM; it was proposed that distress and/or impairment were fundamental. This idea was adopted, with elaborations and qualifications, in the DSM-III (American Psychiatric Association 1980), and it remains, with some modifications to the qualifications, in the current DSM-IV (American Psychiatric Association 1994):

In DSM-IV, each of the mental disorders is conceptualized as a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (e.g., a painful symptom) or disability (i.e., impairment in one or more important areas of functioning) or with a significantly increased risk of suffering death, pain, disability or an important loss of freedom. In addition, this syndrome or pattern must not be merely an expectable and culturally sanctioned response to a particular event, for example, the death of a loved one. Whatever its original cause, it must currently be considered a manifestation of a behavioral, psychological or biological dysfunction in the individual. Neither deviant behavior (e.g., political, religious, or sexual) nor conflicts that are primarily between the individual and society are mental disorders unless the deviance or conflict is a symptom of a dysfunction in the individual, as described above. (pp. xxi–xxii)

The fundamental idea then, is that mental disorders are associated with present distress or disability/impairment. This idea is also in the ICD-10, though with less conviction, elaboration, and qualification, and a recent proposed amendment of the DSM-IV conceptualization for the DSM-5 does not attempt to change it (Stein et al. 2010). The lesson here, I suggest, is that for all its problems, the emphasis on distress/impairment is essentially correct. Distress and impairment constitute the fundamental personal and social phenomenology of the conditions people bring to the clinic, and so will appear at the very least as operationalized markers of whatever else we may suppose illness/disorder really is.

1 The ICD-10 has: “Disorder is not an exact term, but it is used here to imply the existence of a clinically recognizable set of symptoms or behaviour associated in most cases with distress and with interference with personal functions. Social deviance or conflict alone, without personal dysfunction, should not be included in mental disorder as defined here” (World Health Organization 1992, p. 5).
Let us consider key points of the DSM-IV conceptualization, the key idea and the elaborations and qualifications, in turn:

*Distress and impairment*. This was the key idea of the conceptualization proposed for and incorporated into the DSM-III, and it served as a principled ground to exclude homosexuality from the third edition. It captures a very sound and presumably very ancient healthcare principle: people attend to the clinic in states of distress and impairment—as noted in the first section.

*Should not be an expectable response to an event*. Much hangs on this qualification. It is meant to exclude "normal" responses to life's problems. Put another way: if we—for good reason—put distress and impairment center stage in our understanding of mental illness, how do we distinguish normal distress from "pathological" distress warranting health care attention? This is a good question to which there is no straightforward answer; in effect it re-asks the question: what is mental illness/disorder? Invoking "expectability" raises the question but does not answer it. Many physical and mental health problems are (somewhat) "expectable" in any readily available sense, such as broken limbs following a road traffic accident, or depression in the context of several major adverse life-events and chronic difficulties. What matters is that there is something seriously wrong that may be helped by healthcare attention, and what the "seriously wrong" means is open to the same options as "what is mental illness?" The DSM emphasizes distress and impairment as fundamental; other options will be reviewed in the next section.

Another aspect of the problem of distinguishing what is normal from what is illness arises in connexion not with life-events but with traits, though this is not expressly addressed in the DSM conceptualization. Issues here include, for example, differentiation between

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4 The background to the construction of the definition adopted for the DSM-III is given in papers by Robert Spitzer and colleagues on the American Psychiatric Association's working party set up for this purpose, particularly Spitzer and Endicott (1978), Spitzer and Williams (1982, 1988), and Klein (1978). These papers are essential reading for understanding why the DSM conceptualizes mental disorder in the way that it does, and they remain, in the present author's opinion, among the very best theoretical papers on the definition of mental illness and illness generally.

5 The vexed nature of the issue shows up in the fact that DSM apparently envisages a range of expectable responses to events that, while distressing/imparing, are not illness but rather expectable (normal), only bereavement is cited as an example; while in the diagnostic criteria for Major Depressive Disorder, only bereavement (not any other major loss) is permitted to exclude diagnosis. This has raised the question, vigorously discussed in the literature in the context of the DSM-5 revision: given that bereavement is an expectable (or understandable) reason for depressed mood, thinking and behaviour which isn't illness, and which therefore may exclude diagnosis of illness, why should other major losses also not mitigate against diagnosis? or, should the major losses not be added, and the bereavement exclusion deleted for consistency, in effect removing the non-expectability issue from the diagnosis of depression. Recent positions and reviews include Kendler (2010) and Maj (2012). Discussions of this issue revolve mainly around the cause and outcomes of depression with and without bereavement and other major adverse life events and are not primarily theoretical. Theoretical issues are however in the background, particularly whether expectability/understandability of responses in relation to context excludes attribution of disorder, or whether it is distress/impairment, regardless of context, that are the crucial considerations for diagnosis (Bolton 2008; Horwitz and Wakefield 2007).
normal shyness and Social Anxiety Disorder (Lane 2007), and between the high end of normally distributed activity levels in children especially boys, and ADHD (Timmis and Taylor 2004). Again, the DSM emphasizes distress and impairment as key considerations in making such distinctions.

**Not culturally sanctioned.** This qualification acknowledges cultural differences, relativizing the appraisal of patterns of mental life and behavior to cultural norms. That said, there are very rigorous debates as to whether and to what extent Western psychiatry gives due weight to cultural differences (e.g., Alarcón 2009; Kleinman 1987; Littlewood 1990).

**Not social deviance.** Spitzer and Williams (1982, p. 21) explain that the last statement in the DSM definition of mental disorder "was added to express indignation at the abuse of psychiatry, as when, in the Soviet Union, political dissidents without signs of mental illness are labelled as having mental disorders and under that guise incarcerated in mental hospitals." Related concerns have been expressed recently regarding use of psychiatry in China (Birley 2002). Aside from political abuse of psychiatry, the distinction between mental disorder and social deviance invoked in the DSM-IV conceptualization of mental disorder is not straightforward. Inside the book there are mental disorders defined apparently in such terms. For example the primary criterion (A) in the DSM-IV diagnostic criteria for Antisocial Personality Disorder, (American Psychiatric Association 1994, p.649–650), refers to a "pervasive pattern of disregard for and violation of the rights of others," followed by examples including "failure to conform to social norms with respect to lawful behaviors." Compulsory admission to hospital of people under the UK Mental Health Act raises related issues, in authorizing detention under state powers for public safety, without guilt of crime, in the context of mental disorder. In an important paper on the political abuse of psychiatry, Richard Bonnie argues that the key issue is not the definition of mental disorder as opposed to social deviance, but the political and legal context in which psychiatry services operate (Bolton 2008; Bonnie 2002).

In general, it is plain enough that the "definition" of mental disorder raises far more and too complex issues than can be sorted out in the space of an introductory page of the DSM or any other psychiatric textbook. The DSM cannot be expected to solve these problems, and in any case its main purpose is something else, to specify reliable and as valid as possible diagnostic criteria for diagnosis. The DSM conceptualization is helpful, however, in my opinion, as something more like a position statement. Key features of which are:

- "Mental disorder" is essentially linked to distress and impairment.
- It is to be distinguished from normal distress (and impairment) [somehow].
- It is not to be muddled up with other cultural/subcultural ways of doing things.
- Being in conflict with society, in the absence of something being wrong with the person (on which the first two points), is nothing to do with health care.

In this way the DSM definition is reasonable and very well constructed. As to what mental illness really is, as to elaborations of the qualifications and conundrums to which the DSM
Whose Norms Are These?

The DSM conceptualization of mental disorder was constructed in the midst of and in response to much controversy. The background was the so-called anti-psychiatry critique of the 1960s of Foucault, Laing, Szasz, Rosenhan, Goffman, and others.6 The critiques of the 1960s laid major charges against mainstream psychiatry and its medical model: that it medicalized and pathologized what were essentially socially and morally defined problems.

Most of the explicit debate about the concept of mental disorder since the 1960s has revolved around the question of whether mental disorder attributions rest on some hard medical fact or whether they are rather expression of social norms and values (see Sadler, Chapter 45, this volume). Here is the psychiatrist Robert Kendall reviewing the problem in the 1980s:

> The most fundamental issue, and also the most contentious one, is whether disease and illness are normative concepts based on value judgements, or whether they are value-free scientific terms; in other words, whether they are biomedical terms or socio-political ones. (Kendall 1986, p. 25)

Kendall was one of the first theoreticians to note that the current understanding of illness as physical lesion, well grounded in nineteenth-century biomedicine, was hardly plausible in psychiatry and was in fact losing traction, and was being joined by other paradigms, even in physical medicine (Kendall 1975). He was among the first to turn attention in this context to concepts of evolutionary theory (Kendall 1975; Klein 1978). The key idea is that evolutionary theory can deliver—what is needed to deliver—objective norms of function and dysfunction which will underpin illness diagnosis. “Objective” here means: ascertainable by scientific method and biomedicine specifically. But in particular, it (also) means: independent of social/sociopolitical norms and values. The theoretical literature since has struggled with the issue of whether and how the evolutionary theoretic approach really works.

Kendall (1975) considered a simple and verifiable start to the evolutionary theoretic approach, understanding illness in terms of conferring “biological disadvantage,” marked by lower life expectancy and fertility for example. He found, however, that the matter of biological disadvantage was less clear-cut than might have been hoped (social disadvantage appearing as a possible confound), and that it did not provide anything like a plausible demarcation criterion between mental health and illness. Since that simple or at least

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6 See Foucault (1965, 2006), Goffman (1961), Laing (1960), Rosenhan (1973), and Szasz (1961). Reactive defenses of psychiatry included Clare (1976); Spitzer (1976); Roth and Kroll (1986); and Resnek (1991). The critiques remain essential reading for the project of understanding how and why psychiatry and mental health services generally have been shaped and have shaped themselves over the past half-century—including in the microcosm, as it were, of the conceptualization of mental disorder in the DSM. Recent critiques of psychiatry from social science perspectives include Kutchins and Kirk (1997) and Horwitz (2003).
empirically testable hypothesis did not work well, the evolutionary theoretic approaches have been more theoretical. Christopher Boorse proposed defining "normal" functioning in (theoretical) statistical terms, as average for the human species, so that abnormal functioning is a matter of functioning below this species-typical level (e.g., Boorse 1975/1981; and for critical commentary, e.g., Fulford 2001; and Kingma, Chapter 25, this volume). Another approach to normal functioning—proposed in the early 1990s by Jerome Wakefield (1992)—is in terms of functioning "as designed" (as selected for). This has been the most influential version of the evolutionary theoretic approach to defining "mental illness" and will be considered briefly here.7

Wakefield's proposal has come to be called the "harmful dysfunction" analysis and it can be stated briefly along the following lines: "A 'mental disorder' is a harmful disruption of a natural function, where 'natural function' is to be understood in terms of functioning in the way 'designed' (selected for) in evolution." According to the first component in the analysis—"harmful"—negative evaluation, by the person with the condition, and/or because of deviance from social norms, is necessary for a condition to be a disorder. Its inclusion in the definition is consistent with the social science perspectives in the 1960s anti-psychiatry critiques. On the other hand, Wakefield emphasizes that his approach puts a definite limitation on what legitimately counts as a mental disorder, namely that it also has to involve, as a necessary condition, a failure of a natural function.

There have been many and diverse criticisms of Wakefield's analysis.8 I will focus here on the question of the norms that are involved in illness attribution, specifically on the fundamental question whether it is valid to distinguish natural/biological norms from social/evaluative norms, given the context of the new genetic science paradigms of the past decade or so.

Wakefield's analysis is based on the plausible assumption that concepts of function and dysfunction refer to systemic "design": normal functioning is functioning as designed, abnormal functioning is otherwise. In relation to abnormal functioning invoked in illness attribution, Wakefield's plausible view is that we are not concerned with social norms of social functions, but rather—this making the required contrast—with natural norms of natural functions. He then supposes, again plausibly, that the current best science of the "design" of natural functions is evolutionary theory, with "design" in scare quotes since

7 Before leaving evolutionary theoretic approaches in psychiatry generally it should be noted that they are not at all limited to serving as a possible basis for defining (the norms involved in) mental disorder. Also important to note in the context of the broad evolutionary theoretic approach to psychopathology is that it broadens out the range of possible pathways by which people may come to be in serious mental and behavioral trouble, to include not only lesions, or failing evolutionarily "designed" mechanisms, but also e.g., "design/environment mismatch, and unhelpful learning. Key papers on these implications are Cosmides and Tooby (1999) and Richters and Hinshaw (1999). In addition there is the approach—often known as "evolutionary psychiatry"—which would stress the adaptive value of what we think of as psychopathology, in the present environment or at least in the environment of evolutionary adaptiveness (see, e.g., Baron-Cohen 1997; Brie 2008).

8 Criticisms include that it has a limited or oversimplified approach to evolutionary psychology (Cosmides and Tooby 1999; Richters and Hinshaw 1999), that it implies modularity in mental architecture that may not apply for some mental disorders (Murphy 2006), and that it makes diagnosis of mental disorder a speculative and unreliable hypothesis that is unsuited for both clinical and research purposes (Bolton 2007). Another problem is that the dichotomy between the natural (or "biological") and the social, which is basic both to Wakefield's analysis and to the problem it is designed to solve, is out of date in terms of the current science (Bolton 2008); this line of criticism is summarized in the text.
there is no designer. Putting all these plausible assumptions together—and adding the "harmful" proviso, delivers the "harmful (evolutionary theoretically defined) dysfunction" analysis.

However, recent developments and new paradigms in genetics question the crucial assumption that social functions can be identified as a separate class contrasted with natural functions, understood in this context as what are evolved and genetically transmitted. This dichotomy has broken down in two main ways:

1. Because human evolution has been in social groups, some evolved functions are social, in which case the contrast between the natural and the social breaks down. Examples include courtship, mating, child-rearing, and social collaboration.
2. In the case of psychological and behavioral phenotypes, genes may contribute a predisposition to particular outcomes, depending on subsequent social (and other) environmental factors, from infancy and beyond. The emphasis in current genetics on gene–environment interactions brings out that psychological/behavioral phenotypes are typically not simply evolved functions, on the one hand, or produced by environmental conditions alone, including by social processes, but are typically the product of interaction between the two.5

In this context, so far as concerns our mental life and behavior, who or what is responsible for design and function? These are the two familiar options:

1. Our natural constitution—how we are at birth—how we "naturally" are, prior to
2. Socialization processes (education, training, culturalization).

In the 1960s and 1970s these were the only two players on the pitch, conscripted then into the question of mental illness: in illness, what norms have broken down? Social, or natural? Given the forced choice, the answer has to be "natural," or both; and Wakefield is right about this—given the forced choice.

In the 1970s and 1980s evolutionary biopsychology and genetic theory were seen as giving specific content to the first proposition, so we have as influences on psychological and behavioral phenotypes:

1.* Evolutionary natural selection; genetic inheritance; prior to
2. Socialization processes (education, training, culturalization).

But while these two have plausibility as exclusive and exhaustive, and this is relied on in Wakefield's analysis, the plausibility derives only from what went before, prior to the new evolutionary biopsychology and genetics. The dichotomy between what is natural, meaning evolved and inherited, and what is social, did not survive, as already indicated. Rather, it has turned out on the one hand that socialization processes are profoundly influenced by genes, and on the other, that for mental and behavioral phenotypes, typically both sets of influence interact with each other to produce the outcome.

5 The literature on gene–environment interactions is extensive and rapidly expanding; reviews include Belsky et al. (2009) and Rutter et al. (2009).
Further, in addition to the breakdown of the dichotomy between what is natural and what is social, to their entanglement, the new genetics has also highlighted a third kind of influence responsible for "design and function" of human behavior:

3. Individual choice—signaled by individual differences notwithstanding 1* and 2

In the new genetics, psychology, in this context in its role as study of individual differences, becomes a third factor alongside, or rather interwoven with, our natural makeup, the genes we inherit, and socialization processes. The origin and design of psychological functioning typically include a complex mixture of genetic, evolved factors, and social factors, with individual differences running through them both. Depending on which is dominant, or which is thought to be dominant, we can attribute the origin—the design—of the behavior to human nature, to society, to subculture, to family (to family genes or behavior or both), or to the individual's constitution, character, or personal values.

Given the linkage between functional norms and design, to each kind of the three kinds of design there corresponds a type of norm: evolutionary/genetic, social, and individual—but again with no clear divisions, and interplay between them. It follows then that a mental state or behavioral response can be said to be dysfunctional—to deviate from design norms—in one or more of three ways:

1. It fails to operate in the way selected for in evolution.
2. It fails to operate in the way taught and sanctioned by the culture.
3. It fails to work in the way the person intends, according to his needs and values as he sees them.

These three kinds of dysfunction are not clearly separated, and they interact. The first kind belongs to an evolutionary theoretic framework and is relative to conditions in the Environment of Evolutionary Adaptiveness. The second kind of dysfunction is the one accessible to social theory; it is immersed in the present, in more or less diverse social realities. There is however a third reading of dysfunctional psychic life, the one at the individual level involving deviation from personal norms and values, evident to the person involved. This meaning has been neglected, to do with the fact that "madness" was silenced—though it is apparent in discourse led by service users. These are not, however, three meanings of psychological function and dysfunction—the evolutionary, the social, and the individual—they are rather three interwoven themes which run through all kinds of cases.

So where does this leave Wakefield's approach to the analysis of mental disorder? It has survived notwithstanding the burdens of many shortcomings and this may be due not so much to its fitness but to having no distinguished competitors in this particular environment. On the other hand its insistence on the key idea that the concept of illness is distinct from the concept of social deviance is correct. We have a term—in fact many terms—for what we believe is (just) failure to keep to social norms: naughty, lazy, rude, bad, criminal, etc. (and terms with neutral or positive evaluations: free thinking, original, eccentric, innovative—etc.). However, if the argument proposed earlier is correct, we cannot make out this difference between mental/behavioral disorder and social deviance by positing, on the one hand, a class of mental/behavioral functions that are entirely "natural"/evolved, as opposed to, on the other hand, a class that is entirely "social"—with failure of one of the former class
then being a "natural" dysfunction rather than a "social" dysfunction. According to current paradigms in genetics, the former class—of psychological functions that are entirely natural/evolved without social environmental influence—is probably empty; the main point being that the natural/social dichotomy is no longer valid.

So to preserve something of what is correct in Wakefield’s analysis we might say something like: mental disorder typically involves either or both failure to comply with socially or personally identified norms (hence, by the way, there is no need then to add "harmful" except to emphasize severity)—but either or both of those is not enough: there also has to be a breakdown in a "natural function." "Natural function" would presumably have to be understood as a psychological function which is common to human beings, the population variance in which is attributable to a high genetic component. However, making distinctions here is difficult since probably all psychological functions have some genetic heritability component, and how high is high? And on the other hand, probably all psychological functions are operational in personal and social activities. In brief all our activities involve the natural/genetic as well as the personal and social, so again there is no clear way here of distinguishing a subclass of psychological functions that do, as opposed to a class of functions that do not, involve the natural/genetic as well as the personal and the social. The latter class—psychological functions with no natural/genetic component—is again probably empty, and it is in any case unclear how anything like a demarcation criterion could be made out in these terms. Further, since psychological functions cannot be identified independent of the activities in which they operate, it is unclear what their "breakdown" would amount to other than breakdown in those personal and social activities, pointing again to the fundamental importance of personal and social phenomenology in the attribution of illness or disorder. Let us consider these implications further, with reference again to the core feature of the conceptualization of mental disorder in the DSM.

UNMANAGEABLE DISTRESS AND IMPAIRMENT

We have terms for what we believe is (just) failure to keep to social norms: naughty, lazy, rude, bad, criminal, etc. (and with neutral or positive evaluations: eccentric, innovative—etc.). We also have terms for a person failing to keep up with his own standards, such as—and these are all negative—lazy, weak-willed, insincere and hypocritical. Crucially, all these negative terms circle around the discourse of illness; illness discourse, the discourse of the clinic, is the alternative we acknowledge. In brief, illness attribution protects from condemnation. At least, all being well; otherwise, in a less positive outcome, the person suffers double trouble: the condemnation plus the illness. This refers to the discrimination faced by people with a diagnosis of mental illness (Hinshaw and Cicchetti 2000; Thornicroft 2006).

All being well, illness attribution protects from condemnation. The idea is that the persons cannot do what they are supposed to be doing, according to social expectations or their own standards—not because they are naughty, lazy, rude, bad, weak-willed, or insincere—but because they are ill. And the underlying principle is: illness involves incapacity—the person just cannot help not doing what they are not doing, or help doing what they are doing.

This insight into the logic of illness attribution is explicit though not elaborated in the conceptualizations of mental disorder in the DSM and ICD, in the references to distress and
disability or impairment. I considered earlier the question then arising about the difference between illness distress and normal distress. It is possible to make out this difference by adding the qualification "unmanageable" or "disabling." We are all often distressed, upset, and anxious, with variations according to life circumstances, with different frequencies and degrees—but to the extent that a person can manage, with their own resources or social supports, then that person does not typically seek professional help. Conversely, people are more likely to go to the clinic to the extent that they cannot manage. Unmanageability means that the distressing anxiety or mood state is too intense or too frequent to allow the person to get along satisfactorily with their lives as they usually do or want to lead them; in brief, it blurs into impairment. Emphasis is put here on unmanageable, disabling distress rather than what is expectable or not, or normal or not. So, it may be normal and expectable for a person to be unable to sleep much when they have high levels of worry and low mood levels while going through one or more life stresses or losses, at work or in personal relationships or both, but to the extent that the person is finding their mental state unmanageable and disabling, a visit to the clinic and healthcare may be warranted. Obviously many therapeutic approaches could be considered, including pharmacotherapy and brief psychotherapy, or simply rest, or a change of job; or, especially important to note explicitly, just keep a health care eye on things, "watchful waiting" as it is sometimes called, because the problem may well be self-limiting.

The possibility that illness in general and mental illness in particular may be explicated in terms of the person not being able to help doing or not doing as they are—in terms of "incapacity" in this sense—has been relatively neglected in the theoretical literature, perhaps due to the relatively high amounts of attention paid in the sociological literature to the social influences and power plays at work in diagnosis, on the one hand, and, on the other, to claims and counterclaims about the "natural dysfunction" that illness attributions allegedly track. It is possible, in some contrast with both these approaches, that illness attributions actually track our intuition that people sometimes cannot help what they are doing, or not doing, that they are sometimes not in control of their own actions. However, what this amounts to may be different for different conditions, as has recently begun to be explored in the literature.10

There is no objective hard and fast diagnostic threshold available here. What counts as intolerable distress, and what counts as serious impairment, what counts as disability (as being unable to do), all depend not only on individual psychological differences and individual life-circumstances but those in interaction with cultural expectations—all of these general headings themselves covering much diversity, and admitting opinions from many points of view.

**BIOMARKERS: CAUSES AND BOUNDARIES**

Can we expect science to deliver some clarity here? Are there objective factors which would tell us what are illnesses and what are not?

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10 For example, Bolton and Banner (2012), Kennett and Matthews (2003), and Pearce and Pickard (2011).
There is currently an extensive research effort in physical medicine to identify internal markers of disease processes reliably, to plan appropriate management, and early, to optimize prognosis under treatment, with progress in many areas. Similar benefits could accrue in psychological medicine, in psychiatry, if biomarkers could be identified. In addition, there would be the promise of clearer distinctions between mental illness and non-illness conditions, of tightening up the difference and distinction between, e.g., depressive illness and normal life distress, or normally distributed populations traits and ADHD, or Autistic Spectrum Disorder. There would be a proper laboratory test to bring clarity to what are otherwise vague and contested areas. So far, however, it would be fair to say that no well replicated, reasonably sensitive and specific biomarkers have been identified for any mental illnesses. But is this just a matter of time? Can we look forward to having, one day, a clear scientific grasp of what mental illness is?

Important background here is the stunning success of biomedicine between approximately the mid-nineteenth and mid-twentieth centuries. For some conditions it constructed the notions of signs and symptoms, and of syndromes, taking into account course over time; then in key breakthroughs it identified processes at the cellular level that causally explained those complex, variable surface features. Further, with the development of penicillin, treatment was developed too. In addition, the understanding of causes and processes of transmitted diseases enabled prevention through public health interventions. Game, set and match to nineteenth/twentieth-century biomedicine and its disease theory. The nineteenth/twentieth-century biomedical disease paradigm was taken into the new psychiatry at the turn of the century—along with, it should be added for completeness, quite distinctive paradigms from neurology and psychology. As is well-known the biomedical paradigm had a stunning success early on with syphilis: it all worked in the new psychiatry too. Very diverse signs and symptoms at and over time were unified into a syndrome caused by a kind of bacterium, a spirochete, invading the central nervous system, and which was treatable by penicillin. This early achievement of the biomedical model applied to psychiatry has not been repeated since, and there are, as is well known, ample reasons from research in the past half-century—as alluded to earlier—to cast doubt on whether it will ever be repeated, and indeed reason to believe that it will not be. As Kendler put it in a recent paper on the philosophical framework for psychiatry: no more spirochete-like discoveries, but rather multiple causes at multiple levels (Kendler 2005).

Research in psychiatry in the past few decades has revealed much about causes of risks for psychiatric conditions, including: genetic risks, typically involving multiple (perhaps hundreds) of genes adding relatively small risk; prenatal placental nutrient and hormonal environment affecting fetal programming; birth complications; early maternal and child rearing practices including neglect and abuse; life-stressors; maladaptive cognitive styles; social determinants such as social exclusion, poverty, and wealth inequality; and so on and on; and all interacting, and all, presumably, affecting brain development and functioning in some way.

A publisher’s announcement for a recent major edited volume on biomarkers in psychiatry states: “Biological markers, as physiological indicators of disease, hold immense promise for diagnostics and clinical drug trials. While for other complex disorders like diabetes and heart disease a limited number of markers are at hand, there are currently no biomarkers available for psychiatric disorders.” (Springer 2009). The science is rapidly expanding and is to be found usually under specific conditions.
In this context the possibility arises that the complex array of biopsychosocial causes may reduce to a single final common biological pathway, underlying the thought referred to at the end of the previous paragraph, that all the distant (early) biopsychosocial causes and the current psychosocial causes must somehow be implemented in the brain. This line of thought is a complex combination of philosophy of mind, especially mind–brain identity theory, and the philosophy of explanation, especially the assumption that causes must be proximate to their effects, and an empirical theory of illness, especially the theory of illness as disease. The philosophy is plausible enough but the thinking that derives from the disease model in particular needs closer examination. One point is that it is an empirical matter, not an a priori one, whether or not there is a final common pathway leading from multiple pathways to a single clinical syndrome, especially when, as is often observed, the clinical spectrum, a biomarker may be just an (other) sign of the illness, internal (inside the skin) as opposed to external, but as yet hardly worth distinguishing from the external signs and symptoms of the illness, from the point of view of the etiological model, which, we may suppose, stays as highly complex and multifactorial as before.

Or, at the other end of the spectrum, the biomarker may be something like a spirochete, in which case it has, let us suppose, a relatively simple mode of appearance in the body, in principle perhaps preventable, and a reliable response to treatment. But, as noted earlier, it looks implausible now to continue supposing that there are spirochete-like discoveries still on offer in psychiatry—and in this case biomarkers, even if we find them, won’t much change the current paradigms of complexity of etiology and features of the conditions that interest us.

But if biomarkers were found in psychiatric conditions, would this solve the boundary problems? Well they probably would if they were as precise, as specific, as the linkage between the bacterium *Treponema pallidum* and syphilis: identification of the bacterium fixes the diagnosis. Otherwise, the biomarker will associated, correlated with the condition in some degree, and its presence or absence will not necessarily fix the boundaries of mental illness, but would rather be another factor to be taken into account in the context of the personal and social phenomenology of the conditions that we describe as mental health problems.

**REFERENCES**


