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Harm should not be a necessary criterion for mental disorder: some reflections on the *DSM-5* definition of mental disorder

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Abstract

The general definition of mental disorder stated in the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* seems to identify a mental disorder with a harmful dysfunction. However, the occurrence of distress or disability, which may be dubbed the harm requirement, is taken to be merely usual, and thus not necessary: a mental disorder can be diagnosed as such even if there is no harm at all. In this paper, we focus on the harm requirement. First, we clarify what it means to say that the harm requirement is not necessary for the general concept of mental disorder. In this respect, we briefly examine the two components of harm, distress and disability, and then trace a distinction between mental disorder tokens and mental disorder types. Second, we argue that the decision not to regard the harm requirement as a necessary criterion for the general notion of mental disorder is tenable for a number of practical and theoretical reasons, some pertaining to conceptual issues surrounding the two components of harm and others involving the problem of false negatives and the status of psychiatry vis-à-vis somatic medicine. However, we believe that the harm requirement can be (provisionally) maintained among the specific diagnostic criteria of certain individual mental disorders. More precisely, we argue that insofar as the harm requirement is needed among the specific diagnostic criteria of certain individual mental disorders, it should be unpacked and clarified.

Keywords Disability · Distress · DSM-5 · Harm · Mental disorder · Psychiatry

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Journal : SmallExtended 11017	Article No : 9499	Pages : 17	MS Code : 9499	Dispatch : 4-9-2019

Introduction

The fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-5*) seems to identify a mental disorder with a harmful dysfunction:[1]

> 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. [2, p. 20] (emphasis added)

Two requirements are established, but they are clearly ascribed different importance. First, the definition indicates that a mental disorder "reflects" a dysfunction. This means that dysfunction, which may be understood as a proximal or underlying pathological cause, is taken to be a necessary requirement for qualification as a mental disorder: no mental disorder can be correctly recognised as such without a dysfunction underlying it. Second, the definition goes on to say that a mental disorder is "usually associated with" significant distress or disability. This means that the occurrence of distress or disability, which may be dubbed the harm requirement, is taken to be merely usual,[2] and thus not necessary: a mental disorder—either as a specific occurrence or as a type of condition—can be correctly recognised as such even if there is no harm at all.

In the present paper, we bracket the problems raised by the dysfunction requirement[3] (which we directly address in [4]) and focus on the harm requirement alone. It should be noted that we do not aim to defend any particular definition of mental disorder, either value-free or value-laden; we simply argue that the definition, whatever it is, should not contain the harm requirement. Moreover, we consider the general notion of mental disorder to be a theoretical one—in Christopher Boorse's sense [5–7]—geared towards discriminating (metaphysically) between normal and pathological mental conditions in psychiatry, just as the notion of disease is typically geared towards discriminating between normal and pathological physical conditions in somatic medicine.

To begin, in the next section, we attempt to clarify what it means to say that the harm requirement is not necessary for the general concept of mental disorder. First, we briefly examine the two components of the harm requirement—namely, distress and disability. We then trace a distinction between mental disorder tokens and mental disorder types. If one focuses on mental disorder tokens, denying the necessity of the harm requirement would amount to saying that certain specific occurrences of a given mental disorder might be not harmful. On the other hand, if one focuses on

[1] Jerome Wakefield originally introduced the definition of mental disorder as a harmful dysfunction [1].

[2] For the purpose of this paper, it is not important to specify the exact meaning of 'usual', but it is sufficient to assume that it implies that the harm requirement is not necessary for mental disorder [3].

[3] As the problems related to the dysfunction requirement are not the focus of this paper, we simply follow the *DSM-5* definition in assuming its necessity.

Journal : SmallExtended 11017	Article No : 9499	Pages : 17	MS Code : 9499	Dispatch : 4-9-2019

mental disorder types, denying the necessity of the harm requirement would amount to saying that at least certain kinds of conditions count as mental disorders even though they are not harmful at all.

In the third section, we argue that the decision not to regard the harm requirement as a necessary criterion for mental disorder is tenable for a number of theoretical and practical reasons. Some of those reasons pertain to conceptual issues surrounding the components of harm (i.e., distress and disability). Others include the problem of false negatives and the status of psychiatry vis-à-vis somatic medicine. Our main point here is that the harm requirement is unfit to serve as the definiens of medical disorder and thus should not be included within the *DSM-5* general definition. However, we believe that the harm requirement can be (provisionally) maintained among the specific diagnostic criteria of certain individual mental disorders.

More precisely, in the fourth section, we argue that insofar as the harm requirement is (provisionally) needed among the specific diagnostic criteria of certain individual mental disorders, it should be unpacked to clarify (i) what its role is as a diagnostic criterion and (ii) with respect to whom, by whom, and how distress and disability should actually be judged and evaluated. Our aim here is to show that the harm requirement can be used and interpreted in many different and contrasting ways, making its current wording ambiguous and problematic. A general claim stating that 'the disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning' is still too imprecise.

The harm requirement

Departing from previous editions of the manual, *DSM-5* downgraded the harm requirement from a necessary constituent to a frequent or typical characteristic of mental disorders—that is, from a *prescription* of what should be regarded among mental disorders to a *description* of what mental disorders usually look like: 'Mental disorders *are usually associated with* significant distress or disability in social, occupational, or other important activities' [2, p. 20] (emphasis added). By contrast, harm was presented as a necessary requirement in the definition of mental disorder given in the third revised edition (*DSM-III-R*) [8] and then reiterated in the fourth edition (*DSM-IV*) [9] and its text revision (*DSM-IV-TR*) [10]: '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 … or disability … or with a significantly increased risk of suffering' [9, pp. xxi–xxii] (emphasis added).[4]

We acknowledge that the harm requirement of course served an important historical role, as it enabled the exclusion of homosexuality from the range of mental disorders [12]. In 1973, the nomenclature committee of the American Psychiatric Association (APA) 'reviewed the characteristics of the various mental disorders and

[4] The conceptual history of the upgrading and downgrading of the harm requirement is well illustrated by Rachel Cooper [3]; we briefly address this issue in [11].

Journal : SmallExtended 11017 | Article No : 9499 | Pages : 17 | MS Code : 9499 | Dispatch : 4-9-2019

concluded that, with the exception of homosexuality and perhaps some of the other "sexual deviations," they all regularly caused subjective distress or were associated with generalized impairment in social effectiveness of functioning' [13, p. 211]; and on the basis of this, members of the APA voted for the removal of homosexuality per se from the manual with a referendum in 1974. Homosexuality per se was then replaced with sexual orientation disturbance [14] and ego-dystonic homosexuality [15], so as to diagnose those individuals who were homosexual and harmed by their condition, and then later removed entirely [8]. To be clear, the harmful dysfunction account of mental disorder does successfully explain why homosexuality has been eliminated from *DSM* [16].

Nevertheless, we also believe that the harm requirement is now no longer necessary in order to exclude homosexuality from psychiatric diagnoses, as the other criterion for qualification as a mental disorder—the dysfunction requirement—can provide sufficient reason for such exclusion in its own right. Current theories of homosexuality largely agree that it is a case of normal variation, with no dysfunction in play [17].

That being said, Jerome Wakefield has recently argued that no one 'knows today what causes exclusive homosexuality … so one can't really argue the dysfunction question on evidential grounds' [18, p. 317]; for this reason, the harmful dysfunction account of mental disorder, including the value-laden component of the harm requirement, is still better suited than value-free definitions—such as those using the biostatistical theory [5–7]—to explain the elimination of homosexuality from *DSM* [16].

On this point, it is important to repeat that we are not supporting any explicit definition of mental disorder; in particular, we are not defending a completely value-free account of mental disorder, as our argument holds when either dysfunction or harm is a naturalistic or evaluative concept. Our main concern here consists in the technical features of the concept of harm, not in whether it is value-laden (as Wakefield believes) or not, and our thesis is that the harm requirement is unfit to be considered a necessary condition for the general concept of mental disorder. Indeed, other concepts—such as risk factors—could play an evaluative role in determining whether or not a condition is a mental disorder, irrespective of whether it is harmful. This possibility, which is perfectly compatible with our argument against the harm requirement, would also exclude homosexuality from the battery of mental disorders, even if homosexuality should in fact count as a dysfunction according to some definitions of function.

Returning now to the features of the harm requirement, the *DSM* definitions construe harm as having two main components: distress and disability.

Distress is defined neither in *DSM-5* nor in the most recent revision of the *International Classification of Diseases* (*ICD-11*). However, there are many definitions implicitly employed or more explicitly stated in the scientific literature, ranging from a state of worry, anxiety, and preoccupation to a condition with quasi-depressive symptoms [19]. All of these characterisations are underspecific and vague and, as such, can easily be interpreted in many different ways.

The other conceptual component of the harm requirement is disability. The *International Classification of Impairments, Disabilities, and Handicaps* defines

Journal : SmallExtended 11017	Article No : 9499	Pages : 17	MS Code : 9499	Dispatch : 4-9-2019

disability as interference with activities of the whole person in relation to the immediate environment [20, 21]. In the same vein, the *ICD-11*, *International Classification of Functioning, Disability and Health*, and World Health Organization more broadly approach disability as a consequence of diseases, not as a part of their definition [22, 23] (see also [24, 25]). The *DSM-5* endorses this line of thought and, in fact, contains an explicit claim that the concept of mental disorder and the concept of disability should not be conflated with one another: 'There have been substantial efforts by the *DSM-5* Task Force and the World Health Organization (WHO) to separate the concepts of mental disorder and disability (impairment in social, occupational, or other important areas of functioning)' [2, p. 21]. Disability is generally considered to be an intrinsically relational concept, which involves an environmental and social component. A person with a certain pathological condition (mental or somatic) can be either disabled or nondisabled by such condition, depending on where she lives, what she does for work, and how she acts more generally. This is the idea behind the *social model* of disability, which is dominant in non-psychiatric medicine [26]. For the purpose of this paper, we will assume this model.

In the next section, we argue in favour of the claim that neither distress nor disability should be part of the general definition of mental disorder. Our discussion should be read as a justification of what has already been done, or a defence of the move to downgrade the harm requirement against objections levelled by authors such as Cooper [3] and Wakefield [1, 16, 27], among others.[5] First, however, we specify what this downgrade amounts to in view of the metaphysical distinction between tokens and types of mental disorders.

Generally speaking, a mental disorder type is an idealisation of what happens to a potentially infinite range of diverse patients; it is the exemplar or model that medical researchers study and that the clinician identifies as the kind of condition that a person has when she makes a diagnosis. A mental disorder token is the exemplification or instantiation of a mental disorder type in a specific individual [28, 29].

If one focuses on mental disorder tokens, arguing against the necessity of the harm requirement would amount to saying that some occurrences of a given mental disorder type—that is, some instances of a certain kind of a mental disorder (e.g., erectile dysfunction, schizophrenia, alcohol abuse disorder)—might be harmless. In this respect, some occurrences of a mental disorder type could be correctly recognised as such even if some individuals affected with it experience no harm at all. To put it differently, a specific individual may find a certain well-recognized pathological condition, considered in and of itself, totally harmless, in the sense of being neither distressing nor disabling, but still be considered mentally disordered. For example, consider a condition like erectile disorder with respect to an asexual person or a religious person who has made a chastity vow; or, following Cooper's example [30], consider a condition like schizophrenia with respect to someone who positively values her hallucinations (for more examples of this kind, see, e.g., [31]). Similar reflections can be offered even if harm is evaluated in relation to people other than

[5] Of course, it would be important to address what is wrong with each of these objections in greater details, but that would fall outside the scope of the present paper.

Journal : SmallExtended 11017 | Article No : 9499 | Pages : 17 | MS Code : 9499 | Dispatch : 4-9-2019

the patient herself (as we discuss later): many people diagnosed with a certain type of mental disorder do not cause any harm to their family or society.

If one focuses on mental disorder types, arguing against the necessity of the harm requirement would amount to saying that at least certain kinds of conditions can count as mental disorders—that is, can belong to the general mental disorder category—even though they are not harmful at all. Put differently, mental disorders—regarded as exemplars or models that medical researchers study and that clinicians identify as the kind of condition that an individual is affected by—do not need to meet the harm requirement to be recognised as such. In this respect, certain types of conditions could be correctly recognised as pathological (i.e., as mental disorders) even in the absence of any distress or disability—that is, even if they are intrinsically harmless, with respect to the patient, her family, or society. In general, think of lanthanic diseases or trivial diseases, such as minor rashes, skin lesions, or moles; and, more to our point, about petty mental disorders, such as minor tics—a tic being 'a sudden, rapid, recurrent, nonrhythmic motor movement or vocalization' [2, p. 81]. The argument that the harm requirement is not necessary for qualification as a mental disorder type is contentious, and indeed continues to divide philosophers of medicine today, but this claim is in line with the *DSM-5* nosology. In fact, focusing on tic disorders, it becomes clear that the harm requirement is not needed, as it is explicitly claimed that 'many individuals with mild to moderate tic severity experience no distress or impairment in functioning and may even be unaware of their tics' [2, p. 84].

Against the harm requirement

In this section, we present and defend the main reasons—both practical and theoretical—for not including the harm requirement within the general definition of mental disorder. We also try to rebut some of the arguments that have been advanced in favour of retaining the harm requirement within this definition. We begin by addressing reasons for discarding the harm requirement that have to do with the two components of harm—namely, distress and disability.

As noted above, 'distress' is never defined in *DSM-5*, standing for a range of concepts from desperation to mild anxiety. This underspecificity and vagueness in the concept of distress is already reason in and of itself for not including distress in a general definition of mental disorder. Suppose we face a discrimination problem—that is, a problem of determining whether a certain condition is a mental disorder that should be added to the nosology or not. The verdict would be very different depending on how distress is intended to be understood. As such, a definition that includes distress among its components would not be helpful in the resolution of this discrimination problem.[6] Of course, the above difficulties related to the

[6] Even if it is true that there is no distress where a condition causes no negative feelings, it can still be possible for that condition to be a mental disorder; cases of severe lack of insight in psychopathy or schizophrenia are examples of this (see the following section).

Journal : SmallExtended 11017	Article No : 9499	Pages : 17	MS Code : 9499	Dispatch : 4-9-2019

notion of distress are not by themselves sufficient to conclude that the harm requirement should be eliminated from the general definition of mental disorder. In fact, the harm requirement could be differently articulated to avoid including the distress component; or the distress component could be better spelled out to mitigate its current underspecificity and vagueness. That being said, as it stands, the notion of distress is presently unfit to figure into the general definition of mental disorder.

Another problem with this component is that distress (e.g., having symptoms of anxiety or depression) is often a totally normal part of our proper reactions to stressful and negative life events. This makes it very difficult to know how to draw the line between normal distress and pathological distress. Should a condition of deep and prolonged distress after the death of a loved one be classified as a depressive disorder? Different normativists have tried to discriminate between normal and pathological distress by appealing to the presence of a dysfunction [32] or an underlying objective cause [33], thus dismissing distress as a sufficient criterion for mental disorder. Nevertheless, ongoing discussions on this issue prove again that the concept of distress, given its ineliminable vagueness, is unfit to serve as the definiens of the general notion of mental disorder [19, 34, 35].

A further reason for not including the harm requirement in the general definition of mental disorder is that it can easily lead to *false negatives*. False negatives are cases in which someone's condition has been wrongly classified as a nondisorder, where it is in fact a mental disorder, and the mistake is due not to the clinician or researcher's misapplication or ignorance of the criteria, but rather to the inadequacy of the criteria themselves [36, p. 1857].

Some of these false negatives may come as a consequence of the distress component of harm. While distress may be relevant to the phenomenology of depressive and anxiety disorders, there is no significant distress experienced by individuals diagnosed with conditions such as narcissistic personality disorder and, to a certain extent, histrionic personality disorder [37].[7,8] A recent review of studies on hoarding disorder [38]—the acquisition and inability to let go of a large number of possessions, resulting in clutter that precludes the use of one's own living spaces—shows that patients' subjective evaluation of their distress (and quality of life) is not in line with more objective measures of social and occupational functioning, intuitively because such patients do not have sufficient insight into their situation. Again, if distress were endorsed as a general criterion within the definition of mental disorder, these conditions could not be classified as mental disorders (provided that disability is absent as well).

Other false negatives are connected with the disability component. While disorders such as schizophrenia, bipolar disorders, and major depressive disorder may often be disabling conditions, others—such as alcohol or substance use disorders

7FL01 [7] Whose distress is relevant, and who should evaluate it? In the next section, we argue that some of the
7FL02 criteria for specific disorders involving harm are ambiguous with respect to such questions.

8FL01 [8] The distress experienced can have different sources, as people can be distressed either by their person-
8FL02 alities as such or by the reactions that others have to their personalities. Both kinds of distress, however,
8FL03 seem not to be necessary to diagnose mental disorders such as narcissistic personality disorder or histri-
8FL04 onic personality disorder.

without severe symptoms, certain paraphilic disorders, and tic disorders—are compatible with having and maintaining a job, significant sentimental relations, and social roles. Alcohol abusers, for instance, may be temporarily high-functioning but also severely addicted, at least for a time [39]. The same point can be made about people showing early signs of mental disorders such as schizophrenia or neurocognitive disorders whose symptoms are clear enough but still sparse [40], or about people diagnosed with similar disorders whose symptoms manifest in a way that is compatible with high-functioning. These kinds of conditions—regarded either as tokens or as types—do not always make people significantly less able or proficient in basic life skills. As such, if disability were endorsed as a general requirement, many people would not be given a diagnosis of mental disorder, and thus would not be granted the consequent entitlement to treatment (again, provided that distress is absent as well).

In sum, even if mental disorders usually cause distress or disability, it is possible to have one without the other, thus making the harm requirement unnecessary for mental disorders to qualify as such (when regarded as either tokens or types). Some scholars, however, give an opposite reading of the above examples, conceiving them as *false positives*, rather than false negatives. Let us consider this point of view before illustrating the other reasons against adopting the harm requirement.

Cooper [3, 30], for instance, has recently argued that it would be better to retain the harm requirement within the definition of the general concept of mental disorder because a person whose mental (or physical) dysfunction causes her no harm—'a particular "symptomatic" but flourishing individual' [3, p. 91]—should not be classified as having a mental disorder (or a disease). Her general point is that in all the above examples, the best thing to say is that, evaluated in and of itself, 'the same condition can be pathological for one person but not for another. The schizophrenic for whom it is a good thing to be schizophrenic is not diseased, while another for whom it is a bad thing is' [30, p. 274]. Indeed, there are entire movements of individuals—such as the Mad Pride and neurodiversity movements—who do not feel harmed by their diagnoses of schizophrenia, bipolar disorder, or autism spectrum disorder [41]; many of them would also dovetail Cooper in thinking of themselves as merely diverse, not mentally disordered.

We agree with Cooper, and the Mad Pride and neurodiversity movements, that a particular individual might find conditions like erectile disorder or schizophrenia totally harmless in and of themselves, being neither distressing nor disabling from that individual's personal perspective. However, we do not support the conclusion that these conditions are not bona fide mental disorders—finding this to be extremely counterintuitive, especially as one moves from mental disorders to somatic diseases. Think about conditions like sterility with respect to someone who does not want to have babies; rolandic epilepsy with respect to someone who values her unpredictable seizures; or even infectious diseases, such as tuberculosis, with respect to someone who finds her condition existentially advantageous and somehow desirable. This, in fact, is one of the readings of Hans Castorp in Thomas Mann's novel *The Magic Mountain,* set in a sanatorium for tuberculosis—arguably, Castorp felt good about the idea of having this condition [42]. Should we conclude that Castorp's tuberculosis was not a disease, and Castorp

Journal : SmallExtended 11017	Article No : 9499	Pages : 17	MS Code : 9499	Dispatch : 4-9-2019

himself was not diseased, because he was fine with it? Given the burden of mortality that this infectious disease has caused in the past, and still causes today, and current knowledge about its causes and effects on the human body, this would not be an acceptable conclusion. Therefore, it is not better to say—*pace* Cooper—that the same condition, evaluated in and of itself, can be a disease for one individual but not for another; on the contrary, it is better to say that the same *disease*, evaluated in and of itself, can be *harmful* for one individual but not for another. The same goes, *mutatis mutandis*, for mental disorders: it is better to say that the same mental disorder, evaluated in and of itself, can be harmful for one individual but not for another. Hence the conceptual connection between mental disorder and harmfulness can be erased: it is possible to have bona fide mental disorders that one is still happy and proud to accept and identify with. Then, it can simply be acknowledged that all of the above cases exemplify instances of a well-recognized pathological condition—either a somatic disease or a mental disorder—that is harmless for some particular individuals. To recap, we believe that as far as mental disorder tokens are concerned, Cooper's objection is not compelling.

Similar reflections can also be applied to mental disorder types. Imagine that all people affected by tuberculosis feel the same as Castorp. Should one conclude that tuberculosis is not a disease just because people affected by it experience no distress or disability? Given current knowledge about its causes and effects on the human body, we find such a possibility extremely implausible. Similarly, should one conclude that syndactyly of the foot (webbed toes) is not a disease just because people affected by it experience little distress or disability? Again, we think that this would hardly be acceptable. So, from the bare fact that people diagnosed with conditions such as tic disorders experience no distress or disability, it should not be concluded that these conditions are not mental disorders.

Let us return to other conceptual reasons for excluding the harm requirement. One further involves disability. The main conceptual point about disability is that it is a relational, context-dependent condition, as it varies considerably with the environment a person lives in—this is the social model of disability that we briefly introduce above [43–45]. According to this model, a child with blindness, for example, can be either very disabled or minimally disabled depending on whether she lives in a familiar and instructive environment where appropriate learning tools and facilities are provided (in principle, given the right environment, she could even not be disabled at all). Analogously, a learning disorder such as dyslexia can be a highly disabling condition for children living in an environment where there are no resources providing her with suitable educational tools, while it might be a nondisabling condition for children who are adequately helped. Factors such as socioeconomic status, family links, occupation, and even artistic giftedness affect the degree of disability one experiences [46]. One of the advantages of this model is that it makes it possible to focus on what society can do for people with pathological conditions. Distinguishing disability from the mental disorder itself helps in identifying cases where proper environmental changes and provision of social resources, and not, say, individual therapy or medications, would make a difference to patients' conditions [44, p. 85]. By the same token, not distinguishing disability from the mental disorder

itself obfuscates the reality that, like blindness, a condition like dyslexia reflects a dysfunction, irrespective of one's living environment.

Moreover, distinguishing between being disordered and being disabled not only increases conceptual clarity, but also brings with it several types of practical, political, and ethical advantages. One practical reason for downgrading the harm requirement has to do with the status of psychiatry as a science. Including distress and disability as criteria for mental disorder would, in effect, serve to further distance psychiatry from the rest of medicine. The notion that the concept of disease must reflect its current use in somatic medicine and—more to our point—the idea that psychiatry should aim at becoming closer and more like the other specialties of medicine are both certainly contentious and contested, but they are also claims that can be backed with good reasons, having to do with theory [5, 28, 47], research [48], and health care issues [43]. In somatic medicine, harm—and, more specifically, distress and disability—is not considered necessary for a condition to qualify as a disease: lanthanic diseases, trivial diseases such as minor rashes, skin lesions, or moles, and very early-stage cancers are clear examples to this effect. Consider asymptomatic early-stage cancers, which cause neither distress nor disability—given the benefits of early diagnosis in terms of prognosis, imposing a harm condition would amount to preventing the possibility of treating and saving many patients. Similar considerations can easily be extended to mental disorders as well.

There is at least one political advantage to endorsing the conceptual link between mental disorder and disability. When disability was added to public health measures, which were previously focused only on mortality, mental disorders were eventually put on public health priority lists, and psychiatry received more attention [43, p. 82]. Here, however, we are not questioning the importance of knowing and communicating that mental disorders are significant causes of disabling conditions. What we are denying is a more specific and genuinely philosophical claim—namely, that harm should be a criterion for being a mental disorder, and for having one.

Of course, reflecting on the amount of harm a disease might bring about is important, as such considerations can impact on judgments about whether a disease should actually be diagnosed in practice or whether an aggressive or excessively expensive treatment is appropriate [49]; however, similar considerations should not impact on judgments—from a theoretical and metaphysical point of view—about whether or not a certain condition is a disease. The same reasoning can be applied to mental disorders: considerations about the amount of harm a mental disorder can bring about may influence decisions about its clinical diagnosis and treatment, but they should not impact on theoretical and metaphysical judgments about whether or not it is a mental disorder in the first place. More generally, distress and disability can be useful for distinguishing between clinical/therapeutic normality and anormality, not for distinguishing between health and disease or mental disorder, which is what is at issue here (see Boorse [7, p. 13] for further elaboration on this distinction).

A general objection could be raised here: while it is true that some mental disorders do not present *current* harm, they still have the *potential* to cause harm—as also stated in the *DSM-III-R*, *DSM-IV*, and *DSM-IV-TR* definitions of mental disorder [9, pp. xxi–xxii]. We think this objection is flawed for two reasons. First, the notion of harm is not suitable for explaining those conditions that are known to be

Journal : SmallExtended 11017	Article No : 9499	Pages : 17	MS Code : 9499	Dispatch : 4-9-2019

possible initial stages of other conditions which clearly have a negative impact on the life expectancy or quality of life of a person. In fact, the notion of risk factors, not potential harm, is used in other areas of medicine; this concept comes from epidemiology and has nothing to do with distress or disability. Second, the notion of potential harm inherits all the problems associated with the two components of harm (distress and disability) discussed above, as well as ambiguities in the very notion of harm—whose harm is relevant, and who should evaluate it?—which we discuss in the next section.

The harm requirement as a diagnostic criterion

In the previous section, we defended the choice of the *DSM-5* Task Force to downgrade the harm requirement from a necessary criterion within the general definition of mental disorder to a 'usually associated' characteristic of mental disorders that is not conceptually linked to them. In this section, we argue that listing the harm requirement among the specific diagnostic criteria for certain individual mental disorders is not only compatible with this choice but also potentially useful for various reasons, which we discuss below. However, it is necessary to disambiguate the concept of harm, as different uses and conceptions of harm may give rise to contradictory diagnostic judgments. At least two questions are worthy of consideration: (i) What is the role of the harm requirement as a diagnostic criterion? And (ii) with respect to whom, by whom, and how should distress and disability be judged and evaluated?

Let us start by assessing the different primary roles of the harm requirement as a diagnostic criterion. Why is it needed among the specific diagnostic criteria for certain individual mental disorders? (Of course, the following list is merely descriptive; that is, we surveyed the different roles that the harm requirement *does* play—or seems to play—in *DSM-5*.)

First, harm can help to mediate the current lack of relevant biological markers and clinically useful measurements of severity [2, p. 21; 45], thus helping to distinguish mental disorder from nondisorder and differentiate between mental disorder types. For instance, even if disability can be measured using the Disability Assessment Schedule (WHODAS 2.0) [50], it is worth noting that the concept of *severity* of disease, and not that of disability, is actually employed in somatic medicine in order to set thresholds for clinical significance. Severity is operationalized in terms of aetiology and/or symptoms, without considering specific activities that one may come to find difficult to perform. For example, the degree of severity for hypertension (mild, moderate, or severe) depends on blood pressure level; the severity of a tumour correlates with its stage of development and diffusion; and the severity of diabetes mellitus is measured by blood tests as well as degrees of complication. In general, disability is not compatible with severity measures, given that it is highly relational in nature [39; 43, p. 84]. That being said, severity can hardly be assessed for many mental disorders, at least given the current state of knowledge, and disability could thus provisionally fill this role. Consider anxiety disorders such as social anxiety disorder [2, p. 202]. Even if similar syndromes presumably reflect a

dysfunction, it is still unclear how one might assess the severity of such disorders and establish the right thresholds for demarcating normal and pathological anxieties. Put differently, when normality and pathology are on a continuum, and no biological markers or clinically useful measures of severity have been identified, the harm requirement—that is, the presence of distress or disability—can (provisionally) be used to distinguish between dysfunction and nondysfunction, between disorder and nondisorder. Similarly, focusing on the difference between mild and major neurocognitive disorders, the harm requirement seems to be used to recognize different grades of dysfunctionality, and thus to discriminate between types of mental disorders.

In other cases, the presence of a dysfunction might be more dubious, as with restless legs syndrome [2, p. 410], gambling disorder [2, p. 585], or some paraphilic disorders [2, p. 685]. Here the harm requirement can (provisionally) be used to supplement the current lack of knowledge about underlying dysfunctions, and thus to separate normal from pathological conditions. Of course, should it be found that in similar cases no dysfunction is actually in play, the condition under analysis would be expunged from the *DSM-5* nosology, even if it remains harmful, as the dysfunction requirement is taken to be necessary for mental disorders. This move, of course, would not exclude the possibility of continuing to treat such a condition, as clearly stated in the introduction to *DSM-5*: 'The diagnosis of a mental disorder is not equivalent to a need for treatment'; in particular, 'the fact that some individuals do not show all symptoms indicative of a diagnosis should not be used to justify limiting their access to appropriate care' [2, p. 20].

Finally, there are conditions where the presence of a dysfunction is quite clear, and thus the label of mental disorder should be applied following the general *DSM-5* definition. However, there might be good reason not to diagnose or treat some of these conditions in practice. Consider erectile disorder [2, p. 426] or female orgasmic disorder [2, p. 429]: even if a dysfunction is surely present, there might be no need to diagnose or treat these conditions as mental disorders in practice unless they cause clinically significant distress to or disability for the individual. In such cases, however, the harm criterion is used not to discriminate between normal and pathological conditions from a metaphysical point of view—that is, between mental disorders and nondisorders—but rather to discriminate between mental disorders that must actually be diagnosed or medically treated in practice and mental disorders that need not be. In this sense, as we mentioned at the end of the prior section, the concept of harm can be extremely useful for discriminating between conditions that are diagnostically or therapeutically normal and those that are diagnostically or therapeutically abnormal. In other words, harm is taken to be a necessary requirement for a definition of diagnostic or therapeutic abnormality [7, p. 13].

Let us continue by unpacking the harm requirement and clarifying with respect to whom, by whom, and how distress and disability should be judged and evaluated (again, the proceeding list is merely descriptive). We aim to show that the harm requirement can in reality be interpreted in many different and contrasting ways, making its current general wording—'the disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning' [2, p. 21]—ambiguous and problematic.

Journal : SmallExtended 11017	Article No : 9499	Pages : 17	MS Code : 9499	Dispatch : 4-9-2019

First, it is pivotal to clarify with respect to whom distress and disability—if present—should actually be judged and evaluated. At first blush, the most reasonable choice seems to be to assess the amount of harm, if any, that is directly experienced by the disordered subject. This is clear when considering mental conditions such as autism spectrum disorder [2, p. 50], schizophrenia [2, p. 99], bipolar disorders [2, p. 123], major depression disorder [2, p. 160], anxiety disorders [2, p. 189], or sexual dysfunctions [2, p. 423]; in all of these cases, if distress or disability is actually present, it directly harms the disordered subject. Other cases, however, are less obvious.

Consider mental disorders such as pyromania [2, p. 476], kleptomania [2, p. 478], or antisocial personality disorder [2, p. 659]. In these cases, the harm potentially experienced by the subject (e.g., being imprisoned, isolated from the community, and so forth) seems to be not only indirect—stemming not from the underlying dysfunction itself, but from the society the subject lives in—but also irrelevant to the diagnosis. In fact, the harm to assess seems to be that experienced by people other than the disordered subject (her family, her community, etc.). For instance, focusing on antisocial personality disorder, criterion A, 'a pervasive pattern of disregard for and violation of the rights of others' [2, p. 659], seems to be recognized as a symptom of a dysfunction, and thus of a pathological condition, when it causes harm to other people, not to the disordered subject. A similar point can be made regarding certain paraphilic disorders, where harm can be assessed either in relation to the disordered subject or in relation to people other than the disordered subject. With regard to sexual sadism disorder [2, p. 695], for instance, criterion B states that 'the individual has acted on these sexual urges with a nonconsenting person, *or* the sexual urges or fantasies cause clinically significant distress or impairment' [2, p. 695] (emphasis added); the use of disjunctive 'or' in criterion B leaves open the possibility of recognizing the syndrome as a mental disorder even when it causes harm only to people other than the disordered subject—that is, when 'the individual has acted on these sexual urges with a nonconsenting person', thus causing harm to that person, but does not subjectively experience any clinically significant distress or disability. Again, the subject can be indirectly harmed by the society she lives in (e.g., being imprisoned, isolated from the community, and so forth), but this kind of harm potentially experienced by the subject seems irrelevant for judging whether the syndrome is a mental disorder.

Second, it should be determined who is best suited to decide what exactly counts as distress and disability, as well as their respective threshold values. Sometimes it is reasonable to suppose that the disordered subject who is experiencing harm is most entitled to judge and evaluate this harm. Consider conditions such as major depressive disorder [2, p. 160], specific phobias [2, p. 197], social anxiety disorder [2, p. 202], most sexual dysfunctions [2, p. 423], or gender dysphoria [2, p. 452]. In the case of erectile disorder, for instance, the subject is clearly the only person entitled to make judgments about the amount of distress or disability he is actually experiencing. Some complications might arise, however, since in certain instances of the above mental disorders (e.g., in some cases of major depressive disorder), a medical specialist, like the psychiatrist, may be more capable of judging and evaluating whether or not the signs and symptoms experienced by the subject are pathological (again, given the current lack of other relevant biological markers or clinically

useful measurements of severity). Similarly, there seem to be some mental disorders for which harm can be better evaluated by a psychiatrist in the majority of cases: as when subjects are severely intellectually impaired (e.g., major neurocognitive disorders [2, p. 202]); when subjects' medical conditions may render them unable to recognize the harm they are experiencing (e.g., hoarding disorder or anorexia nervosa [2, pp. 247, 338]); or when subjects may be unable to recognize the harm they are causing to others (e.g., antisocial personality disorder [2, p. 476]).

Third, it is also critical to establish what kinds of standards should be used to evaluate distress and disability. Here, at least two alternatives seem viable: on the one hand, it is possible to have certain clinically 'objective' standards, as may be used for mild and major cognitive disorders [2, p. 202]; and on the other hand, it is possible to have standards that are largely context-sensitive. The latter may be used for hoarding disorder [2, p. 247], where distress and disability are also judged and evaluated on the basis of contextual variables, such as the kind of environment the subject is living in.

To recap, it could be pragmatically useful to include the harm requirement among the specific diagnostic criteria of many individual mental disorders, but only as long as its role is made explicit and its characteristics are better specified. These final considerations could suggest another way to defend, from a theoretical point of view, the necessity of the harm requirement for the general notion of mental disorder. One might say that the harm requirement just needs to be appropriately refined before being included in the general definition of mental disorder; should such refinement occur, the harm requirement could then be regarded as a necessary condition for mental disorder. We find this proposal quite problematic, however.

To start, we have shown that there are several mental disorders (as tokens or types) that can hardly be considered harmful. But let us assume for the sake of argument that there is a way to refine the harm requirement so as to encompass all of these, deeming them harmful in one way or another. In such case, of course, the harm requirement would not be as general as its present iteration (which includes just two relatively unspecific disjuncts), but would instead include many different more precise disjuncts. We feel, however, that this latter point strengthens the arguments we have developed in the preceding sections against the harm requirement as a necessary criterion for mental disorder: as the refined harm requirement would include a wide variety of disjuncts, it would be unfit to figure within the general definition of mental disorder, which needs a general definiens. Thus, it would make more sense to speak of numerous harm *requirements*, in the plural, that can be used as specific diagnostic criteria—at least given the current state of psychiatric knowledge—but do not figure in the general definition of mental disorder.

Tentative conclusions

In the present paper, we have sought to clarify what it means to say that the harm requirement is not necessary for the general concept of mental disorder and to explore arguments that may be advanced in favour of that position. As a preliminary point, we briefly considered the two conceptual components of the harm

requirement—namely, distress and disability—and traced a distinction between mental disorder tokens and mental disorder types. We then argued that denying the necessity of the harm requirement is not only in line with the *DSM-5* nosology but also extremely tenable for a variety of theoretical and practical reasons. Our main point here has been to demonstrate that the harm requirement should not be included within any general definition of mental disorder.

Given all this, two options are theoretically available: either the general definition of mental disorder must be dropped or, if one wishes to maintain it, the harm requirement must be downgraded from a necessary component to a frequent or typical characteristic of mental disorders. Other fields of medicine, such as oncology, do not feel the need to integrate their nosologies with a general definition of disease and have thus simply abandoned the definition and the effort; psychiatry, being a more recent field of medicine, still likely needs an operative general definition of mental disorder, and in this sense we support the decision of the *DSM-5* Task Force to downgrade the harm requirement, retaining the dysfunction requirement as the only necessary component of mental disorders.

Even if the harm requirement is not considered a necessary component of the general definition of mental disorder, we also believe that—given the current state of knowledge—it can possibly be maintained among the specific diagnostic criteria of certain individual mental disorders. That being said, we have also argued that, in such case, the requirement must be unpacked in order to clarify (i) what its precise role is as a diagnostic criterion and (ii) with respect to whom, by whom, and how distress and disability should actually be judged and evaluated in practice. Our aim in this regard has been to show that the harm requirement can be used and interpreted in many different and contrasting ways, making its current general wording ambiguous and problematic and—more importantly—making it unfit to figure within any general definition of mental disorder.

Notes

Although this paper was mutually conceived and discussed, Maria Cristina Amoretti should be considered responsible for the sections entitled ‘The harm requirement’ and ‘The harm requirement as a diagnostic criterion’, while Elisabetta Lalumera should be considered responsible for the sections entitled ‘Introduction’ and ‘Against the harm requirement’.

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Journal : SmallExtended 11017	Article No : 9499	Pages : 17	MS Code : 9499	Dispatch : 4-9-2019

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