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ORIGINAL ARTICLE

Why the mental disorder concept matters

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The mental disorder concept has not been paid due attention to. The aim of this paper is twofold: first, to assess how much space has been given to the mental disorder concept in textbooks of psychiatry, and second, to show in how many domains both within and beyond psychiatry the mental disorder concept plays a key role. A number of textbooks written in English, German, French, Spanish, and Italian, selected as examples, have been scanned so as to see if there is a chapter dealing with mental disorder, in particular with its definition. Also, the fields in which the mental disorder plays a major role have been identified, and the reasons why the concept of mental disorder is relevant for them have been explored. There is no chapter dealing with the definition of mental disorder in some textbooks of psychiatry in English, German, French, Spanish, and Italian that have been selected as examples. Yet there are numerous domains, directly or indirectly related to psychiatry, in which the mental disorder concept is a substantial element. The results show that the concept of mental disorder should be kept high on psychiatric agenda and given due space in textbooks of psychiatry accordingly.

Keywords: mental disorder, textbooks of psychiatry, epistemology of psychiatry, psychiatric agenda

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INTRODUCTION

The mental disorder concept is implied in most psychiatrists' activities. In so far it is one of the key notions in psychiatry. If psychiatrists do not address the question of normal and pathological, and this question is at the heart of the concept of mental disorder, it may damage the credibility of psychiatry as a discipline and as a profession (Maj, 2010: 264). Hence, this concept is legitimately expected to be largely elaborated in textbooks of psychiatry.

1. THERE IS NO DISCUSSION ABOUT THE CONCEPT OF MENTAL DISORDER IN TEXTBOOKS OF PSYCHIATRY

A survey has been carried out to detect how much space has been assigned to the mental disorder concept in a number of textbooks of psychiatry written in English, German, French, Spanish, and Italian, selected as examples. The survey showed that there is no chapter devoted to the notion of mental disorder in *Clinical Psychiatry* by Mayer-Gross et al. (1960) that has been the main textbook of psychiatry in the UK for decades. In *Lehrbuch der Psychiatrie* by E. Bleuer (revised by M. Bleuler) (1966), from which many generations of psychiatrists in German speaking countries have learned psychiatry, there is no chapter dealing with the notion of mental disorder either. In French speaking countries, *Manuel de Psychiatrie* by Ey et al. (1967) was mandatory literature for those specializing in psychiatry and psychiatrists for years. There is no section dedicated to the consideration of the mental disorder concept in this textbook either. This is also the case with *Textbook of Psychiatry* by Ewalt et al. (1963), published in the U. S.

In more recent times, the elaboration of the notion of mental disorder is missing in the following textbooks: in five-volume *Handbook of Psychiatry* edited by Shephard (1983), *Systematischer Lehrtext für Studenten und Ärzte* by Huber (1976), and in *Psychiatrie* by Guelfi et al. (1987). In most recent times, those who are curious about the mental disorder concept will not find a chapter assigned to this topic in many textbooks and manuals; for example, in Kaplan and Sadock's *Comprehensive Textbook of Psychiatry* (Sadock et al., 2009), in *Instruccion*

a la Psicopatologia y la Psiquiatria by Ruibola (2006), in *Trastornos Mental Comunes – Manual de Orientacion* by Retoleza (2009), in *Manuale di Psichiatria* by Biondi et al. (2009), and in *Manuale di Psichiatria* by Rossi (2009).

2. THERE IS NO CONSENSUS ABOUT THE MENTAL DISORDER CONCEPT

Indeed, there are various definitions of mental disorder. For example, Boorse (1977) holds that disease, mental disease including, is something objective in so far as it indicates how much one fails to conform to the "species-typical design" of humans, and thereby how much he/she fails to fulfill the organism's basic goals: survival and reproduction. Along the similar lines Kendell (1986) claims that people with mental illness are at biological disadvantage because they live shorter and have fewer children than the rest of the population. The DSM-IV's architects conceptualize mental disorder as "a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress […] or disability […]" (APA, 1994: XXI). Wakefield (2007), for his side, contends that mental disorder is a harmful dysfunction, "where 'harmful' is a value term, referring to conditions judged negative by sociocultural standards, and 'dysfunction' is a scientific factual term." Kecmanovic (2011: 23) asserts that there are four key characteristics of a mentally ill person: behavioral-functional deviation from the behavior and belief standard of the given society; impairment of mental function(s) that either precedes or follows psychological dysfunction; deviation and impairment of mental function(s) is beyond an individual's control, and mental suffering.

A number of distinguished scholars have taken part in the discussion about the cons and pros of the existing definitions of mental disorder (e.g., Aragona, 2009; Bolton, 2001; Fulford, 2001; Gert and Culver 2003). Also, in the preparation of DSM-V due out in 2013, a revision of the DSM-IV definition of a mental disorder has been proposed and discussed (Stein et al., 2010; First et al., 2010; Verhoeff et al., 2010; Broome and Bortolotti, 2010). Yet to date there is no consensus in the psychiatric community about the concept of mental disorder. Some authors are pessimistic about the chances of ever having widely agreed-upon definitional criteria for mental disorder that will be instrumental in clearly differentiating those with mental illness from those with no mental illness (Frances, 1994: VII; Bolton, 2008: 35).

The absence of a largely acknowledged mental disorder concept on the one hand and opinions that there is a bleak prospect of ever procuring it on the other does not diminish its relevance for psychiatry because "the concept of mental disorder is at the foundation of psychiatry" (Varga, 2011). Besides, the mental disorder concept is not the only major concept the meaning of which has been debated in psychiatry for years. The question of which psychiatric model is the most appropriate one is another case in point.

In the text below I specify the fields in which the mental disorder concept is most needed, and explain why and how it plays a major role in them.

3. RELEVANCE OF MENTAL DISORDER CONCEPT WITHIN PSYCHIATRY

3.1 Classification of Mental Disorders

A classification of mental disorders should include the definition of generic mental disorder. As individual forms of mental disorder in a classification are expected to have characteristics of mental disorder as such, the definition of mental disorder foreshadows the kinds of mental disorders that are covered by that particular classification. Needless to say that the definition of mental disorder that is the integral part of a classification mirrors the way in which the authors conceptualize mental disorder, i.e., what they mean by it. As there are varying general orientations or models within psychiatry, each of which in a different way conceives the nature of mental disorder, the definition of mental disorder as part of a classification, openly or covertly, indicates which model the authors of a particular diagnostic and classificatory system adhere to (Sartorius, 2010).

Moreover, on the nature of the definition of mental disorder depends whether it could be operationalized, and if yes, how much it might be helpful in endeavors to elevate reliability of the

diagnosis of mental disorders (Stein and Baldwin, 2000). In this context, it is of note that the existence of the definition of generic mental disorder in DSM-III and DSM-IV is one of the advantages of these classifications in relation to DSM-I and DSM-II, in which there is no definition of mental disorder.

3.2 Early Treatment of Psychosis

The field of early treatment of psychosis is burgeoning. Among others, McGorry (McGorry et al., 2005) should be credited for this. There is talk about introducing "Psychosis Risk Syndrome" or "Psychosis Attenuated Syndrome" as a new diagnostic entity in DSM-V (APA, Psychosis Attenuated Syndrome, 2011).

There are two major goals of early intervention in psychosis. First, to detect those at risk of an onset of psychosis, and then to treat them by CBT, atypical antipsychotics, omega-3 fatty, glycine, psychoeducation and family intervention so as to prevent or delay a full-blown psychosis (pre-onset intervention); and second, to start treating young people in the earliest possible stage of disorder so as to minimize the duration of untreated psychosis (post-onset intervention). A key issue continues to be the predictive validity of the prodromal or UHR (a group of ultra-high risk) selection criteria. Studies report a transition rate to a full psychotic disorder of, on average, about 30 percent. In other words, about two thirds of those who meet the criteria for ultra high risk of psychosis do not develop psychosis (Cannon et al., 2007).

The mental disorder concept, i.e., what those who deal with early intervention in psychosis mean by this notion, plays a crucial role in the whole business of psychosis prevention. The way in which they define disorder shapes their view of pre-morbid symptoms and of a developed disorder; thereby it determines time-frame for pre-onset and post-onset intervention. So, it turns out that the concept of mental disorder underpins both the ideology and practice of early intervention in psychosis. Disagreement with the early interventionists' concept of mental disorder, schizophrenia in the first place, implies disagreement with the concept of early intervention itself, or it substantially changes the early intervention time-frame at the very least.

3.3 Epidemiological studies

Those dealing with the assessment of the prevalence or incidence rate of mental disorder or some specific form(s) of mental disorder in a geographic area, or in a particular collective, use a definition of mental disorder as such, or the definition of a specific form of mental disorder. They cannot properly do their job unless they have as clear-cut as possible a definition of mental disorder. Thus, the concept of mental disorder is crucial for epidemiological research. In 1958, Scott wrote: "A serious obstacle to research in the area of mental illness lies in the lack of a clear definition of the phenomenon to be studied." Fifty years later, it was rightly noticed that psychiatric epidemiology still lags behind other branches of epidemiology due to the difficulties encountered in conceptualizing and measuring mental disorders (the caseness question) (Burger et al., 2007).

Two findings of two large community surveys conducted in the United States, The Epidemiological Catchment Area study (Robins et al., 1991) and The National Comorbidity survey (Kessler et al., 1994) have drawn the attention of the psychiatric community and of the psychiatric epidemiologists in particular. The first finding relates to the significant discrepancies in the prevalence of mental disorders in these two community studies, and the second finding shows an unreasonably high life-time and 1-year prevalence rate for major disorders. In providing plausible explanation for these results both Frances (1998) and Spitzer (1998) point at the fact that there is no accepted way how to define the boundary between pathology and normality, that is, between mental disorder and psychological health.

One does not have to participate in these kinds of studies to become aware of how important the definition of mental disorder is. All those who are keen to critically analyze epidemiological studies dealing with the incidence and/or prevalence rate of mental disorder(s) have to be knowledgeable about various aspects of the definition of mental disorder and about difficulties one faces up to when trying to operationalize it for epidemiological purposes. In a word, the importance of the mental disorder concept for psychiatric

epidemiology cannot be overestimated.

4. RELEVANCE OF MENTAL DISORDER CONCEPT BEYOND PSYCHIATRY

4.1 Legal field

Legal field is one of the domains in which the mental disorder concept is indispensable.

> "The infiltration of psychiatry into law may be broadly catalogued into matters of credibility, culpability, competency, compensation, and custody. So the intermix of psychiatry and law includes problems of a witness's credibility, the culpability of the accused, a defendant's competency to stand trial, the imposition and carrying out of death penalty, the individual competency to make a will or contract or to take care of oneself or of one's property, the compensation of injured persons, and the custody of children" (Slovenko, 2009: XI).

Even though a clear-cut concept of mental disorder and the assessment of its impact on an individual's specific mental functions is necessary in any particular case of the aforesaid intermix of psychiatry and law, the insanity defense and civil commitment both *explicitly* require the presence of mental disorder or mental defect which usually refers to mental retardation (Huss, 2009: 203). In other words, "all the formulations of the insanity defense require that the impairment claimed in mental functioning be a result of mental disease or defect" (Appelbaum and Gutheil, 1991: 274).

The legal and medical definition of mental disorder is not identical, the legal definition being narrower (Huss, 2009: 203). A psychiatrist as expert witness might benefit from knowing the legal definition. However, he/she has to rely on the psychiatric definition of mental disorder in his/her diagnostic decision making. This virtually means that psychiatrists in the legal arena cannot do without knowing the definitional criteria for mental disorder and without being able to explain, if asked, why they stick with a particular definition of mental disorder.

4.2 Health Insurance Sector

Whether health insurance agencies will cover and how much they will cover the costs of the management of a particular person with mental illness depends on the definition of mental disorder embraced by insurers. The definition of mental disorder also matters in assessing if there was a pre-existing condition, that is, a health problem that existed before one applied for a health insurance policy or enroll in a new health plan. This means that the definition of mental disorder determines accessibility to mental health care. In a word, "the definition of mental illness […] is not simply a question of semantics or terminology" (Peck et al., 2002)

Peck et al. (2002) analyzed the definitions of mental illness used in state parity laws in the U.S. What is meant by parity is "insurance coverage for mental health services that is subject to the same benefits and restrictions as coverage for other health services" (Varmus, 1998). They found that three terms are used to define mental illness in state parity legislation: "broad-based mental illness", "serious mental illness", and "biologically based mental illness." These are quite different definitions. The first is in tune with DSM's definition of mental disorder; the second one is variously conceptualized (there are 17 definition of the severely and persistently mentally ill: Schinnar et al., 1990), and the third one relies on the claim that mental illnesses have a biological underpinning.

The fact that entitlement to psychiatric services, in particular consequences of full or partial accessibility, or no accessibility to mental health care, depends on the definition of mental disorder, and that there are various terms used to define mental illness does indicate how much the definition of mental disorder matters in the health insurance sector.

4.3 The Stigma of Mental Illness

The mental disorder concept a psychiatrist endorses, be it the one that is presented in an official diagnostic and statistical manual or a psychiatrist's own view of mental disorder, shapes definitional criteria he/she uses for diagnosing people as mentally ill. Thus, ultimately, the preferred concept of mental disorder is of utmost importance in decision making about whether a particular person is mentally sound or disturbed. The thing is that once one is diagnosed as mentally ill he/she can hardly eschew the stigma of mental illness, which is, according to Goffman (1963: 3), an attribute that is deeply discrediting.

There are authors (Bracken and Thomas, 2005; Pilgrim and Rogers, 2005) who argue that

psychiatrists should stop diagnosing people with mental disorder so as to prevent their stigmatization. Reportedly this is the proper way to dissociate mental disorder from the stigma of mental disorder. This demand is, however, utterly unrealistic because psychiatrists cannot stop diagnosing people with mental disorders both for practical and scientific purposes.

The point is that "the stigma of mental illness is in many ways both the most important handicap people with mental disorders have to face and the most important challenge confronting contemporary psychiatric services" (Kendell, 2004: XXI). This comes from double negative effect of stigma: mental illness results not only in the difficulties arising from the symptoms of the disease but also in disadvantages through society's reactions (Rusch, et al. 2005). Given the double negative effect of stigma and its resistance to change (Phelan et al., 2000; Read and Hasslam, 2004), it is small wonder that "the stigma attached to mental illness and all that is related to it […] is the obstacle to better mental health care and better quality of life of people who have mental illness, of their families, of their communities and of health service staff who deals with psychiatric disorders" (Sartorius and Schulze, 2005: XIII).

Thus, the mental disorder definition a psychiatrist uses in diagnostic procedure has far-reaching effects on the civil status, mental condition, and social destiny of people diagnosed with psychiatric disturbance.

5. EPISTEMOLOGICAL REMARKS: WHY MENTAL DISORDER CONCEPT MATTERS

5.1 Psychiatry vs Antipsychiatry

In the sixties and early seventies, the proponents of the antipsychiatric movement accused psychiatrists of abusing psychiatry, primarily for political purposes. They claimed that psychiatrists label dissenters as mentally ill. They have gone even further by saying that the only mentally healthy people in modern societies are those who psychiatrists diagnose as mentally disturbed, whereas those who abide by inhuman conditions of the capitalist society are in fact mentally disturbed (Laing, 1967). According to antipsychiatrists, psychiatrists can easily label mentally healthy as mentally ill because there is no reliable way to verify if someone is, in fact, mentally disturbed or is just diagnosed as such; in other words, because – given the absence of biological markers of mental disorders – there are no firmly established defensible defining criteria for mental disorder.

Hence, it is vitally important that psychiatrists determine the specificity of mental disorder at the clinical or descriptive level, to precise the difference between mental disorder and non-disorder. The DSM-III and DSM-IV definition of mental disorder is, among other things, the result of such an endeavor. It is a response to demands to constitute mental disorder at the clinical (observable) level. It aims to secure the particularity of mental disorder in contradistinction to "close neighbors", be they political dissenters, eccentrics, or rebels for no apparent reason.

One thing is for sure: the better founded the definition of mental disorder the less difficult is to defend psychiatry against antipsychiatry inspired or any other challenges.

5.2 Psychiatry as a Distinct Discipline

Psychiatry is not a clearly delineated discipline. The lack of an agreed-upon definition of mental disorder is most responsible for fuzzy boundaries of psychiatry.

Stefanis (1986: 11) argues that our inability to convincingly and unequivocally define our subject matter, that is, mental disorder is the major factor that has made psychiatry vulnerable to multiple criticisms and subject to suspicion that it may be used as an alibi or as a tool for advancing interests other than those strictly related to the patient's welfare. Obviously, the mental disorder concept shows up as crucial in designating what psychiatry deals with. "Psychiatry is uniquely problematic because debates over what mental disorders *are* have presented substantial challenges to medical practice and ethics" (Patil and Giordano, 2010). (*italic in the original*)

There are four key reasons why a widely agreed-upon definition of mental disorder is markedly elusive.

(1) Mental disorder has been closely interwoven with unreason and all possible evils and misfortunes for centuries. Even though, about

two hundred years ago, when psychiatry was established as a separate discipline, unreason and mentally ill were officially disassociated, they remained linked in people's perception of either of them. There is double saturation of the concept of mental disorder by values: first, "the strange notions entertained by madmen have consistently provided a foil against which the proper way to reason is recognized and defined" (Radden, 2011: XII); second, "decline in functioning", "loss of control" and "distress" which are evaluated as negative are associated with mental disorder. Indeed, in any one particular society, a mentally disturbed person is perceived as opposed not to some universal values but first and foremost to the value(s) which are dominant in the given society or epoch. For example, depending on the prevailingt social values he/she is recognized either as evil spirit, or as someone who is not rational, or as someone who despises hard work, or as a person who is not free. The role that the dominant social value system plays in the definition of a mentally disturbed person cannot help but to make the achievement of a consensus about what mental disorder is all about even more arduous.

(2) Mental disorder lies on the boundary between the given natural world and the constructed social world (Wakefield, 1992). Or, to put it other way, psychiatry is a middle ground between natural and social sciences, between neurology and psychology, as Shorter (1997: 326) claimed. And, needless to say, borderline phenomena are most difficult to define.

(3) Since biological substratum of most mental disorders is unknown psychiatry is not defined by models of causation or treatment (Sharfstein, 1989: 216). It would be less difficult to define mental disorder if there were identified biological correlates of individual mental disorders. As we are (still) in the dark regarding neurobiological basis of most mental disorders, we have to identify the specificity of mental disorder at the clinical level. Yet many scholars see the clinical presentation of mental disorders insufficient and unreliable for the definition of mental disorder. That is why in their attempts to formulate the most befitting concept of mental disorder they look for a (stable) datum beyond the clinical picture like natural selection, or the fertility and mortality rate. The variety of data on which scholars attempt to anchor their concept of mental disorder is one of the sources of the variety of definitions of mental disorders; in so far it is a stumbling block in the way to a widely acknowledged concept of mental disorder.

(4) The definition of mental disorder implies the definition of normal and pathological, i.e., the designation of the border between them. The threshold is always a matter of consensus; it is not a given, it is not given in the nature. In disciplines other than psychiatry a consensual line dividing normal and pathological is denoted in objective measurable data. In psychiatry, however, the assessment of such line is a matter of subjective perception, of subjective interpretation as well as of the dominant value system. For example, how would be possible to asses if depression or anxiety is serious enough to be qualified as pathological, and to make assessment uniform from one psychiatrist to another? Thus, the definition of mental disorder in the sense of a line dividing normal and pathological is susceptible to arbitrariness.

As a result of the afore-mentioned controversies and dilemmas in defining mental disorder the boundaries of psychiatry are blurred and changeable. Consequently, the status of psychiatry as a distinct discipline has so often been challenged.

CONCLUSION

There are fields both within and outside psychiatry in which the crucial role of the mental disorder concept is more conspicuous than in other areas. Yet the mental disorder concept is relevant for psychiatry as a whole. The credibility of psychiatry as a medical discipline to a certain degree depends on a convincing definition of mental disorder (Varga, 2011).

However, a convincing and unequivocal definition of mental disorder is as elusive as ever. The farther psychiatrists are from an agreed-upon mental disorder concept, the more psychiatry needs it. Given the number and relevance of situations and circumstances in which psychiatrists beg a concept of mental disorder, and the fact that the way in which mental disorder is concep-

tualized makes psychiatry more or less problematic, this concept should be given more attention than it has been the case, to date. The more so as deliberations about the most appropriate definition of mental disorder imply discussion about a whole range of key psychiatric topics.

Textbooks of psychiatry are one of the main, if not the major reading selections from which psychiatrists learn the basics of psychiatry. If psychiatrists are not sensitized to the importance and complexity of the mental disorder concept on time, i.e., at the early stages of their psychiatric education, when textbooks of psychiatry are most read, this handicaps them all the way through their day-to-day practice, and makes them less competent in dealing with the challenges psychiatry so often faces. This is why to give a proper place to the mental disorder concept in textbooks of psychiatry is long overdue.

The point is not "adoption of a generic, presumably universal, definition of 'mental disorder'", which according to Jablensky (2007) would be premature, and "may cause more harm than good to psychiatry". Yet, as shown in this text, psychiatrists, and not only psychiatrists, need a widely accepted definition of mental disorder for operative and conceptual purposes. And in waiting the time to come when an agreed-upon definition of mental disorder will not be premature, psychiatrists have to discuss at length which definition of mental disorder is most useful in the sense of providing them most help in varying domains both within and beyond psychiatry. At the same time such definition is expected to serve the best interests of those in need of psychiatric assistance.

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REFERENCES

American Psychiatric Association. Diagnostic and statistical manual of mental disorders (fourth edition). American Psychiatric Association, Washington DC, 1994.

American Psychiatric Association. Attenuated Psychosis Syndrome. 2011: www.dsm5.org/ProposedRevisions/Pages/proposedrevisionaspx?rid=412

Appelbaum PS, Gutheil TG. Clinical handbook of psychiatry and the law (second edition). Williams and Wilkins, Baltimore, 1991.

Aragona M. The concept of mental disorder. Dial Phil Ment Neuro Sci 2009; 2: 1-14.

Biondi M, Carpinello B, Muscettola G, Placidi G, Rossi A, Scarone S. Manuale di psichiatria. Elsevier SRL, Milano.

Bleuler E (revised by Bleuler M). Lehrbuch der Psychiatrie (tenth edition). Springer Verlag, Berlin, 1966.

Bolton D. Problems in the definition of mental disorder. Philos Quart 2001; 51: 182-199.

Bolton D. Mental disorder. An essay in philosophy, science and value. Oxford University Press, Oxford, 2008.

Boorse C. Health as a theoretical concept. Philos Sci 1977; 44: 542-573.

Bracken P, Thomas Ph. Postpsychiatry. Cambridge University Press, Cambridge, 2005.

Broome M, Bortolotti L. What's wrong with "mental" disorder? Psychol Med 2010; 40: 1783-1785.

Burger H, Neelman J. A glossary on psychiatric epidemiology. J Epidemiol Community Health 2007; 21: 185-189.

Cannon TD, Cornblatt B, McGorry P. The empirical status of the ultra-high risk (prodromal) research paradigm. Schizophr Bull 2007; 33: 661-664.

Ewalt JR, Farnsworth DL. Textbook of psychiatry. McGraw-Hill, New York, 1963.

Ey H, Bernard P, Brisset S. Manuel de psychiatrie (third edition). Masson, Paris, 1967.

First MB, Wakefield JC. Defining "mental disorder" in DSM-V. Psychol Med 2010; 40: 1779-1782.

Frances A. Foreword. In: Sadler JZ, Wiggins OP, Schwartz MA. (Eds.). Philosophical perspectives on psychiatric diagnostic classification. The Johns Hopkins University Press, Baltimore, 1994: VII-IX.

Frances A. Problems in defining clinical significance in epidemiological studies. Arch Gen Psychiatry 1998; 55: 119.

Fulford KWM. 'What is mental disorder': an open letter to Christopher Boorse. J Med Ethics 2001; 27: 80-85.

Gert B, Culver CM. Defining mental disorder. In Radden J. (Ed.). The philosophy of psychiatry: A companion. Oxford University Press, New York, 2003.

Goffman E. Stigma. Penguin Books, Middlesex (UK),1963.

Guelfi JD, Boyer P, Consoli S, Olivier-Martin R. Psychiatrie. Presse Universitaire de France, Paris, 1987.

Huber G. Systematischer Lehrtext für Studenten und Ärzte (second, revised edition). FK Schattauer, Stuttgart, 1976.

Huss MT. Forensic psychology: research, clinical practice, and applications. Wiley Blackwell, Chichester (UK), 2009.

Kecmanovic D. Controversies and dilemmas in contemporary psychiatry. Transaction Publishers, New Brunswick-London, 2011.

Kendell RE. What are mental disorders? In Freedman AM, Brotman R, Silverman I, Hutson D. (Eds.). Issues in psychiatric classification: science, practice and social policy. Human Sciences Press, New York, 1986: 23-45.

Kendell RE. Foreword. Why stigma matters. In Crisp AH (Ed.). Every family in the land. Understanding prejudice and discrimination against people with mental illness. Rev. Edition. London: The Royal Society of Medicine, 2004: XXI-XXIII.

Kessler RC, McGonagle KA, Zhao S, Nelson CB, Hughes M, Eshleman S, Wittchen HU, Kendler KS. Lifetime and 12-month prevalence of DSM-III psychiatric disorders in the US. Results from National comorbidity survey. Arch Gen Psychiatry 1994; 51: 518-519.

Jablensky A. Does psychiatry need an overarching concept of “mental disorder”? World Psychiatry 2007; 6: 157-158.

Laing RD. The politics of experience and the bird of paradise. Penguin, Harmondsworth (UK), 1967.

Maj, M. Is it true that mental disorders are so common, and so commonly co-occur? In Millon T, Krueger RF, Simonsen E. (Eds.). Contemporary directions in psychopathology. New York, Guilford Press, 2010.

Mayer-Gross W, Slater M, Roth M. Clinical psychiatry. London, Cassel and Company, 1960.

McGorry P, Nordendoft M, Simonssen E. Introduction to early psychosis: a bridge to the future. Br J Psychiatry 2005; 187 (suppl. 48), S1-S3.

Patil T, Giordano J. Editorial. On the ontological assumptions of the medical model of psychiatry: philosophical considerations and pragmatic tasks. Philos Ethics Humanit Med 2010; 5 doi:10.1186/1747-5341-5-3.

Peck MC, Scheffer RM. An analysis of the definitions of mental illness used in state parity laws. J Psychiat Services 2002; 53: 1089-1095.

Phelan JC, Link BG, Stueve A, Pescosolido BA. Public conceptions of mental illness in 1950 and 1996: what is mental illness and is it to be feared. J Health Soc Behav 2000; 41: 188-207.

Pilgrim D, Rogers AE. Psychiatrists as social engineers: A study of an anti-stigma campaign. Soc Sci Med 2005; 61: 2546-2556.

Radden J. On delusion. Routledge, London and New York, 2011.

Read J, Hasslam N. Public opinion: bad things happen and can drive you crazy. In Read J, Mosher RL, Bentall RP. (Eds.). Models of madness: psychological, social and biological approaches to schizophrenia. Brunne-Routledge, Hove (UK) 2004: 133-146.

Retoleza A. Trastornos mentales comunes – manual de orientación. Asociatión Española de Neuropsiquiatria, Valladolid, 2009.

Robins LN, Regier DS (Eds.). Psychiatric disorders in America: The epidemiological catchment area study. Free Press, New York, 1991.

Rossi G. Manuale di psichiatria. Piccin-Nuova Libraria, Padova, 2009.

Ruibola JV. Instrucion a la psicopatologia y la psiquiatria. Masson, Barcelona, 2006.

Rusch N, Angermeyer MC, Corrigan PW. Mental illness stigma: concepts, consequences, and initiatives to reduce stigma. J Eur Psychiatry 2005; 20: 529-539.

Sadock BJ, Sadock WA, Ruiz P. Kaplan and Sadock’s comprehensive textbook of psychiatry. Lippincott, Williams and Wilkins, Philadelphia, 2009.

Sartorius N. Revisions of the classification of mental disorder in ICD-11 and DSM-V: work in progress. Adv Psychiat Treat 2010; 16: 2-9.

Sartorius N, Schulze H. Introduction. Reducing stigma of mental illness: A report from a global programme of the World Psychiatric Association. Cambridge University Press, Cambridge, 2005: V-XVI.

Schinnar AP, Rothbard AB, Kanter R, Yung YS. An empirical literature review of definition of severe and persistent mental illness. Am J Psychiatry 1990; 147: 1602-1608.

Scott WA. Research definition of mental health and mental illness. Psychol Bull 1958; 55: 29-45.

Sharfstein SS. What are the boundaries issues? In Talbott JA (Ed.). Future direction for psychiatry. American Psychiatric Association, Washington, DC 1989: 215-216.

Shephard M (Ed.). Handbook of psychiatry. Cambridge University Press, Cambridge, 1983.

Shorter E. History of psychiatry: From the era of the asylum to the age of Prozac. John Wiley, New York, 1997.

Slovenko R. Psychiatry in law/Law in psychiatry (second edition). Taylor and Francis Group, New York, 2009.

Spitzer RL. Diagnosis and need for treatment are not the same. Arch Gen Psychiatry 1998; 55: 120.

Stein DB, Baldwin S. Toward an operational definition of disease in psychiatry: Implications for diagnosis and treat-

ment. Int J Risk Safety Med 2000; 13: 29-46.

Stein DJ, Phillips KA, Bolton K, Fulford KWN, Sadler JZ, Kendler KS. What is mental/psychiatric disorder? From DSM-IV to DSM-V. Cambridge University Press, 2010, doi: 10.1017/S003329170999992261.

Stefanis C. Current developments in psychiatry: a challenge for the World Psychiatric Association. In Rosenberg R, Schulsinger E, Stromgren S. (Eds.). Psychiatry and its related disciplines. The next 25 years. Copenhagen, Denmark: WPA Regional Symposium 1986: 9-20.

Varga S. Defining mental disorder. Exploring the 'natural function' approach. Philos Ethics Humanit Med 2011; 6 doi.1186/1747-5341-6-1.

Varmus H. Parity in coverage of mental health services in an area of managed care: An interim report to Congress by the national advisory mental health council. NIM pub. 98-4322. Department of Health and Human Services, Bethesda MD, 1998.

Verhoeff B, Glas G. The search for dysfunctions. Psychol Med 2010; 40: 1787-1788.

Wakefield JC. The concept of mental disorder. On the boundary between biological and social values. Am Psychol 1992; 47: 373-388.

Wakefield JC. The concept of mental disorder: diagnostic implications of the harmful dysfunction analysis. World Psychiatry 2007; 6: 149-156.